Hidden Breast Cancer Disparities in Asian Women in the U.S.

According to the American Cancer Society, breast cancer is the second leading cause of cancer death in women, exceeded only by lung cancer. Breast cancer is also the most common cancer diagnosed among women living in the U.S. Nevertheless, within the United States, incidence rates vary significantly by racial and ethnic categories. Asian Americans have the lowest reported rates, but within this group, breast cancer incidence rates vary considerably by specific ethnicity. New research aims to disaggregate incidence rates by ethnicity and migrant status to more specifically detail the hidden breast cancer disparities in Asian women living in the U.S.

In the April 2010 American Journal of Public Health, Gomez and colleagues estimated trends in breast cancer incidence rates for specific Asian populations in California to determine if health disparities exist by immigrant status and age. Using new cancer and population data estimates for women by immigrant status, Gomez and colleagues found breast cancer rates were higher among U.S.-born Chinese and Filipina women (80% and 30%, respectively), than among their foreign-born counterparts, but similar between U.S.- and foreign-born Japanese women. U.S.-born Chinese and Filipina women who were younger than 55 years had higher rates than did white women of the same age.

U.S.-born Filipina and foreign-born Korean women had the largest increases in breast cancer incidence (4% annually) over time, and across all time periods, the highest incidence rate was observed for U.S.-born Filipina women diagnosed from 2000 to 2004, exceeding the rate for white women in the same time period.

Gomez and colleagues’ work benefits from earlier research that has shown immigrant status is associated with breast cancer risk through changes in both reproductive (higher age at first live birth, lower breast feeding rates, earlier onset on menstruation) and lifestyle factors (diet). These current findings offer greater detail on specific groups within defined populations and highlight a need for targeted cancer control and research within the Asian community.
U of M studies why some ethnic groups have higher lung cancer risk

Tobacco researchers at the University of Minnesota Masonic Cancer Center are teaming up with researchers at the University of Southern California and the University of Hawaii to figure out why African Americans and Native Hawaiians are far more susceptible to getting lung cancer from cigarette smoking than other ethnic and racial groups. The Masonic Cancer Center’s Stephen Hecht, Ph.D., will lead this five-year research study, funded with a new $10.7 million program project research grant from the National Cancer Institute (NCI).

This new study picks up on previous research published in the January 25, 2006 New England Journal of Medicine that noted while 85 percent of lung cancer cases can be linked to cigarette smoking, African American and Native Hawaiian smokers have the highest risk of getting smoking-related lung cancer.

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Heart failure affects nearly 5 million people in the United States and is the leading cause of hospitalization among Medicare beneficiaries. Despite progress in treatment, patients with advanced heart failure have only a 50% to 70% one-year survival rate, and hospice care is increasingly recommended in guidelines for such patients. Designed to provide comfort and emotional support to patients with terminal illness and their families, hospice care can offer substantial benefit to patients with terminal illnesses, including end-stage heart failure. Research by Givens and colleagues published in the March 8th *Archives of Internal Medicine* examines racial and ethnic differences in hospice use among patients with heart failure.

This study was an analysis of a national sample of 98,258 Medicare beneficiaries 66 years and older with a diagnosis of heart failure. Among those who used hospice care, a higher percentage of whites entered hospice care for heart failure treatment (18.5%) than blacks (14.1%), Hispanics (13.2%), and other racial and ethnic groups (15.8%). After adjustment for the aforementioned factors, African Americans had 41% lower odds of hospice use and Hispanics 51% lower odds of receiving hospice care than whites. Notable age differences in beneficiaries were found among the groups, with blacks and Hispanics being younger than whites and other groups.

Including this study, the research literature points to no single explanation for these disparities. In addition to the controlled factors of this study, cultural beliefs and values, a lesser likelihood of completing advance directives, inadequate access to information regarding end-of-life care, having less favorable beliefs about hospice care, preference for more aggressive treatments, a more pronounced lack of trust of physicians, and low health literacy have been found to partially explain racial and ethnic differences in end-of-life treatment preferences.

Populations differing by race, ethnicity, culture, gender, age, and disease states experience end-of-life care differently. Givens and colleagues research findings from the largest non-cancer study of hospice entry to date are significant because increased hospice use is associated with desirable individual outcomes such as increased quality of life for patients and their loved ones as well as societal outcomes such as decreased cost of care at the end of life. "Those findings imply that African American and Native Hawaiian smokers metabolize nicotine and tobacco carcinogens differently than whites, Japanese Americans, and Latinos,” Hecht said. “Our new research study will aim to find out why this appears to be the case.”
Director’s Report continued

presentations on the outcomes from previous grantees.

In collaboration with the Masonic Cancer Center, we welcome the 10 students that are joining us this year with the summer health disparities internships. The purpose of this federally-funded program is to provide paid summer job opportunities in cancer research and education to 10 undergraduates from minority and underserved communities in Minnesota. The individual research projects conducted with their mentors from last year are available on our website under the “Media” link.

During the end of July, a group of incoming first-year U of M Medical School students will begin the Introduction to Urban Area. This program, which is in its second year, was created by medical students to help orient incoming medical students to the challenges and opportunities facing medically underserved communities in the Twin Cities and offer opportunities for community engagement.

I hope you’ll enjoy reading this issue of The Connection, and we look forward to receiving any feedback or suggestions that you may have. Feel free to visit us on the Web or contact us at: phdr@umn.edu.

Fairly Healthy

What Role do U.S. Medical Schools Play in Eliminating Health Disparities?

by Rachel Hardeman, M.P.H., School of Public Health and Eduardo Miguel Medina, Medical School, School of Public Health

The article The Social Mission of Medical Education: Ranking the Schools examines how medical schools in the U.S. compare based on the following percentages: graduates practicing primary care, graduates practicing in an underserved area, and students from underrepresented minority communities. Published in the June 15, 2010 Annals of Internal Medicine, Mullan an colleagues used these criteria to create a composite index that allowed them to rank schools based on a metric called the social mission score.

The findings of the report are in stark contrast to traditional methods of ranking medical Schools such as U.S. News & World Report. For example, the three schools with the highest scores, Morehouse, Meharry, and Howard all rank lower in the traditional ranking scheme. Additionally, the study found “substantial variation in the success of U.S. medical schools in addressing these issues.”

The criteria used to establish the social mission score are all associated with a high quality, better performing, more just health-care system. The variability found in the rankings suggests that as a whole, medical schools are struggling to create the kind of workforce necessary to achieve a desirable health-care system.

The University of Minnesota Medical School is one of four large institutions in the top quartile of medical school recipients of NIH funding and of primary care output rankings. In addition, University of Washington and University of Minnesota are in the top quartile for overall social mission score.

U.S. medical education must bear the responsibility of producing the elements necessary for a high quality health-care system. The authors rightly note, “no other institution involved in creating physicians has as much influence as the medical school.” To date this burden has been shouldered unevenly. Eliminating health disparities will require a strong commitment by all schools to train future doctors to do the work necessary to eliminate the burden of unequal treatment and outcomes.