

Financial barriers to screening might explain some of the observed disparities in cancer screening rates. The National Breast and Cervical Cancer Early Detection Program provides free or low-cost screening and diagnostic breast and cervical cancer services to low-income, underinsured, and uninsured women, and access to state Medicaid programs for treatment if breast or cervical cancer are diagnosed.\* The Affordable Care Act is expected to reduce financial barriers to screening by expanding insurance coverage. Breast, cervical, and colorectal cancer screening are now covered free in Medicare and in newly offered private insurance plans. State Medicaid programs that provide these services free will receive an enhanced federal match rate. Other efforts are needed, such as developing systems that identify persons eligible for cancer screening tests, actively encouraging the use of screening tests, and monitoring participation to improve screening rates.

Previous studies have shown that racial and ethnic subgroups differ in cancer screening use.<sup>9,10</sup> Large variations were seen between some subgroups. Subgroups that were more likely to receive one type of cancer screening were not necessarily more likely to receive all types. This study further illustrates the importance of identifying and tracking differences among racial and ethnic subgroups and provides guidance for future targeted interventions.

The age ranges examined in this report correspond to the specifications in *Healthy People 2020* objectives, based on current guidelines from USPSTF,<sup>2,3</sup> but some persons younger or older than those ages also might benefit from screening. For cervical cancer screening, USPSTF recommends screening women aged >65 years who previously have not been screened or for whom information about previous screening is not available. For adults aged 75-85 years who previously have not been screened for colorectal cancer, USPSTF recommends that screening decisions be made considering the person's health status and competing risks. For mammography screening, USPSTF states that evidence is insufficient to assess the additional benefits and harms of screening in women aged ≥75 years.

The findings in this report are subject to at least four limitations. First, NHIS data are self-reported, and any report of testing for cancer was classified as a screening test; therefore, these data are subject to inaccuracies. Second, screening recommendations have changed over time. Third, before 2005, the NHIS survey allowed incomplete responses to questions about the date of the test, often requiring assumptions to recode screening measures. To facilitate comparisons over time, this analysis imposed the 2000 method, which allows use of data defined consistently across all years. As a result, the description of screening rates might be less accurate, so that the percentages shown for 2010 in the trend analysis differ slightly from those reported in the tables.<sup>5</sup> Finally, the 2003 NHIS did not include questions on prior hysterectomy; consequently, 2003 data for Pap smears in the trend analysis were excluded to allow for exclu-

sion of women who had undergone hysterectomy.

Although progress toward achieving the *Healthy People 2020* objective for colorectal cancer screening is being made, screening for breast cancer and cervical cancer has not increased over the past decade, and screening use remains low for many groups. This study shows the disparity in subgroup screening rates. Monitoring of these groups is important to assess progress toward reaching *Healthy People 2020* cancer screening targets. Efforts should be made to improve screening rates in all population groups (including targeted efforts for populations with particularly low levels of cancer screening).

REFERENCES

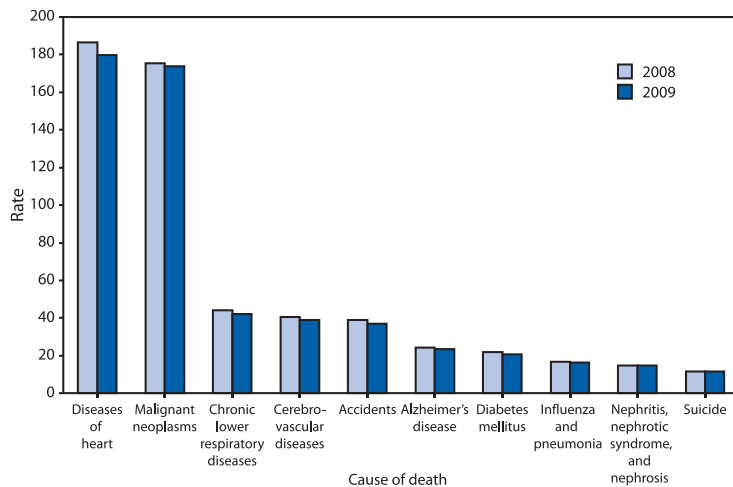
10 Available.

\*Additional information is available at <http://www.cdc.gov/cancer/nbcedp>.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Age-Adjusted Death Rates\* for the 10 Leading Causes of Death† — National Vital Statistics System, United States, 2008 and 2009



\* Rate per 100,000 U.S. standard population.  
 † Data for 2008 are final. Data for 2009 are preliminary. Rank based on 2009 preliminary data.

The 10 leading causes of death in the United States were the same in 2008 and 2009. The rankings also remained the same. The preliminary age-adjusted death rate for the leading cause of death, diseases of heart, decreased by 3.6%. The age-adjusted death rate for malignant neoplasms decreased by 1.0%. Deaths from these two diseases combined accounted for 48% of deaths in the United States in 2009.

Source: Kochanek KD, Xu JQ, Murphy SL, Miniño AM, Kung HC. Deaths: preliminary data for 2009. *Nat Vital Stat Rep* 2011;59(4). Available at [http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59\\_04.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf).