

Why Is Disaggregated Cancer Data Needed?

Recognizing the complex multilevel approaches necessary to address health disparities, the U.S.

Department of Health and Human Services in April 2011 released the first strategic plan to eliminate health disparities. A part of the plan is to enhance data collection and research because incomplete and poor-quality data on race, ethnicity, and language prevent a comprehensive and accurate assessment of the health disparities.



Examples below from recent studies highlight the heterogeneity of people within each of the racial and ethnic minority groups, and underscore the necessity to collect and analyze disaggregated cancer data so that community- and/or population-specific strategies can be developed and implemented to address cancer health disparities:

American Indian or Alaska Native

Compared to the American Indian or Alaska Native individuals living in the Northern Plains region, those living in Alaska were more than twice as likely to be diagnosed with colorectal cancer, but 45 percent less likely to be diagnosed with prostate cancer.

Asian

Compared to non-Hispanic White males, the risk of dying from stomach cancer was more than double for Chinese American males, but less than half for South Asian American males.

Black/African American

Compared to Black men born in the U.S., Black men who recently migrated from Africa were 76 percent less likely to die from lung cancer but 64 percent more likely to die from liver cancer.

Hispanic/Latino/a

Compared to the Hispanic women living in the continental U.S. and Hawaii, those living in Puerto Rico had a similar incidence rate of breast cancer, but 28 percent higher likelihood of dying from breast cancer.

Native Hawaiian or Other Pacific Islander

Compared to Native Hawaiian males, Samoan males were 66 percent more likely to be diagnosed with prostate cancer, but 34 percent less likely to be diagnosed with colorectal cancer.