

Snapshot of Cancer in New York

I. Introduction – The Burden of Cancer

In 2015 . . .

111,951 New Yorkers were diagnosed with cancer²

35,088 New Yorkers died of cancer²

1,043,900 (estimated) living New Yorkers had ever been diagnosed with cancer¹

The burden of cancer in New York is considerable.

Each year, over 110,000 New Yorkers learn they have cancer, and about 35,000 succumb to the disease, making it the second leading cause of death in the state. In 2015, the overall cancer incidence rate of 482.0 cases per 100,000 persons in New York was the fourth highest among the 50 states and the District of Columbia, significantly above the national average of 437.7/100,000².

Cancer affects not only the people with the disease, but their families, caregivers and entire communities. People with cancer must contend with the effects of the disease and its treatment on their health, well-being, family and social relationships and economic productivity. Accessing and affording quality health care can also be a struggle for many families. Issues related to cancer and cancer control account for significant allocations of the resources of many community, public health and health care organizations.

The burden of cancer is not distributed evenly. Risks of developing or dying from various cancers often differ for people of different racial or ethnic origins or socioeconomic backgrounds. Much of these disparities are related to differences in lifestyles and behaviors and in the environments in which people live, work, and play. Such factors as economic resources, insurance status, language, and geographic location may affect access to preventive and diagnostic services and medical treatment.

II. Demographics of New York

New York is notable for both its size and its diversity. With a population approaching 20 million³, New York is the fourth most populous state in the nation, after California, Texas and Florida. These 19.8 million persons are spread out over a land area of 47,126 square miles, the largest in the northeast.

Extremes of population density

over 69,000 persons per square mile in
Manhattan (New York County)

2.8 persons per square mile in Hamilton
County (Adirondack Park)⁴

People in New York, however, are not spread out evenly. Although much of New York's population is concentrated in the metropolitan area comprising New York City and its suburbs, there are sizeable rural regions upstate where distance can be a barrier to accessing health services.

New York is home to persons of various races and ethnicities in significant numbers. In 2016, 55.5 percent of the population were estimated to be non-Hispanic white, 19.0 percent Hispanic (of any race), 14.3 percent non-Hispanic black, and 8.4 percent non-Hispanic Asian⁵. In addition, 22.6 percent of the population was foreign born³, and 30.4 percent spoke a language other than English³. Cultural factors associated with race, ethnicity and national origin can have an important impact on cancer risk factors, attitudes towards disease, and interactions with health care providers.

Access to medical care is an important determinant of cancer-related morbidity and mortality. In 2016, approximately 8 percent of New Yorkers 19 to 64 years of age were without health insurance, and 21 percent reported Medicaid as their primary source of health care coverage⁶. In October 2017, there were 3.0 million New Yorkers ages 21-64 enrolled in Medicaid⁷, or about 26 percent of the population in this age range.

Other population characteristics affect the burden of cancer in New York and measures taken to address it.

- 14.7 percent of New Yorkers (approximately 2.9 million) have incomes below the poverty level³,
- 65.3 percent of New Yorkers age 25 and over (approximately 8.8 million) do not have bachelor's degrees³,
- 14.1 percent of New Yorkers age 25 and over (approximately 1.9 million) do not have high school diplomas³, and
- 11.1 percent of New Yorkers (approximately 1.6 million) report poor mental health⁹.

All of these features of New York's population affect cancer prevention and control efforts. Public health and community organizations, health care providers, policy makers, advocates and health systems will need to ensure that cancer services across the continuum of care are available and accessible for all populations. Particular efforts to promote health equity among the most vulnerable populations are needed.

III. Cancer in New York

Leading types of cancer in males and females

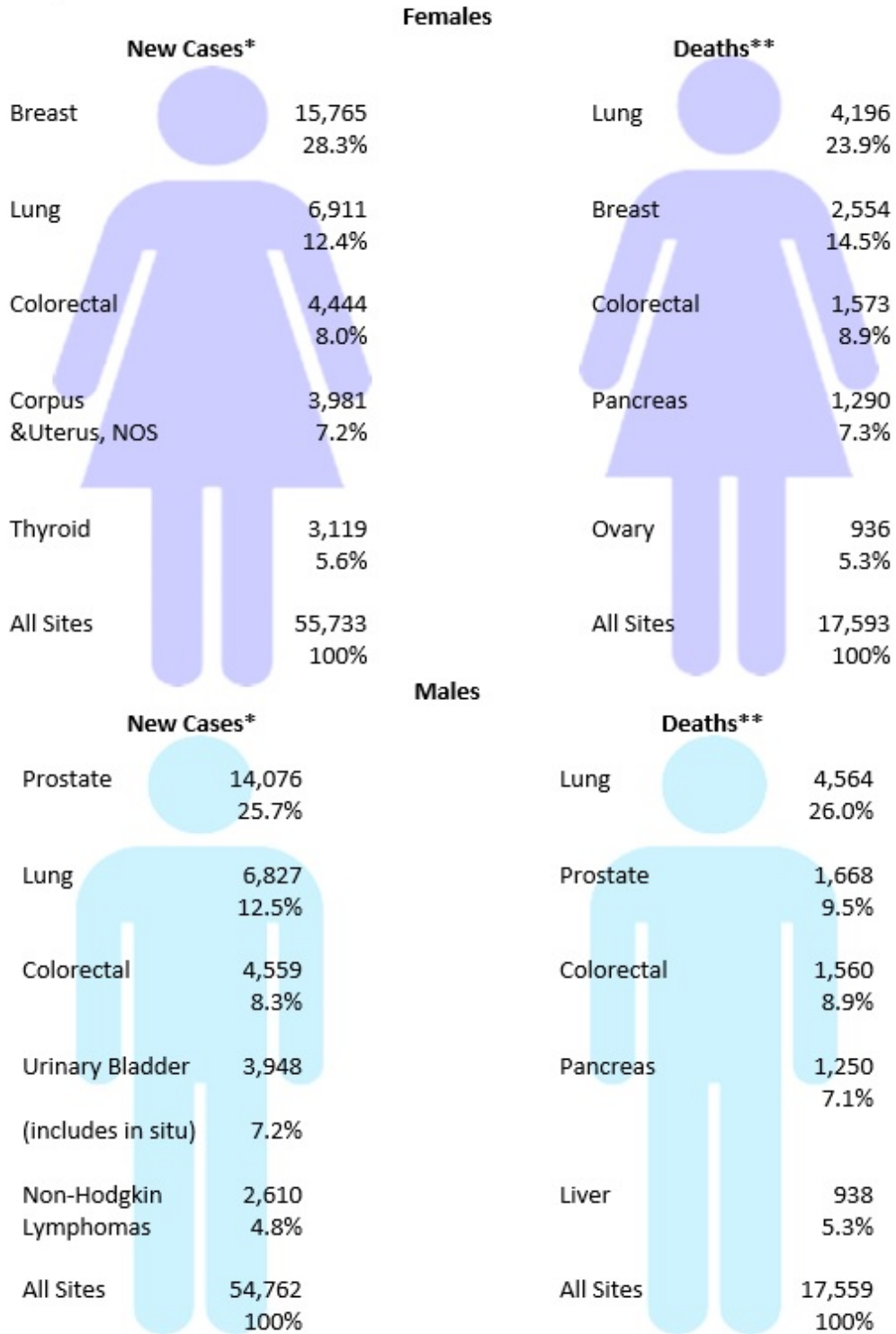
Cancer is not a single disease, but a collection of over 100 different diseases, each with its own set of causes, occurrence pattern, natural history, effective treatments, and outlook for survival. Although cancer occurs in both males and females, the types of cancer males and females are most likely to develop, and are most likely to die from, are different. The five most frequently diagnosed types of cancer and the five leading causes of cancer deaths are illustrated in Figure 1 for males and females.

Trends over time

The number of people in New York diagnosed with cancer each year has been increasing steadily. In part, this is due to increases in New York's elderly population, persons who are more likely to develop cancer. To account for differences in the size and age distribution of populations, statisticians calculate age-adjusted cancer rates. Age-adjusted cancer incidence and mortality rates are measures of the risk of developing or dying from cancer that can be compared across populations, regardless of their age distributions.

Cancer rates change over time. Cancer incidence rates can change due to changes in the prevalence of cancer risk factors and the underlying occurrence of the disease, but also because of changes in cancer screening and clinical practices. Cancer mortality rates are affected by the occurrence of the disease in the first place, and also by the effectiveness of screening and treatment. Figure 2 tracks the most frequently diagnosed cancers and Figure 3 tracks the most frequent causes of cancer death in males and females combined (except where noted) in New York State between 1995 and 2015. Cervical cancer is included as well due to its interest for cancer screening.

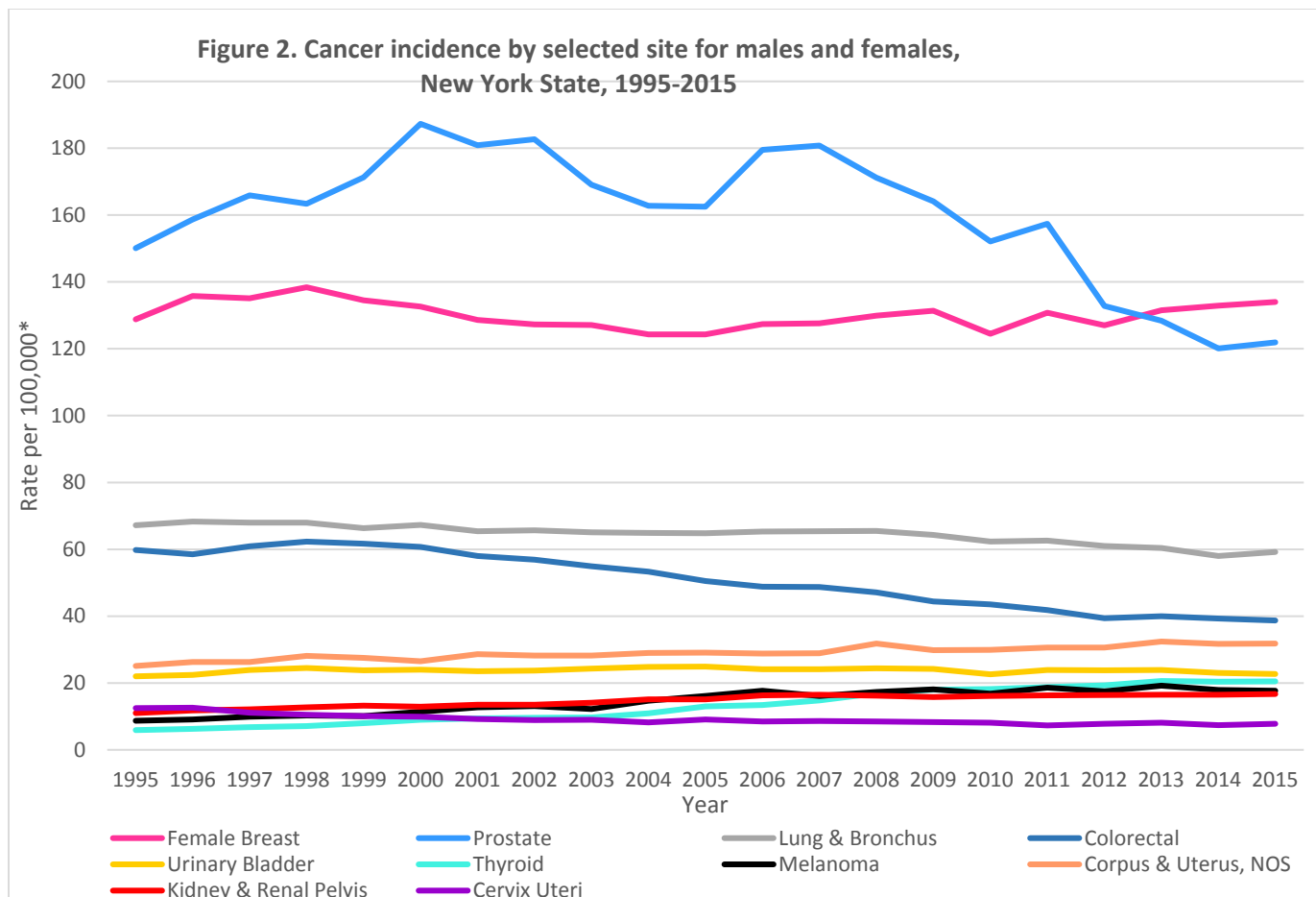
Figure 1. Most frequently diagnosed cancer types and causes of cancer death in males and females, New York State, 2011-2015



*Average annual incident cases, New York State, 2011-2015

** Average annual deaths, New York State, 2011-2015

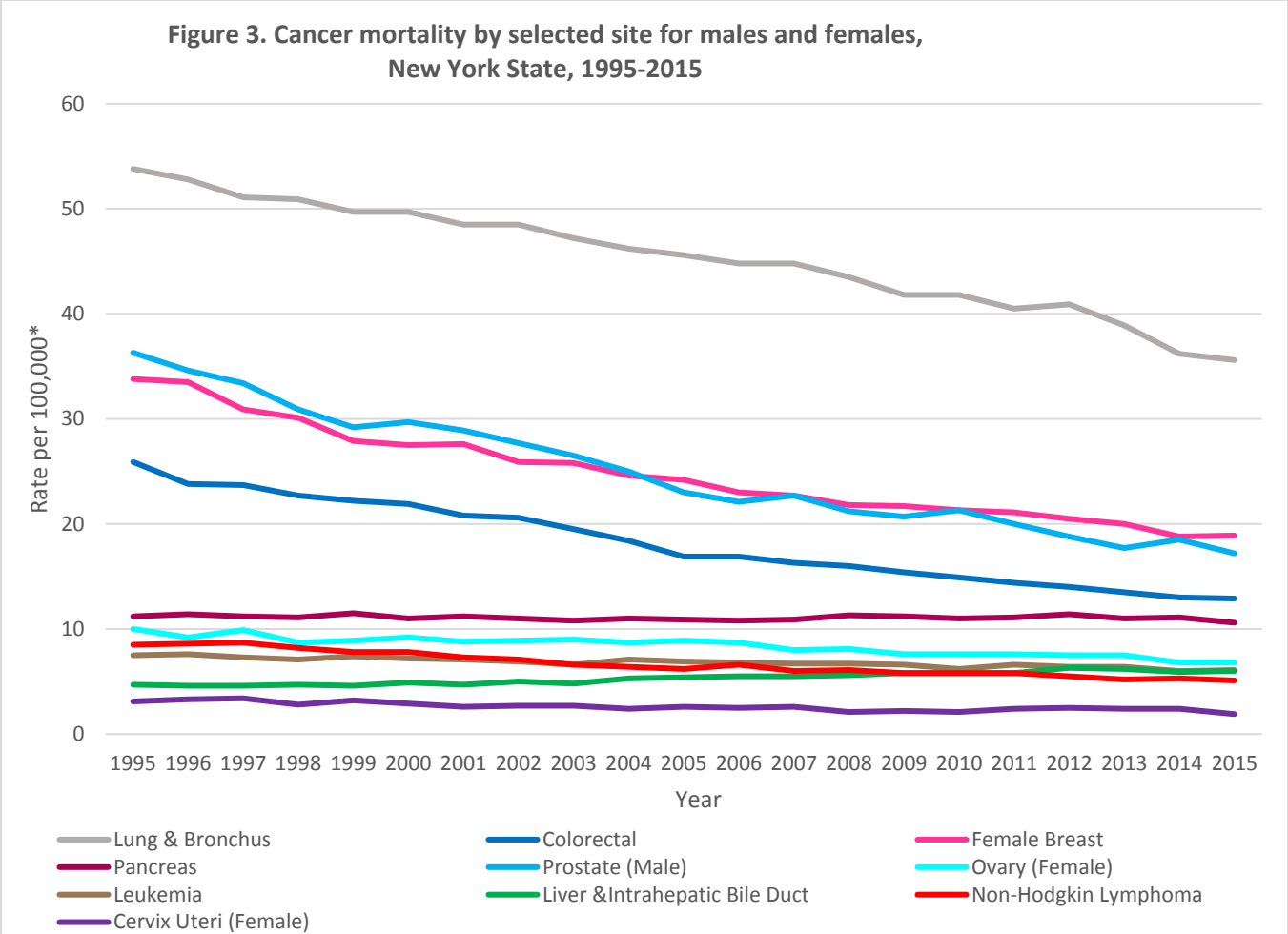
Source of data: New York State Cancer Registry



* Age-adjusted to the 2000 U.S. standard million population

Source of data: New York State Cancer Registry

- Prostate cancer incidence rates have been decreasing since 2007. Female breast cancer became the most frequently diagnosed cancer in New York State in 2013.
- For males and females combined, rates of kidney cancer, melanoma, and thyroid cancer are increasing. In females, the rate of cancer of the uterus is increasing.
- The overall incidence of lung cancer has been decreasing since 2008, although incidence rates in males have been decreasing since 1995 while rates in females only began to decrease in 2008.
- Colorectal cancer has been decreasing since 1999, cervical cancer has been decreasing since 1996, and urinary bladder cancer rates have been trending downward since 1998.



*Age-adjusted to the 2000 U.S. standard million population

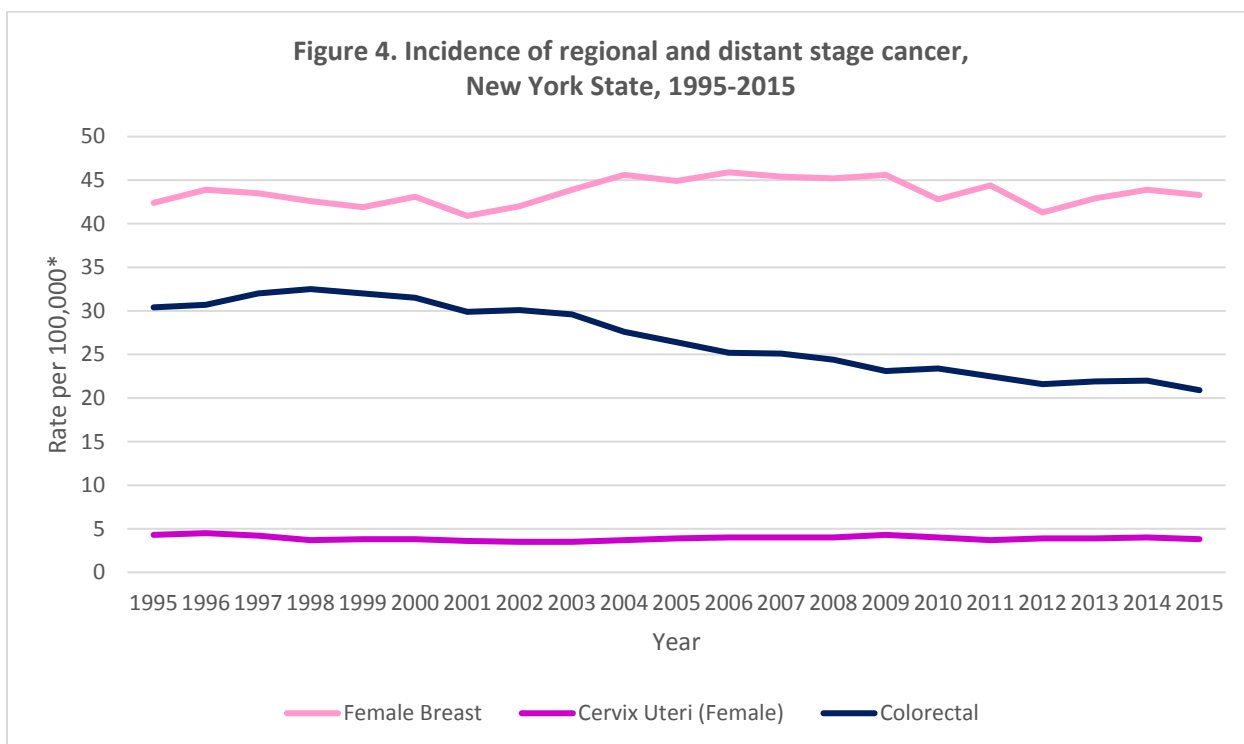
Source of data: New York State Cancer Registry

- Death rates for the leading causes of cancer death, including lung, prostate, female breast, and colorectal cancers, have been steadily decreasing. Death rates for non-Hodgkin lymphoma, leukemia, and, in females, ovarian and cervical cancers have also been declining.
- Pancreatic cancer mortality rates have remained steady over the last 20 years.
- Liver cancer mortality rates are increasing.

Stage of cancer at the time of diagnosis

Stage of disease refers to how far a cancer has spread at the time it is diagnosed. Generally, the earlier a cancer is diagnosed, the greater the chances for survival. Cancers diagnosed at a local stage of disease are confined to the organ where they started growing, while regional stage disease has spread to nearby organs or lymph nodes. Cancers diagnosed at a distant stage, where cancerous cells or tumors have spread to other parts of the body, confer the least favorable outlook.

Cancer screening is intended to detect cancers at their earliest stages, when treatment is most effective. Screening increases the proportion and rate of early stage cancers, but ultimately reduces cancer deaths. Some screening tests, such as colonoscopy for colorectal cancer and Pap smears for cervical cancer, can also detect pre-cancerous lesions, which are removed before they become cancer. This reduces the incidence of cancers at all stages and also reduces cancer deaths. In either case, increased utilization of cancer screening would be expected to reduce the incidence of cancers diagnosed at later stages. Figure 4 illustrates changes with time in the incidence of regional- and distant-stage disease for three cancers for which screening tests have been widely used (female breast cancer, cervical cancer and colorectal cancer). Screening of high-risk individuals for lung cancer by means of helical low-dose computed tomography was first recommended in 2011, and the procedure has been covered by New York’s Medicaid program since 2015.



*Age-adjusted to the 2000 U.S. standard million population

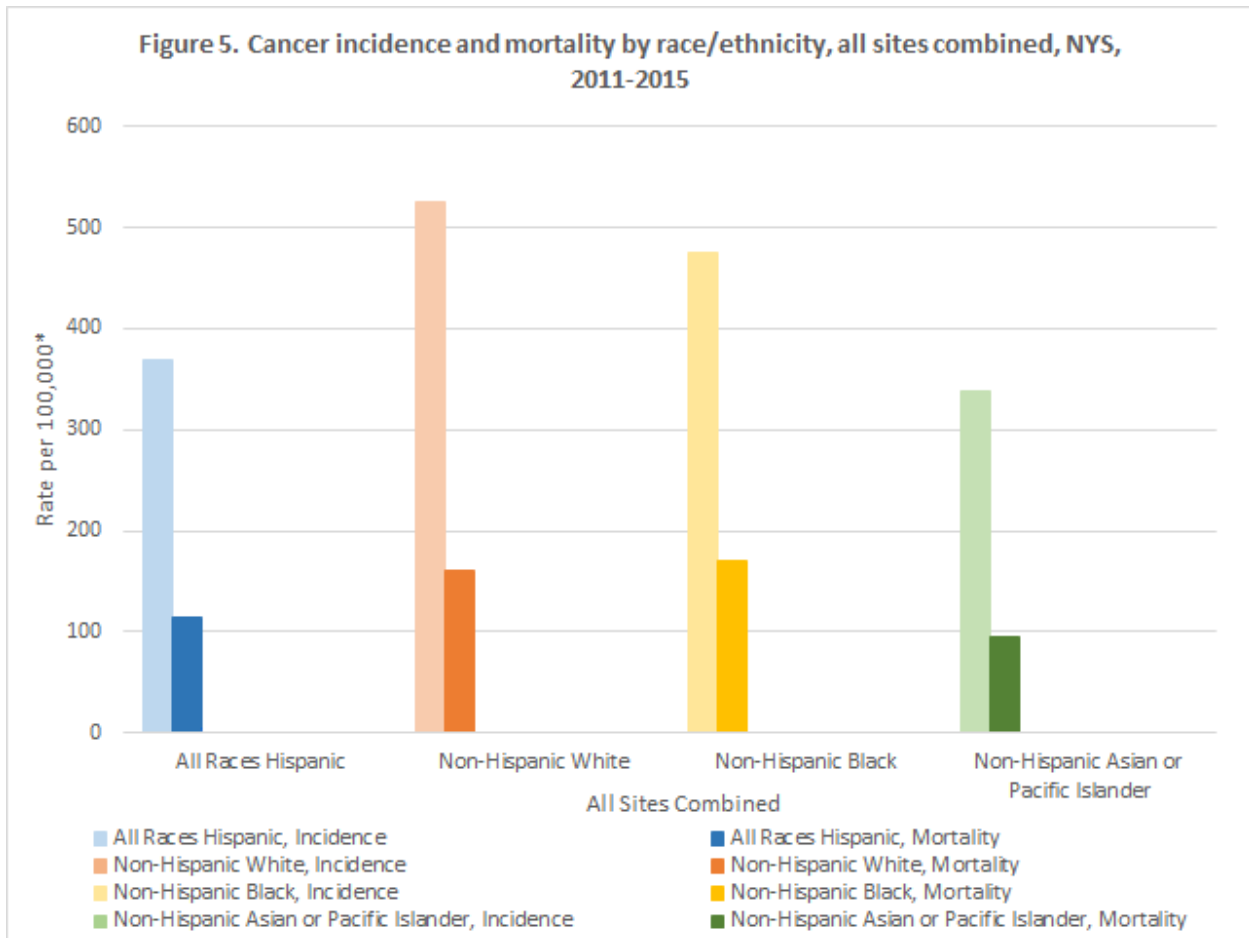
Source of data: New York State Cancer Registry

- The diagnosis rate of regional and distant stage colorectal cancer declined between 1999 and 2015.
- Regional and distant stage female breast cancer rates declined between 1996 and 2001, and between 2004 and 2015.
- Regional and distant stage diagnosis rates for cervical cancer declined between 1996 and 2002, and have remained steady since then.

More data on cancer in New York may be found at the web site of the New York State Cancer Registry at <http://www.health.ny.gov/statistics/cancer/registry/> .

IV. Cancer-Related Health Disparities in New York

The National Cancer Institute defines cancer-related health disparities as “differences in the incidence, prevalence, mortality and burden of cancer and related adverse health conditions that exist among specific population groups. These groups may be characterized by gender, age, race, ethnicity, education, income, social class, disability, geographic location, or sexual orientation.”⁹ Information on cancer outcomes in different groups can be used to focus cancer control efforts on those in greatest need, and to help understand and address the causes of these disparities. Figures 5 and 6 illustrate differences in cancer incidence and mortality for all types of cancer combined and for selected cancer types in New Yorkers of different races and ethnicities.

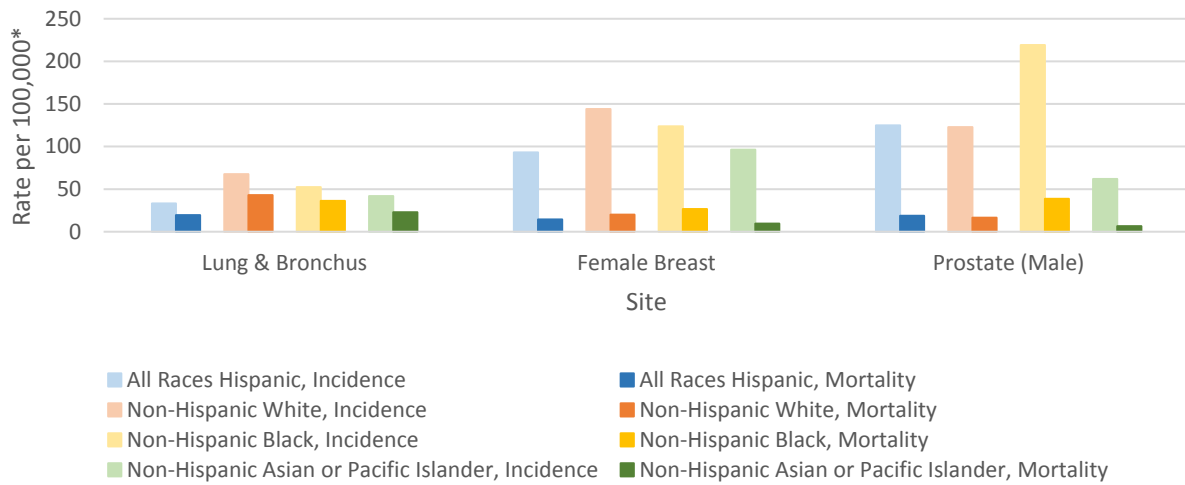


*Average annual, age-adjusted to the 2000 U.S. standard million population

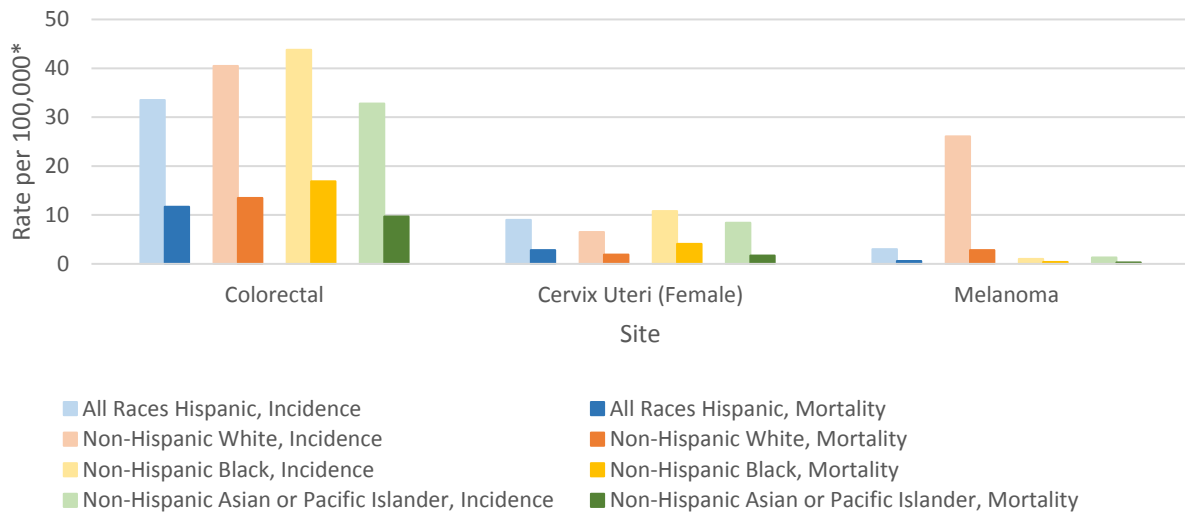
Source of data: New York State Cancer Registry

- Non-Hispanic whites have the highest rate of newly diagnosed cancers in New York State.
- Non-Hispanic blacks have the highest rate of death from cancer in New York State.
- Cancer incidence and mortality are lower in persons of Hispanic origin, and in non-Hispanic Asians and Pacific Islanders.

**Figure 6. Cancer incidence and mortality by race/ethnicity,
New York State, 2011-2015
a. Lung & Bronchus, Female Breast, Prostate (Male)**



b. Colorectal, Cervix Uteri (Female), Melanoma

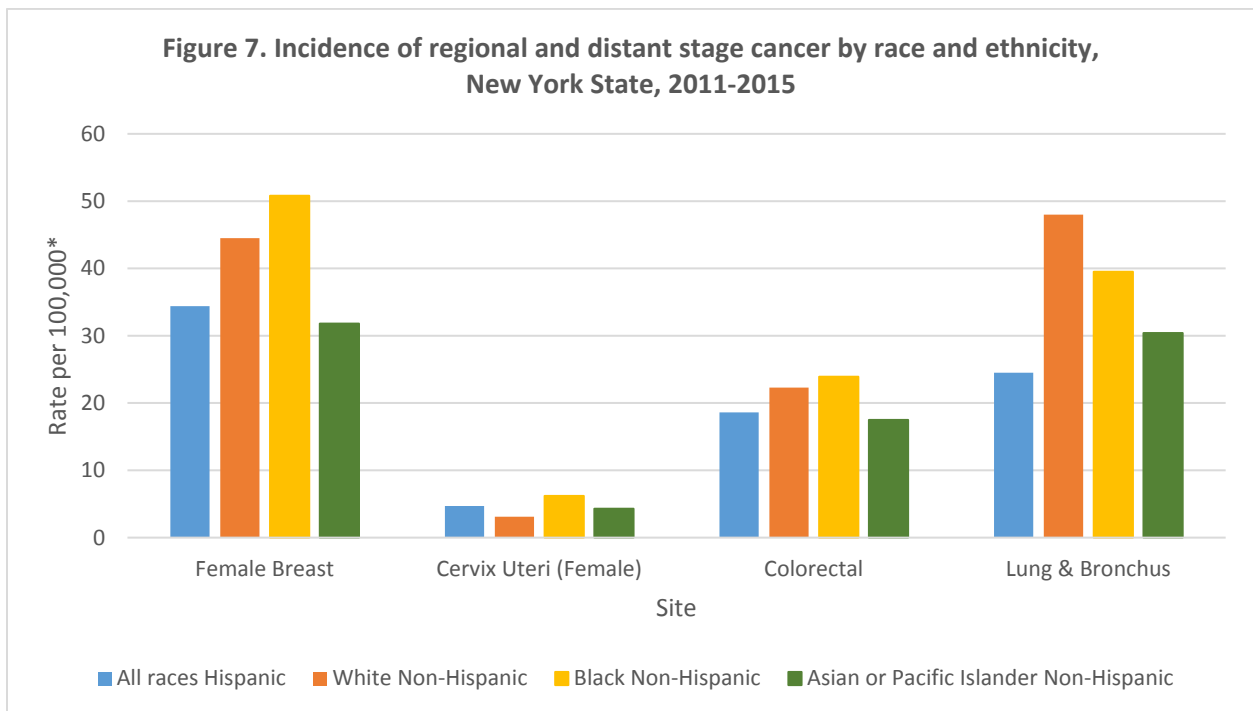


*Average annual, age-adjusted to the 2000 U.S. standard million population
Source of Data: New York Cancer Registry

- Different cancers have different patterns of incidence and mortality by racial/ethnic group.
- Non-Hispanic black males have by far the highest rates of prostate cancer incidence and mortality of any racial/ethnic group.
- The incidence of breast cancer is highest among non-Hispanic white women, while mortality is highest among non-Hispanic black women.

- Lung cancer incidence and mortality rates are highest among non-Hispanic whites.
- While non-Hispanic blacks experience the highest rates of death from colorectal cancer, incidence of this cancer is only slightly greater than in non-Hispanic whites.
- Cervical cancer incidence and mortality are higher among non-Hispanic black and Hispanic women.
- Rates of incidence and mortality from melanoma of the skin are very low among Hispanics, non-Hispanic blacks, and non-Hispanic Asians and Pacific Islanders.

Disparities also exist in the incidence of regional and distant stage disease. While some disparities may reflect the underlying occurrence of the disease, identification of groups with disproportionate incidence of regional and distant stage disease may help to inform strategies for cancer screening. Figure 7 illustrates racial and ethnic differences in the incidence of regional and distant stage disease for four cancers for which screening is currently recommended.



*Average annual, age-adjusted to the 2000 U.S. standard million population
 Source of data: New York State Cancer Registry

- The non-Hispanic black population experiences higher incidence rates of regional and distant stage disease for female breast cancer, cervical cancer, and colorectal cancer.
- The non-Hispanic white population experiences a higher incidence rate of regional and distant stage disease for lung cancer, while the Hispanic population has the lowest incidence rate.
- The non-Hispanic white population has the lowest incidence rate of regional and distant stage disease for cervical cancer.

- The non-Hispanic Asian or Pacific Islander population has the lowest incidence rate for regional and distant stage female breast and colorectal cancers.
- Disparities in the incidence of regional and distant stage cancer generally parallel disparities in cancer mortality.

More data on cancer in different race/ethnic groups in New York may be found at the NYSCR web site at <http://www.health.ny.gov/statistics/cancer/registry/> .

The information presented above demonstrates both the magnitude and the multifaceted nature of cancer in New York. Together with an understanding of the sociodemographic and geographic context within which the cancer burden exists, this information can be used to inform and improve efforts at cancer control.

References:

¹ New York State Cancer Registry. Cancer Incidence and Mortality in New York State, 1976-2015.

<http://www.health.ny.gov/statistics/cancer/registry/> .

²U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on November 2017 submission data (1999-2015): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz , June 2018.

³Population estimate July 1, 2017, US Census, Quick Facts, <http://www.census.gov/quickfacts/NY>, accessed 5/22/18.

⁴US Census, Population, Housing Units, Area and Density: 2010 – County – Census Tract, table GCT-PH1, http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_GCTPH1.CY07&prodType=table , accessed 8/16/16.

⁵US Census, Hispanic or Latino Origin by Race, 2016 American Community Survey 1-Year Estimates, Table B03002, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_B03002&prodType=table , accessed 5/14/18.

⁶The Kaiser Family Foundation State Health Facts. Data Source: Kaiser Family Foundation estimates based on the Census Bureau's March Current Population Survey (CPS: Annual Social and Economic Supplements), 2014-2016. <https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, accessed 5/14/18.

⁷New York State Department of Health, Office of Quality and Patient Safety, Medicaid Program Enrollment by Month: Beginning 2009. <https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-200/m4hz-kzn3/data>, accessed 8/8/17.

⁸New York State Department of Health, Bureau of Chronic Disease Evaluation and Research, 2013-2014 Expanded Behavioral Risk Factor Surveillance Survey, at <https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n> , accessed 4/28/17.

⁹National Cancer Institute, Health Disparities, <https://cancercontrol.cancer.gov/research-emphasis/health-disparities.html> , accessed 12/13/16.