Racial Disparity in Cancer Assistance

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Disparidade Racial na Assistência ao Câncer

Disparidad Racial en la Asistencia al Cáncer

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The effect of cancer on persons of all ages, races, ethnicities and sex affected by the disease is not similar. Genetic differences, hormones, environmental exposure and other factors can cause unequal risks in different groups of persons[1]. However, beyond the disease's burden, positive or negative cancer outcomes may occur arising from the type of care provided to the patient[2,3].

The country of origin, gender identity, sexual orientation, race or any other demographic feature of the patient should not influence cancer survival rate. Unfortunately, this is not the reality due to the disparities of cancer care for most of the Brazilian population[2,4,5]. Blacks (includes Blacks and Browns) according to the Census of 2022 account for 56% of the Brazilian population.

On October 23, 2023, the Ministries of Health and Racial Equality launched the Epidemiology Report of the Black Population – BESPN containing notifications of harms and diseases for this population, a portrait of the impact of racism as social determinant of health, exposing the vulnerability of the black population in regard to the access to the existing policies[3].

This was the first step of the actual implementation of the National Policy of Full Health of the Black Population (PNSIPN), an initiative of the Ministry of Health to face health disparities this population lives.

The correct response of race/color through the racial self-identification is the base and the first article of the PNSIPN, helping the formulation of strategies[3] to overcome the problems and monitoring of health indicators of the black population.

Since February 1st 2017, the identification of race-color on the patients' charts is mandatory, however, the poor importance given to this information is one of the many obstacles to meet this demand, possibly due to the complexity of interpersonal and institutional racism rooted in the society. It is paramount to increase the awareness of health teams to allow the correct response to this topic.

According to BESPN, the major concerns of public health are associated with non-communicable chronic diseases – among them, cancer responds for the largest part – responsible for more than half of the country's deaths. The disease's risk factors and protective measures are closely related to the population life habits as determinants of the population[3] health-disease process.

Black women with breast cancer have a 10-year survival rate 25% lower than White women, as a study published by "*Cadernos de Saúde Pública*" in 2018 concluded[4].

Mortality rate of Black women with breast cancer is higher than White women in USA, as the statistics show, although cancer screening is lower[1,2].

Black women have worst survival, worst optimal cytoreductive surgery and high platinum-resistant rates of ovarian cancer. Apparently, the most striking disparity is in cervical cancer with more than twofold the risk of death for Black than White women and sixfold than indigenous women. In addition, black women are less likely of being referred for genetic counseling or receiving genetic predisposition to cancer[1,2,4].

Racial disparities in cancer care are driven by a complex combination of existing inequities within and beyond the health system rooted in racism and its structural, institutional and interpersonal dimensions[2,5,6]. Black patients are more likely than White counterparts to be uninsured and to accessing health care that may limit access to screening programs and essential cancer treatments[2,4-6].

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Researches also suggest that hereditary risk and genetic determinants for specific subtypes of cancer may explain a portion of these disparities. This can be seen in higher rates of triple-negative breast cancer for Black women and increased likelihood of being diagnosed with high-grade and metastatic breast cancer compared to all other groups[1,2,4]. Some genetic determinants may influence susceptibility due to genetic variants or cancer-driven gene mutations in obesity, chronic inflammation, and immune responses. A rising area of cancer research is the analysis of tumor biological differences and its relation with race and ethnicity[2,4].

One of the objectives of this discussion is to evaluate whether there are differences of tumor response, tumor immunogenicity and response to treatments among Black and White patients. However, prior research has noted that tumor biological differences may contribute less to racial disparities in cancer outcomes compared to health care access barriers, and that there are no racial differences in efficacy of local or systemic therapy for breast, lung, or colorectal cancers[2,4-6].

Researches suggests that Black patients are less likely than White patients to receive stage-appropriate treatment or guideline-concordant care across multiple types of invasive cancers. Compared to White patients, Black patients are less likely to receive a lung cancer screening after receiving a referral to oncology centers, are less likely to receive a provider recommendation for lung cancer surgery, and are more likely to refuse surgery after it is recommended[2,6,7].

Black people also are treated less frequently with chemotherapy and radiation for colorectal cancer. For breast and gynecological cancers, Black women are less likely than White women to receive certain evidence-based workup procedures or guideline recommended treatments. Other studies have found that, compared to White women with similar treatment plans, Black women more often have delays in breast cancer treatment initiation[2,6,7].

These patients are more propense to report unmet demands for cancer treatment, including supportive care. Black patients have less access to specialized palliative care, receive less analgesics and are submitted more to end-of-life off label therapy. Unmet support care and socioeconomic needs are associated with poor adherence to cancer therapy in Black communities. Even after adjusting the differences of socioeconomic status and access to health system, studies show that North American native Black patients are more likely to perceive an unmet demand in cancer treatment than their White counterparts[6-8].

Beyond life insurance and access to healthcare, these data show that implicit racial biases and discrimination tend to contribute to disparities of cancer outcomes. A significant number of researches point out that biases, institutional and health professionals racism are drivers of health racial disparities contributing to racial differences at diagnosis, prognosis, treatment decisions and health care provided to Black and White patients[7,8].

These researches draw attention to the disparities resulting from communication and interaction among healthcare providers and patients. Improve health services to offer cultural and language-appropriate care and widen the diversity of the work force can help to abate health disparities as a whole.

At last, underrepresentation of Black population in clinical trials corroborate and perpetuate cancer racial disparity. Despite some initiatives, enrollment of Black patients in the trials remains negligible.

In USA, the country where the highest number of cancer clinical trials is conducted, only 3% to 5% of the patients enrolled are Black, which represent 14% of the population. In Brazil, unfortunately, these data are unavailable yet and national studies are necessary to investigate if diversity in clinical trials, a strong desire of the pharmaceutical industry, is actually being achieved.

Expand the diversity of participants in clinical trials and representativeness of minority groups is an important step to fight healthcare cancer disparities and ensure that everyone benefits from continuous advances of cancer treatment.

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