

# Overcoming Disparities in Cancer: A Need for Meaningful Reform for Hispanic and Latino Cancer Survivors

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**Key Words.** Cancer • Health equity • Latino • Racism • Survivorship

## ABSTRACT

Hispanic and Latino (HL) cancer survivors are at a critical disadvantage compared with non-Hispanic White (NHW) patients regarding sociodemographic adversities and access to equitable treatment options. By 2030, there will be about four million HL cancer survivors in the U.S., representing nearly 20% of survivors in this country. Hispanics and Latinos are subjected to significant challenges in accessing and receiving equitable care relative to NHWs. Hispanics and Latinos also experience lower rates of health insurance and financial resources, limiting health care options. These disparities often originate from disparate social determinants of health, including lower funding for education and school programs, greater neighborhood stressors and violence, lower access to healthy and affordable food, and greater barriers to community health and

exercise opportunities. Even among HL cancer survivors with proper access to health care, they experience disparate treatment options, including low inclusion in clinical trials and/or access to experimental therapies. A solution to these barriers necessitates complex and systemic changes that involve, for example, investing in public health programs, increasing the diversity and cultural awareness of the medical workforce, and promoting research opportunities such as clinical trials that are inclusive of HLs. Only through meaningful reform will equitable cancer care be available for all in the U.S. regardless of racial and/or ethnic background. This article reviews some of the critical social determinants of health and biases relevant to HL cancer survivors and provides recommendations for achieving cancer health equity. *The Oncologist* 2021;26:443–452

**Implications for Practice:** Hispanics and Latinos experience a significant and often disproportionate cancer-related burden compared with non-Hispanic and Latino White individuals and other racial and ethnic groups. Meaningful reform to achieve health equity in oncology should focus on approaches to gaining trust among diverse patients, cultural and community sensitivity and engagement in oncology care and research, diversifying the workforce, and improving inclusion in clinical trial participation. Taken together, these recommendations can lead to exemplary and equitable care for all patients.

## INTRODUCTION

Millions of Hispanics and Latinos (HL) diagnosed with cancer are at a critical disadvantage in regard to access to unprecedented advances in cancer therapeutics, personalized oncology care, and comprehensive survivorship programs [1]. The divide between state-of-the-art and cutting-edge cancer care available and the actual care received by many HLs with cancer continues to contribute to persistent disparities in cancer-related morbidity and mortality among HLs and Non-Hispanic White (NHW) individuals. In this review, we

discuss several of the social determinants of health and experienced interpersonal and systemic biases that can negatively impact cancer health outcomes among HLs and provide recommendations for meaningful reform that can help achieve health equity among HLs diagnosed with cancer.

The number of cancer survivors in the U.S. is projected to reach 22.2 million by 2030, many of whom will be HLs (~4 million) [1, 2]. We define HLs as individuals who come from Spanish-speaking countries and primarily those who

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are from Latin America [1]. As the second-fastest growing racial or ethnic minority group in the U.S., HLs experience a significant and often disproportionate cancer-related burden compared with NHW and other racial and ethnic groups [3]. Cancer is the leading cause of death among HLs, whereas heart disease is the leading cause for Black and NHW persons [4]. Hispanic and Latino individuals are also diagnosed with more advanced disease, which partly contributes to higher mortality across select cancers (e.g., colorectal, endometrial, liver, prostate, stomach, etc.) relative to other groups [5]. These disparities are both persistent and pervasive [4]. We do not repeat these troubling statistics but rather examine the contextual and systemic factors that contribute to and exacerbate these disparities. We identify critical areas in which change is needed, including recognizing how social determinants of health (e.g., access to care, language, health literacy) influence cancer outcomes among HLs; understanding the impact of systemic sociopolitical factors, including immigration and documentation policies which can adversely impact access to care; becoming aware of implicit and explicit biases, racism, and discrimination in care; rectifying inadequate inclusion of HLs in oncology clinical trials; addressing limited access to potentially life-saving experimental therapeutics or precision oncology care; and implementing strategies to overcome the staggering lack of racial and ethnic diversity in the oncology workforce. As we strive for equity for all, we have the moral and humane responsibility, and an urgent need, to ensure that all people have the opportunity to access comprehensive and equitable screening, treatment, and follow-up cancer care [6]. We close with a call to action for advancing cancer health equity and discuss specific strategies to reduce inequities in the cancer care of HLs.

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#### **SOCIAL DETERMINANTS OF HEALTH IN HISPANIC AND LATINOS: EFFECTS ON CANCER OUTCOMES**

The Centers for Disease Control and Prevention defines social determinants of health (SDH) as conditions in the places people live, learn, work, and play that affect a wide range of health and quality of life outcomes [7]. Disparities exist in these components across racial and ethnic groups [8]. Hispanics and Latinos are disproportionately affected by poor SDH, with significant and negative implications for their overall health and well-being [3, 9]. Poor SDH significantly impact access to, and quality of, cancer care and subsequent unfavorable clinical outcomes for patients in already vulnerable populations. There are vast documented disparities in clinical and patient-reported outcomes across most malignancies, with overwhelming evidence suggesting that HLs are at a critical disadvantage. Hispanics and Latinos, specifically, present with more advanced disease and have a poorer prognosis for several different cancers relative to NHWs [10–16].

#### **Socioeconomic Status**

Although cancer does not discriminate based on an individual's socioeconomic status, poorer cancer outcomes are well-documented among individuals with lower income,

low education, and lower rates of health insurance. Among HLs, socioeconomic status is related to poor cardiometabolic health (e.g., high blood pressure, dyslipidemia, insulin resistance, etc.), which can adversely affect overall health and cancer-related outcomes [17]. Education level is perhaps one of the most influential components in determining an individual's socioeconomic status [18]. According to the U.S. Census Bureau, less than 70% of HLs have attained a high-school diploma, relative to 90% of NHWs [19]. Only 16% of HLs have a bachelor's degree and 5% have a graduate or advanced professional degree compared with 36% and 14% respectively, in NHWs [19]. These disparities limit financial opportunities and create resource gaps. Furthermore, schools in areas with large HL populations receive less funding, a disparity that influences SDH and may impact cancer and general health outcomes [9, 20, 21].

#### **Health Insurance**

Hispanics and Latinos also have the lowest health insurance rate of any racial or ethnic group, with 34% reportedly without health insurance, more than twice the uninsured rate of NHWs [22]. Educational gaps drive the lack of health insurance as individuals with lower levels of education often hold jobs that do not provide insurance coverage or offer limited plans with significant out-of-pocket expenses. Language barriers and systemic discrimination also impact employment opportunities. Many first-generation HLs primarily speak Spanish at home, and nearly 30% report that they are not fluent in English [19]. Careers and jobs that provide proper or any type of health insurance are less attainable for individuals who do not demonstrate English literacy [23]. Hispanics and Latinos may also be deliberately discriminated against because of their ethnicity, and therefore may not be hired by employers [24]. A scarcity of resources for individuals and their families who have recently migrated to the U.S. often leads to challenges in learning English and securing dependable employment with suitable health insurance benefits [25, 26]. Poor health literacy and inadequate health insurance among HLs result, in part, from disparate and limited educational resources that yield fewer educational opportunities that subsequently limits job opportunities.

#### **Income**

The combination of education and literacy barriers faced by HLs contribute to lower household income. Income inequality, another prominent disparity in HL communities, has been independently associated with poorer health outcomes [27]. In 2017, median household income among HLs was \$50,400 compared with \$68,100 for NHWs, a more than 25% differences in wages [28]. Hispanics and Latinos have held low-skilled and low-paying jobs in disproportionate numbers, a finding that can be attributed to the previously described disparities (e.g., inadequate funding for quality education, underdeveloped programs to promote English fluency and literacy, etc.) [29]. Individuals with lower incomes have been shown to have a decreased life expectancy when compared with individuals of higher economic status, an alarming statistic that shows how the lack

of income equality in HLs can actually lead to earlier mortality [30]. Low income and low socioeconomic status have been linked to an increased stress state, which negatively affects health outcomes in HLs as well [31].

### Stress

Generally because of discrimination and financial burden, stress in HLs is present because of a variety of factors, including ethnic discrimination, language barriers, and acculturation challenges [32, 33]. Hispanics and Latinos also experience significant stress from racism, deliberate exclusion based on their ethnicity, and harassment because of their culture [34]. These stressors have been linked to poorer health-related quality of life and health outcomes [4, 35]. Collectively, the impact of stress from these factors can have harmful consequences and compromise overall adjustment, response to therapy, and survival [36]. Stress has also been linked to decreased neurocognitive function in elderly HLs, a factor that can contribute to poorer health outcomes and compromised cancer survivorship [37]. Additional research is needed, and is currently underway by the authors of this article, to increase the understanding of stress-related outcomes in HLs with malignancies, with particular emphasis on the design and implementation of interventions to ameliorate these disparities [38, 39].

### Neighborhood Context

Neighborhood context can contribute to significant ongoing stress with implications on health outcomes [40]. Financial inequities and inadequate school funding, as discussed above, can contribute to an increase in violent behaviors in some, but certainly not all, HL communities [41, 42]. The presence of neighborhood violence and crime can increase the stress burden in the HL community [43]. Furthermore, continuous stress-activation can have deleterious health and educational consequences, which can be traced back to, for example, a need for investment in equitable schools and educational programs for all children. The increase in neighborhood violence can also impact the ability of HLs to remain physically active and to exercise outside [43]. Whereas nonviolent neighborhoods are conducive to walks, engaging in exercise, and community activities in local parks, violent neighborhoods tend to enforce a sedentary lifestyle and an increased body mass index (BMI) [44]. This sedentary lifestyle, and increase in BMI, contributes to diabetes and cardiovascular and pulmonary disease and may have deleterious prognostic implications for patients undergoing treatment for malignancies [45], such as breast, uterine, prostate, and other cancers [46–48].

### Food Access

Finally, nutritional deficiencies resulting from an inadequate access to healthy and affordable nutrition, remain a constant challenge for HLs [49]. The U.S. Department of Agriculture has demonstrated that low-income and minority populations, including HLs, are more likely to live further from supermarkets, with lack of access to quality produce when compared with NHWs [50]. Additionally, individuals who live in areas with increased neighborhood violence, as described above, may be less able to access these

supermarkets, even if they are close to home, because of an inability to safely walk through their neighborhood to these markets [51]. The dearth of healthy, affordable, and accessible food leads to an increased intake of high fat, high carbohydrate, and low fruit and vegetable meals and a reliance on fast food restaurants [52]. This, in turn, can lead to adverse health effects including increased cardiovascular disease, and poorer cancer outcomes [53, 54]. Investment in community nutrition education and improved access to supermarkets and healthy food options is imperative to alleviate the long-lasting health disparities generated by living in a food desert or in communities without adequate access to healthy and affordable food [55].

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### INTERPERSONAL AND SYSTEMIC IMPLICIT AND EXPLICIT BIAS EFFECTS ON HEALTH EQUITY

Unconscious or implicit bias is defined as a bias that is activated unintentionally but silently influences a person's perception or behavior toward another individual; these biases can affect interactions between health care professionals and patients [56, 57]. For example, physicians caring for HLs may be less likely to arrive at a serious diagnosis or refer the patient to a medical specialist [58]. Providers may even be less likely to refer minorities to specialty services because of an implicit bias that the patient may not be able to pay for the additional services [58, 59]. Studies have also documented that pain and discomfort may be significantly undertreated in HLs [60]. Hispanics and Latinos are less likely to receive opioid analgesics than NHWs and are more likely to remain with untreated pain throughout their cancer treatment [61]. Physicians underestimate pain severity in more than 60% of HLs with cancer-related pain [61, 62]. Cancer-related pain in HLs is disproportionately underidentified and undertreated when compared with other types of pain [63, 64]. The disparities, however, also appear to be related to physician willingness to accept HL patients' assessments of their own pain, which may be an underreported pain severity because of inherent biases [65]. Additionally, it has been reported that some physicians believe HL pain should not be treated with opioids, because of concerns about addictions and potential tolerance, but these biases are unfounded and have no scientific validity [66]. Cancer-related pain is a critical phenomenon, and physicians must remain vigilant when treating HLs for malignancies to ensure that pain is identified and appropriately treated in all patients equally.

Hispanics and Latinos are also not proportionally represented or even included in most clinical trials at the same rate as NHWs, including the National Institutes of Health and U.S. Food and Drug Administration (FDA) trials, so generalizability of therapeutic interventions and therapeutic implications in regard to response and toxicities are limited for this demographic [67–70]. For instance, the FDA reports that HLs make up approximately 16% of the population but only 1% of enrollment in clinical trials [70]. Negative health care interactions, possibly fueled by past injustices or current implicit biases of providers and research programs, may lead to a distrust of the health care system and a decreased rate of enrollment in clinical trials [71]. However,

studies have also shown that HL physicians are less likely to recommend clinical trials to HLs relative to NHW patients [72]. Even when HLs are enrolled in clinical trials, they are more likely to not fully understand the aims of the clinical trial, perhaps because of cultural or language barriers, when compared with non-Hispanic patients, a concerning realization with substantial ethical considerations [73]. Clinical trials in cancer care are the gateway to medical innovation, and patients of all genders, races, and ethnicities must be equally represented in an effort to ensure the results are applicable to all patients [74].

#### SOCIOPOLITICAL FORCES IMPACTING ACCESS TO CARE

Although there are more than 60 million HL living in the United States as citizens or lawful permanent residents (e.g., green card holders), a significant proportion (~11 million) are undocumented and have unique challenges when accessing health care, particularly cancer care [75, 76]. Undocumented patients often lack health insurance coverage and are less likely to have a usual health care source or primary care physician to perform health-maintenance examinations or screen for malignancies [77]. This inequity is associated with a higher proportion of diagnoses at advanced stages of disease as well as a longer diagnosis-to-treatment interval among undocumented patients with cancer [78, 79]. Without health insurance, these patients are not able to access chemotherapy or surgical interventions because of their inability to pay, unless a patient is willing and able to pay substantial out-of-pocket expenses [80–82]. Additionally, undocumented HLs may be less likely to pursue medical care because of a fear of being reported to customs officials or being deported [83–86]. Inadequate insurance coverage and a fear of seeking medical treatment leads to a major disparity in cancer care for this subset of HLs and leads to increased morbidity and decreased overall survival in these patients. As an example, uninsured patients with breast, colorectal, lung, prostate, bladder cancer, or non-Hodgkin lymphoma have a much higher risk of death within 5 years of diagnosis compared with patients with health insurance (97% vs. 41%) [87].

#### ADDRESSING DISPARITIES THROUGH CULTURAL SENSITIVITY AND COMMUNITY ENGAGEMENT

Non-English speaking HLs may experience challenges engaging with health care professionals because of the language barrier, as many providers are English monolingual [88]. Despite efforts to use medical interpreters, patient navigators, or *promotoras*, these challenges persist and may lead to an inadequate patient understanding of illness and a barrier to engaging further with health care providers [89, 90]. Additional language barriers, including regional variability in spoken and written Spanish and stylistic nuances that vary across country of origin, can further complicate HLs' understanding of physician guidance and other medical information [91].

Ensuring adequate access to cancer care for all patients requires trust in the health care system and trust

that physicians and other providers will provide exemplary and equitable care for all patients [92]. Gaining the trust of racial and ethnic minorities, including HLs, often requires engaging community leaders to discuss specific actions the health care community can take to earn and sustain trust [93, 94]. Community organizations such as churches, civic groups, or other community gathering places provide a platform to congregate as well as discuss and deliver health education and services for HLs [95]. Hispanics and Latinos, especially first generation, may not always have access to available or affordable health care; therefore, an effort by physicians, community leaders, and patient advocates must be made to inform this population of available preventative, health-maintenance, and treatment services [96]. Additionally, HL communities may not have adequate representation on the leadership committees or boards of hospitals serving their community, and diversifying board and committee membership may improve community outreach and service delivery [97].

Once a community is engaged and local health care organizations have begun to earn their trust, it is important to draw upon community leaders to identify unmet needs or cancer concerns [98]. Patients in underserved communities, including those of HL ethnicity, appreciate being engaged in discussions about their health care needs [99]. For example, in some communities, patients may be interested in smoking cessation programs or screening for malignancies, whereas other communities may be concerned with opioid addiction, mental health, and sexually transmitted infections and preventing their spread [99, 100]. Through discussions with community leaders, health care providers can help empower patients to take an interest in their health care while also gaining the trust of HLs as discussed above [95]. Only through community partnerships, and establishment of community advisory boards, can HLs and providers achieve a health care system trusted by all and engaged with providing the needed services in a given community [101]. Additionally, sustained community-based engagement and investment in education and other programs have reciprocal benefit for providers and hospital systems as well [102].

Improved access to screening and preventative services is necessary to maintain a healthy community, especially with regard to access. Historically, HLs have had limited access to screening for cervical cancer because of many of the disparities and barriers to care discussed previously [103]. However, we have a precedent on how proper engagement can improve screening behaviors. Community engagement of organization representatives, clergy members, and business leaders, combined with increased patient education, has led to an increase in cervical cancer screening of HLs in recent years through the performance of Papanicolaou tests and pelvic examinations [104, 105]. Additionally, community-academic partnerships have been helpful to increase the acceptance of vaccinations for human papillomavirus virus among HLs in an effort to combat the causative agent implicated in cervical cancer [104, 106].



## CALL TO ACTION: RECOMMENDATIONS FOR ACHIEVING HEALTH EQUITY

### Diversifying the Oncology Workforce

Hispanics and Latinos are under-represented among practicing oncology clinicians and health care researchers. Less than 8% of practicing medical oncologists identify as HL, 3% of practicing radiation oncologists identify as HL, and HLs are under-represented in health research [107–109]. Diversity in the oncology research workforce catalyzes the scientific inquiry needed to problem solve the cancer-related inequities experienced by underserved populations. The lack of diversity among oncology professionals and researchers often translates to an under-represented mentorship among minority faculty, and fewer minority faculty members achieve academic promotions [110, 111]. From a clinical perspective, cultural mistrust and language barriers between patients and physicians can interfere with treatment decision making and, ultimately, care delivery. Diversity in the oncology workforce is crucial to fostering culturally competent care and education [112]. For these reasons, recruitment and retention of diverse clinicians and researchers is a first step toward achieving health equity and optimal health care for all patients afflicted by cancer.

Clinical training should encompass the diverse cultural and linguistic needs of the patient populations clinicians serve. Partnering with communities is key to understanding how best to support local programs and research led by the community to improve cancer health equity. Health systems should value and recognize faculty and staff who focus on community engagement and equity outreach. Moreover, given the time and resources required to develop meaningful partnerships with community organizations and effect change in local communities, institutional committees that evaluate promotion and tenure should consider these contributions to community engagement and equity outreach as tantamount to scientific scholarship when reviewing candidates. These incentives will continue to drive meaningful change in the oncology workforce, which will translate to decreased disparities encountered by HLs. We also recommend that health systems encourage and sponsor professional development opportunities in health equity research and mentorship and mitigate bias in the hiring of minority candidates. Increasing awareness and training to counteract implicit bias can promote culturally competent care and work toward decreasing disparities in HL patients [113, 114].

Enhancing the oncology education and support services pipeline is necessary to diversify the oncology workforce. More specifically, there is a need to increase the number of students and trainees from under-represented groups into clinical and research careers that will directly enhance cancer health equity. Increasing the opportunities for early career development and mentorship for under-represented students and trainees interested in cancer health equity will help strengthen the pipeline. The Partnerships to Advance Cancer Health Equity (PACHE), an initiative championed by the National Cancer Institute [115], provides federal funding for the development of partnerships between institutions

serving medically underserved populations and under-represented students and trainees [116, 117]. Pipeline programs funded through the PACHE, such as the Chicago Cancer Health Equity Collaborative Fellows Training Program, aim to increase the mentoring of minority trainees and early career medical faculty by providing cancer health equity research training opportunities and summer programs for under-represented students interested in careers in oncology [118, 119]. Career development support grants such as the NCI K01, which specifically target under-represented early-stage investigators in cancer, may also help diversify the pool of cancer researchers. The Redes En Acción program has also worked to facilitate opportunities for junior HL scientists to work on projects in cancer control [120]. Finally, it is worth noting that efforts are currently underway nationally to increase the diversity of nursing and medical schools to include more under-represented minorities in their student bodies [121, 122].

### Improving Diversity in Research

Minorities, especially Spanish-speaking HLs, continue to be under-represented in cancer clinical trials [123]. Study eligibility criteria, which may limit enrollment among patients with multiple comorbidities, can be a limitation to enrollment among minority patients with cancer, who are more likely to be diagnosed multiple comorbidities when compared with NHW patients. Fear of being assigned to a placebo or usual care condition are common reasons why patients may choose not to enroll in a clinical trial. This concern may be amplified among minority patients who may have less access to cutting-edge care. When possible, alternate approaches to placebo or usual care randomized trials should be considered to achieve equitable inclusion in cancer research. Additional considerations such as remote and multimedia consenting options and hiring of diverse and bilingual staff who reflect the patient population being enrolled are strategies that might help overcome barriers to enrollment in clinical trials [124]. Meaningful input on study design and support from community stakeholders may also lead to increased recruitment and retention of minorities in cancer research trials. Greater access to phase I and phase II trials may also lead to an increased enrollment in clinical trials, as these phases often do not include randomization, which can be a deterrent to enrollment among some patients.

More attention is needed to better investigate subgroups of HLs because of the heterogeneity of the population and differences seen across these different subgroups (e.g., Cuban, Mexican, South American, etc.), which may be confounded by socioeconomic status or lead to inaccurate conclusions when these populations are grouped together in as a single cohort [125, 126]. For example, Cuban Americans tend to have a higher socioeconomic status compared with Mexican Americans, and South American HLs have higher rates of gastric cancer because of a greater incidence of *Helicobacter pylori* [127, 128]. Both of these examples may impact cancer-related outcomes as described above, and large, nation-wide studies such as the Hispanic Community Health Study/Study of Latinos are needed to enroll a

demographically representative samples of HLs in the U.S. Increasing grant funding for diverse researchers is also an important initiative and has helped cultivate young investigators into leaders in the field of diversity research [129]. Black researchers, for example, are significantly less likely than NHW researchers to be awarded prestigious National Institutes of Health R01 grants. One explanation for this funding gap is that Black researchers propose grant topics focused on health disparities and social determinants of health [130, 131]. Nonetheless, there is a critical need for a prospective, HL cancer survivorship study that can delineate multilevel determinants of cancer and other health outcomes in diverse HLs.

### **Increasing Awareness and Changing Policies to Reduce Inequities in Health Care**

For oncology providers, the implicit biases we carry may affect patient-provider communication, referrals to specialists, underdiagnoses, and recognition and treatment of patient symptoms, like pain [64, 132]. Reducing the effect of these implicit biases requires awareness, gained through reflection, discussion, and education. For example, just as checklists aligned with quality care metrics have improved the safety and quality of care in surgery and other procedures, quality care checklists can be developed for discussions about clinical trials and treatment decision making to ensure that each patient is provided with adequate information, prompting questions and allowing time for discussion [133, 134]. Similarly, for referrals to specialists, financial support services may exist that can provide options or other resources if cost is a potential barrier [135]. Without equitable cancer diagnoses or referrals to appropriate specialists, HLs will receive inadequate care that may affect chemotherapy regimens, radiation therapies, or surgical options [136]. Appropriate treatment for malignancies requires timely discovery of the cancer, prompt workup and multidisciplinary evaluation of disease, and swift intervention to halt progression and eliminate disease [137]. With delayed diagnoses and fewer referrals, HLs are at a disadvantage in cancer outcomes.

Within systems that provide oncology care, those responsible for writing, reviewing, and implementing policies can consider whether existing structures ensure equity in access and quality. For example, health systems can conduct a language audit to determine the areas of cancer care in which more robust language support and translation are needed. These types of language audits are especially important given the rapid uptake of novel health information technologies in ambulatory care. Most patient-facing electronic health portals, for example, are not available in multiple languages. Furthermore, after-care-visit summaries that are provided to patients are not often available in more than one language or designed for patients with low health literacy who might prefer graphical instructions. When possible, pairing patients from a particular cultural background with providers or translators of similar ethnic origins [138] can enhance the quality of care by increasing trust in the medical system, promote greater patient understanding, and lead to improved health outcomes, including oncologic outcomes, in HLs [139, 140]. With a better

understanding of their disease, treatment algorithms, and prognoses, HL can then make informed decisions about their care and feel empowered to guide their own treatment, helping to overcome the large disparities often present. The benefits afforded by pairing a patient with a member of their ethnic background may be partially due to alleviating language barriers, but studies have shown that additional cultural factors help to improve patient comfort as well [88]. Hispanics and Latinos identify more with health care providers of similar cultures, family beliefs, and religions because of a bond formed through shared experiences [140]. Similar preferences in health care providers have been noted throughout many sociodemographic groups, such as pediatric male patients preferring male physicians and pediatric female patients preferring female providers [141]. Patients often find solace in providers who are similar to themselves, and this can be especially important when considering care for malignancies, which evoke a strong emotional response and may create exceptional stress [139]. When facing particularly important decisions, such as chemotherapy regimens, surgical interventions, or whether to pursue treatment at all, HLs, especially Spanish-speaking HLs, may prefer to be cared for by culturally competent providers who understand their beliefs and speak their language [138]. These preferences should be facilitated to achieve the best possible outcomes.

Health care systems can also review metrics such as time between diagnosis and treatment based on different patient populations and evaluate whether specific groups experience longer diagnostic delays. Finally, with the significant financial burden of cancer care, health care systems are urged to employ allied health professionals who can support patients in identifying resources. Patient navigators can provide critical support to patients in terms of overcoming transportation and financial barriers and increasing accessibility to medical services to seek timely cancer care [142]. Other innovative examples include specifically trained financial navigators that can provide guidance on managing financial or immigration barriers among patients with cancer [143]. Although adding these types of positions and structures does cost money, over time, the improvements in care, adherence, and potential reduction in the need for emergency care provide a return on investment [144].

### **CONCLUSION**

This report provides a synthesis of the driving forces that influence inequity in cancer care and related outcomes and recommendations for achieving cancer health equity in HLs. We urge both the individuals who provide care for HLs with cancer and the institutions in which they work to engage in individual and system level reflection, policy review, and implementation of practices and procedures that are equitable such that they do not systematically disadvantage any one race or ethnic group. Although there are some cultural barriers that provide challenges for HL to interface with the medical system, many of the challenges originate from systemic inequities that make it very difficult for HL to access adequate health care. Community engagement and

improving cultural awareness and sensitivity are paramount in guiding HLs into the health care system to receive appropriate care or malignancies and other medical maladies. Programs that increase physician and nursing diversity, and recruitment of minority candidates to graduate programs, empower HLs to engage with their patients in a culturally competent manner and promotes trust in our health care system. Additionally, initiatives to increase funding for cancer studies and trials to include HL help to ensure that treatments will be efficacious to all patients. Although HLs face significant disparities in oncologic care, meaningful reform has begun and must continue to ensure equitable care for all who live and work in this country.

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## DISCLOSURES

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