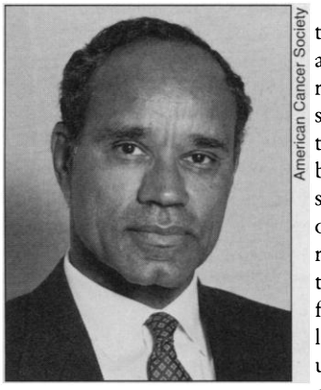
Does War on Cancer Equal War on Poverty?

Some new data suggest the answer is yes; blacks get more cancer not because they're black, but because they're poor

TWENTY YEARS AFTER RICHARD NIXON declared war on cancer, gains have been made on the research front, and some of those have been translated into promising new treatments, but too few of those discoveries are reaching those who most need them. In the neighborhoods inhabited by poor, uneducated Americans, the war is not going at all well: There you can find some of the highest rates of cancer not merely in the United States but in the world.



Harold P. Freeman

"The people who haven't benefited from the war on cancer are those people who don't have knowledge, who don't have resources, and who don't have insurance," says Harold P. Freeman, a Harlem Hospital surgeon who is the newly appointed chairman of the Cancer Panel named by another Republican president, George Bush. It has been known for almost 50 years that cancer is more prevalent among blacks than whites. But only now have researchers begun to disentangle the effects of poverty from those of race—and they're discovering that poverty is a more powerful determinant of cancer risk than race is. Blacks do have higher cancer rates, but it's becoming increasingly clear that that's because a disproportionate number of blacks are poor.

The new data tying cancer to poverty were much discussed at a recent meeting held at the National Cancer Institute (NCI). Also evident at the meeting was the attendees' frustration with the fact that, despite the five decades of data on blacks and the recent findings about the white poor, specific solutions aimed at reducing cancer rates among poor and black people still seem far from implementation—and that's where politics entered the picture. Doctors and scientists at the meeting criticized the Bush Administration for moving too slowly to provide medical insurance for all Americans and for failing to establish adequate educational programs that teach blacks and low-income families how to alter their diets and habits (specifically alcohol and tobacco, which the poor use out of all proportion to their numbers). Bush appointee Freeman acknowledged that, "We haven't done what America should do to allow its citizens a good chance of being protected from and cured of this lethal disease."

To turn around this national embarrassment, those attending the 1-day meeting reached an informal consensus for change. The prescription began with a call for better research. Several researchers noted the paucity of studies that have been carried out over the past 20 years to understand the specific factors related to poverty and low education that contribute to high cancer rates. No comprehensive research on low-income or minority populations has been published—other than the straightforward studies that simply characterize the incidence of cancer.

Indeed, it was data compiled from cancer registries in Atlanta, Detroit, and the San Francisco Bay Area from 1978 to 1982 that threw into question theories that there was something unique about blacks physiologically and culturally that made them more vulnerable to cancer. "For years, everyone's said yes, we know blacks have higher rates for cancer," says Claudia Baquet, NCI's associate director of the division of cancer prevention and control. "But we're saying if you adjust the figures for income and education, blacks actually have a lower rate."

Yet the new data didn't remove the issue of race from the table. One group of researchers not at the meeting (among them Lovell Jones at the University of Texas M.D. Anderson Cancer Center and Dileep Bal, chief of the chronic diseases control branch at the California Department of Health Services) says that cancer remains a problem of race—sociologically if not biologically. Black men, they point out, outnumber whites in poverty by three to one and also experience a 25% higher risk of contracting cancer than their poor white counterparts. And while black women show a lower incidence of breast cancer than white women, they nevertheless die from it more often.

Which leads to a second element of the prescription: ensure more income and education to the poor. But Baquet and other researchers say that may not be the answer, and they argue that more studies are needed to try to distinguish exactly which aspects of cancer incidence are due to race and which to poverty. What, for instance, happens to blacks born in poverty who improve their socioeconomic status later? Such questions won't be answered until results are in from in-depth, case-controlled studies where lower-, middle- and upper-income blacks and whites are interviewed about their diet, alcohol, smoking, and health care habits, as well as their socioeconomic and medical histories, says Jerome Wilson, director of biostatistics data management at Warner Lambert Co., who has helped launch one of four studies on black-white differences that are now under way at NCI, each focused on a different cancer.

While these results are likely to be years off, Freeman spoke for many at the meeting in arguing that the first defense against continuing high cancer levels among the poor would be to provide medical insurance for the 34 million to 37 million Americans who are "too rich to qualify for Medicaid, but too poor for Blue Cross." And there was a general call for better access to health care services.

Next was the call for a national education drive to teach Americans to prevent cancer by altering their diet, alcohol use, and smoking habits. This exists to a great extent today but meeting attendees pointed out that the current campaign would be more effective if educational materials were aimed at people with less than 6 years of education, and took into account differences in cultural attitudes about medical care and lifestyle habits.

Is any of this well-intentioned program likely to be implemented? Louis Sullivan, the secretary of the Department of Health and Human Services, told reporters he's committed to all of the above. "To really address the problem adequately, we must reform the health care system." But when asked about the status of his own health care reform plan at a press briefing last week, he gave a political answer: "I've consistently refused to attach a specific date. I won't be rushed into a decision before we have time for a comprehensive review."

That politician's maneuver proved frustrating to those, such as Freeman, who feel the problem is an urgent one that needs immediate attention. "The very fact that 37 million uninsured people don't get a fair shake speaks for itself," complained Freeman. "How can we morally and ethically accept the fact that we ration health care, and that people are dying?" ■ ANN GIBBONS