

Issue At A Glance:

Racial Disparities in Breast Cancer

This issue brief examines breast cancer disparities across racial and ethnic groups in the United States, highlights their negative consequences, and explores why inequities persist despite sustained policy and public health efforts.

Introduction

Racial disparities in breast cancer outcomes among women in the United States remain substantial despite overall advances in early detection and treatment. Although overall breast cancer death rates have declined over the past several decades due to improvements in screening and treatment, these gains have not been equitably distributed across racial and ethnic groups. Black women experience disproportionately worse outcomes, including later-stage diagnosis and significantly higher mortality rates, despite having similar or slightly lower incidence rates compared with White women.^{1,2} Screening mammography remains the most effective tool for early detection and survival improvement; however, access to timely and high-quality screening varies considerably by race, socioeconomic status, and geography.³

These disparities are driven not only by biological differences in tumor subtypes, but also by structural and systemic inequities embedded throughout the healthcare system. Unequal access to high-quality screening facilities, delays in diagnostic follow-up, inconsistent insurance coverage, and barriers to timely, guideline-concordant treatment disproportionately affect minoritized populations.³ National interventions, including federally supported screening programs, have expanded access to early detection for underserved women, yet their reach remains limited relative to population need.⁴

Survival and Mortality

Survival Rate for Breast Cancer (2022-2024)⁵

- 5-year at 91%
- 10-year at 86%
- 15-year at 81%

Mortality Range Across Races (per 100,000 women, 2018-2022)^{6,7}

- Non-Hispanic Black: ~28–30
- Non-Hispanic White: ~20–22
- American Indian/Alaska Native: ~15–17
- Hispanic/Latinx: ~14–15
- Asian/Pacific Islander: ~11–13

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Breast Cancer Disparities: Causes and Outcomes

Racial disparities in breast cancer outcomes arise from a complex interplay of structural racism, socioeconomic inequality, healthcare access barriers, and systemic bias. Even when screening rates appear similar, marginalized women are more likely to receive care in under-resourced facilities and experience delays in diagnostic follow-up after abnormal results.⁸ Structural inequities in housing, employment, transportation, and healthcare systems further worsen these disparities. Historical redlining and ongoing residential segregation have limited access to healthcare facilities and specialists in predominantly Black and low-income communities, contributing to delayed screening and later-stage diagnoses.^{8,9} Women living in segregated and economically disadvantaged areas are more likely to present with advanced-stage breast cancer, resulting in poorer survival outcomes.⁹ Health insurance remains a key determinant of screening access, as uninsured and underinsured women are less likely to receive routine mammography.^{8,11} Although the Affordable Care Act reduced financial barriers, gaps persist due to coverage instability, state-level Medicaid variation, and limited awareness of screening benefits.¹⁰ Additionally, implicit bias, communication barriers, and mistrust in healthcare settings can reduce patient engagement and delay timely follow-up among racial and ethnic minority patients.^{8,9}

The consequences of these disparities are profound. According to the *Breast Cancer Report 2024-2025*, Black women experience a breast cancer mortality rate approximately 38% higher than White women, despite having a lower overall incidence.¹¹ This disparity reflects not only differences in tumor biology including a higher prevalence of aggressive, triple-negative breast cancer, but also later-stage diagnosis and cumulative social disadvantages.¹¹ While Asian American/Pacific Islander and Hispanic women have lower mortality overall, rising incidence trends and persistent access barriers suggest emerging and ongoing inequities.¹¹ Collectively, these patterns highlight the enduring impact of unequal access to high-quality screening, timely diagnosis, evidence-based treatment, and broader social determinants of health across the breast cancer care continuum.^{8,9,11}

Distribution of Breast Cancer Subtypes by Race and Ethnicity¹¹

- HR+/HER2- (Luminal-A) is the most common subtype case in all racial ethnic groups, with the highest among White women (73%) and the lowest in Black women (59%).
- HR+/HER2+ (Luminal-B) ranges from 9% to 11%, with no big difference across women with different racial and ethnic backgrounds.
- HR-/HER2- (Triple-negative) distributes the highest in Black women as 1 in 5 cases, compared to 1 in 10 cases in other racial/ethnic women. Triple-negative is the most aggressive with higher risk of metastasis and recurrence and more likely to be diagnosed at a later stage.
- HR-/HER2+ (HER2-enriched) breast cancer is the rarest subtype, only representing 3% to 6% of cases by race and ethnicity.



National Efforts: Progress and Persistent Gaps

At the national level, multiple policies and large-scale interventions have been implemented in the United States to reduce the burden of breast cancer and improve equity in outcomes.^{11,12} These efforts include widespread promotion of mammography screening, evidence-based screening guidelines issued by organizations such as the U.S. Preventive Services Task Force (USPSTF) and the American Cancer Society (ACS), advances in systemic therapies, and targeted policy initiatives such as Medicaid expansion under the Affordable Care Act to improve insurance coverage and access to care.^{13,14} The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has made substantial contributions to improving access to screening among underserved populations. Since its implementation, the NBCCEDP program has served over 6.6 million women and delivered more than 17 million screening examinations. The program also facilitated the diagnosis of approximately 80,000 invasive breast cancers and more than 5,300 invasive cervical cancers.¹⁵ Collectively, these interventions have contributed to a 44% decline in breast cancer mortality since 1989 and nearly 518,000 deaths averted nationwide.¹¹ Expanded screening has increased early detection, while advances in endocrine therapy, chemotherapy, and targeted treatments have substantially improved survival, particularly for hormone receptor-positive disease.¹¹ However, the benefits of these national efforts have not been distributed equally across racial and ethnic groups.¹¹

Breast cancer disparities persist because policies and interventions have been unevenly implemented and insufficiently address structural barriers. NBCCEDP has demonstrably improved access and outcomes for underserved women, but its reach covers only a fraction of eligible populations.¹⁵ Legislative efforts such as the [SCREENS for Cancer Act](#) seek reauthorization and increased flexibility but do not yet provide finalized funding totals for all recent years.¹⁵ Although Black women report similar or higher screening rates compared with White women, they are more likely to receive care at lower-resourced or non-accredited facilities, experience longer screening intervals, and face delays in diagnostic follow-up and treatment initiation.^{11,16,17} Insurance coverage improvements have reduced some gaps, yet underinsurance, treatment delays, and lower receipt of guideline-concordant care remain more common among Black and other minoritized women.^{11,17} Hispanic women and American Indian/Alaska Native women continue to experience lower screening prevalence and rising incidence trends, particularly among younger age groups, suggesting barriers to consistent preventive care and early detection.¹¹ Asian American and Pacific Islander women have experienced rapid increases in incidence, reflecting changing risk profiles and immigration patterns, while national data often mask important subgroup differences due to limited disaggregation.^{11,18}

Crucially, breast cancer disparities persist because national policies have historically focused on access to services rather than quality, timeliness and continuity of care across the cancer continuum. Long standing structural racism, residential segregation, socioeconomic disadvantages, and unequal healthcare infrastructure continue to shape where women receive care and how quickly effective treatments are delivered.^{11,19} As a result, survival gains achieved through national breast cancer policies have disproportionately benefited White women, leaving racial and ethnic disparities largely unresolved.¹¹

Conclusion

Racial disparities in breast cancer screening represent a significant and ongoing public health challenge in the United States. While advances in early detection and treatment have reduced overall mortality, structural inequities continue to place Black women and other marginalized populations at disproportionate risk of delayed diagnosis and death. These disparities are driven by systemic barriers including unequal access to care, socioeconomic disadvantage, structural racism, and health system failure rather than differences in individual behavior or biology alone.

Reducing disparities in breast cancer screening and outcomes requires sustained policy commitment, equitable healthcare delivery, and culturally responsive, community-based interventions. Expanding access to high-quality screening along with timely follow up of abnormal screening, improving care coordination, and addressing social determinants of health are critical to lowering mortality and achieving equity. Without coordinated and sustained action, disparities will persist despite continued medical advances.

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Did you know?

Mammography Screening Rates Vary by Race/Ethnicity (Women ages 40+ or 50–74, % screened 2018-2021):^{20,21}

- Non-Hispanic Black: ~70–73%
- Non-Hispanic White: ~67–70%
- Hispanic/Latinx: ~62–65%
- Asian/Pacific Islander: ~60–63%
- American Indian/Alaska Native: ~58–63%



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