

**Ethnic Minority Disparities in Cancer Treatment:
Why the Unequal Burden?**

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**Hearing before the House Committee on Government Reform
Monday, September 25, 2000 at 1:00 pm
2154 Rayburn House Office Building**

Good morning, Mr Chairman and distinguished Members. I am Dr. Harold Freeman, and I am pleased to have the opportunity to speak with you this afternoon about the disparities in the diagnosis and treatment of cancer and the unequal burden of cancer among minorities, poor and underserved. This spring, Dr. Richard Klausner, Director of the National Institutes of Cancer (NCI), asked me to consult with him on these issues and asked if I would consent to become Director of NCI's new Center to Reduce Cancer Health Disparities. My experience as director of surgery at Harlem Hospital for twenty-five years (1974-1999) and as national president of the American Cancer Society (1988-1989), as well as my continued commitment to examining health disparities in cancer treatment were deciding factors in being offered and accepting this appointment.

Profound advances in biomedical science have occurred over the last several decades which for many Americans have contributed to increased longevity and improved quality of life. Despite this progress, a heavier burden of disease is borne by some population groups, particularly the poor and underserved. The unequal burden of disease in our society is a challenge to science as well as a moral and ethical dilemma for our nation. The scientific evidence is compelling - the incidences of cancer do vary among race and ethnic groups - but the number of those dying of cancer vary at higher rates among certain races and ethnic groups. The urgency for action to address these disparities is critical.

Ten years ago, I co-authored an article in the *New England Journal of Medicine* entitled "Excess Mortality in Harlem", in which we documented that a black male in Harlem had less chance of surviving to age sixty-five than a male in Third World Bangladesh. I regret to have to report that too little has changed during the past ten years for many members of the minority populations. Poverty, because of its many effects on resources, environment, behavior and attitude remains to this day to be a major driving force of excess mortality among minorities in this country.

In 1997, the President's Cancer Panel convened a meeting to discuss the meaning of race in science. We invited a number of nationally recognized scholars across many disciplines including scientists, philosophers, sociologists and psychologists. The group confirmed, what many of us had suspected, that race is a social construct which, as

applied to humans, is no longer acceptable and has no legitimate place in biological science.

Racial distinctions in science can provide us with evidence of significant variation in health and disease but this evidence must be interpreted, by examining the social, economic, cultural , and environmental factors in order to understand the underlying causes of the unequal burden of disease among groups.

To begin to examine this complex question of disparities in cancer treatment let us look at some examples of high quality peer reviewed studies published over the last two years.

In October, 1999, the *New England Journal of Medicine* published the results of a study that examined racial differences in the treatment of early-stage lung cancer among patients on Medicare. If discovered at an early stage, non-small-cell lung cancer is potentially curable by surgical resection. However, two disparities between black patients and white patients with this disease were noted in the study.

First, blacks were found to be less likely to receive surgical treatment than whites; and second, blacks were likely to die sooner than whites from this condition. The study further concluded that those black patients who did receive the surgical resection had a survival rate similar to white patients.

Subsequent studies published in the *Journal* indicated similar treatment disparities with respect to renal transplantation. Black patients were found to be less likely than whites to have been evaluated as candidates for transplants that have been shown to extend survival time and improve quality of life. Moreover, this past spring, an NCI-supported study published concluded that both black and Hispanic patients were less likely than white patients to be able to obtain commonly prescribed pain medications, because pharmacies in predominately non-white communities often do not carry adequate stocks of opioids.

Black Americans have a higher overall incidence of cancer, and a higher rate of death from cancer than any other racial or ethnic group. The findings of the study lead us to believe that in addition to these burdens, blacks are also inadequately treated for pain from cancer.

Dr. Klausner and I expect that the new NCI Center to Reduce Cancer Health will be at the forefront of our collective efforts to reduce disparities in health. We are grateful for the generous support Congress has provided NCI so the Center can move forward with its work.

Because minority communities carry an unequal burden of cancer-related health disparities, NCI is working to enhance its research, education, and training programs that focus on racial and ethnic populations in need. In my new position, I will have the unique opportunity to direct the implementation of NCI's ongoing efforts to reduce cancer-related health disparities, and find new ways to translate biomedical research discoveries into practice to reduce these disparities.

Even before I was appointed by Dr. Klausner as Director of the Center, the President's Cancer Panel began to tackle this problem. The Panel has undertaken a series of regional meetings across the country, with representation from every state, to explore in detail the obstacles which prevent us from getting the best available, state-of-the-art cancer care to all people, regardless of their racial or ethnic background.

In 1999, the Panel conducted a series of meetings survey the history and status of the National Cancer Program. Among the most important findings arising from that effort was the discovery that a crucial disconnect existed between the research and delivery enterprises associated with modern medical care. Programs of prevention and treatment that are recognized as effective were not being incorporated consistently into routine medical practice in all the diverse populations and neighborhoods of America. Correcting that shortcoming is vital to improve overall cancer care, access, delivery and quality.

Our Panel's forthcoming regional meetings, each with representatives from nine to twelve states, will include local community members with stories to tell; cancer survivors, employers, health providers, Medicaid officials, and others involved with cancer care will add immeasurably to our store of knowledge. We believe that much of what we will learn at the local and regional level will provide tools for us to address these disparities at the national level as well.

Among other things, we want to find out just who specifically are the under-served for cancer prevention and care in particular areas. Who are the vulnerable populations in each state or region? What factors are preventing patients with treatable cancers from receiving the most appropriate and up-to-date care? Why are people dying from treatable cancers, and who are they? What do states and communities need to do to provide proven interventions for cancer prevention and control? What policy and legislative changes need to be addressed to ensure that all people get appropriate cancer treatment services?

The unequal burden of health disparities among minorities will continue to be a vexing problem. We believe that through the efforts of NCI's Center to Reduce Cancer Health Disparities, working with all areas of the Institute, the President's Cancer Panel, and Members of Congress we will be able to focus national attention on developing policies to address this complex problem.

This concludes my remarks and I will be pleased to take any questions you might have.