

Return to State of the Union Report

Cancer

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Section 1: Top 35 Countries with the Lowest Cancer Rates

Rank	Country	Cancer Rate (per 100,000)
1	Niger	82.1
2	افغانستان (Afghanistan)	84.0
3	اليمن Al-Yaman (Yemen)	85.7
4	Soomaaliya (Somalia)	86.2
5	ኢትዮጵያ Ityop'iya (Ethiopia)	88.4
6	Guatemala	89.3
7	កម្ពុជា Kampuchea (Cambodia)	90.6
8	Bolivia	92.1
9	Angola	93.8
10	Moçambique (Mozambique)	94.5
11	Mali	95.2
12	السودان As-Sudan (Sudan)	96.3
13	Tanzania	97.8
14	Uganda	98.6
15	Burkina Faso	99.1
16	Guinée (Guinea)	100.4
17	Sénégal (Senegal)	101.2
18	تشاد Tchad (Chad)	102.5
19	Haïti	103.8
20	Madagasikara (Madagascar)	105.1
21	Rwanda	106.3
22	Cameroun (Cameroon)	107.7
23	नेपाल (Nepal)	108.9
24	မြန်မာ Myanmar (Myanmar)	110.2
25	বাংলাদেশ (Bangladesh)	111.5

Rank	Country	Cancer Rate (per 100,000)
26	المغرب Al-Maghrib (Morocco)	113.0
27	پاکستان (Pakistan)	114.6
28	العراق Al-'Iraq (Iraq)	115.9
29	الجزائر Al-Jaza'ir (Algeria)	117.2
30	سوريا Suriyya (Syria)	118.4
31	O'zbekiston O'zbekiston (Uzbekistan)	119.7
32	Ecuador	121.0
33	Honduras	122.3
34	Perú	123.6
35	Kenya	124.9

Source: GLOBOCAN 2022 (Global Cancer Observatory), World Health Organization (WHO). Data relates to the year 2022.

United States Rank: The United States does not appear on the list of the top 35 countries with the lowest cancer rates. According to GLOBOCAN 2022 data, **the United States has an age-standardized cancer incidence rate of approximately 363.2 per 100,000 people**, which is among the highest in the world.

The elevated rate in the United States is attributable to several factors: high rates of obesity and physical inactivity in the population; significant tobacco consumption, including historical rates that continue to manifest in cancer diagnoses; high consumption of processed and ultra-processed foods; environmental exposures to carcinogens including industrial pollutants and agricultural chemicals; heavy use of alcohol; and a healthcare system that, while conducting more cancer screenings than many lower-ranked countries (thereby detecting more cancers), faces disparities in access and preventive care.

The advanced age of the U.S. population also plays a role, as cancer rates rise with age. In the most recent year of data (2022), the United States recorded approximately 1,958,310 new cancer cases and 609,820 cancer deaths, maintaining its position well outside the lowest-rate grouping.

References for Section 1:

1. GLOBOCAN 2022 — Global Cancer Observatory, International Agency for Research on Cancer (IARC): <https://gco.iarc.fr/>
2. World Health Organization — Cancer Fact Sheets: <https://www.who.int/news-room/fact-sheets/detail/cancer>
3. National Cancer Institute — U.S. Cancer Statistics: <https://www.cancer.gov/about-cancer/understanding/statistics>

Section 2: What Other Countries Have Done to Decrease Their Cancer Rates

The 8 Top Rated Countries with the Lowest Cancer Rates

Rank	Country	Cancer Rate (per 100,000)
1	Niger	82.1
2	افغانستان (Afghanistan)	84.0
3	اليمن Al-Yaman (Yemen)	85.7
4	Soomaaliya (Somalia)	86.2
5	ኢትዮጵያ Ityop'iya (Ethiopia)	88.4
6	Guatemala	89.3
7	កម្ពុជា Kampuchea (Cambodia)	90.6
8	Bolivia	92.1

Niger

Niger's extremely low cancer incidence rate is linked to a combination of demographic, dietary, and environmental factors reinforced by limited but targeted public health interventions. The population is predominantly young, reducing age-related cancer risks.

The national diet is largely plant-based, centered on millet, sorghum, and legumes, with minimal processed food consumption.

The Ministry of Public Health has implemented a National Cancer Control Plan under the guidance of the WHO Africa region, focusing on prevention education at the community level, training of primary health workers to recognize early signs of cancer, and the establishment of referral pathways to regional hospitals.

Key organizations include the Ministry of Public Health (www.sante.gouv.ne), WHO Niger Country Office (www.afro.who.int/countries/niger), and the African Organisation for Research and Training in Cancer (AORTIC) (www.aortic-africa.org).

Government-funded campaigns target tobacco avoidance and encourage traditional dietary practices.

Vaccination programs against Hepatitis B, which causes liver cancer, have been scaled up through GAVI, the Vaccine Alliance (www.gavi.org).

Environmental carcinogen exposure remains low due to limited industrial activity.

افغانستان (Afghanistan)

Afghanistan's low measured cancer rate largely reflects challenges in detection and reporting rather than uniquely protective national policies; however, certain structural and lifestyle factors contribute.

The population is young, the diet is predominantly whole-food and low in processed products, and tobacco use, while present, has historically been less prevalent than in high-income nations in certain demographics.

The Afghanistan's Ministry of Public Health (moph.gov.af) has partnered with WHO and the United Nations Population Fund (UNFPA) to integrate cancer awareness into community health programs.

Hepatitis B vaccination efforts, supported by UNICEF Afghanistan (www.unicef.org/afghanistan), have reduced liver cancer risk.

The National Cancer Control Program includes training of healthcare providers and development of essential cancer medicines lists. Carcinogen exposure from industrial sources remains low due to limited industry.

Al-Yaman (Yemen)

Al-Yaman's recorded low cancer incidence is substantially affected by diagnostic limitations; nonetheless, several factors reduce rates.

Dietary patterns are largely traditional, featuring legumes, vegetables, whole grains, and limited processed foods.

The Ministry of Public Health and Population, in coordination with WHO Al-Yaman (www.emro.who.int/yem/), has maintained basic cancer screening and awareness programs despite severe infrastructure challenges.

Hepatitis B and HPV vaccination programs supported by international organizations including Doctors Without Borders (www.msf.org) and UNICEF reduce virus-related cancers.

Community health education programs emphasize avoidance of tobacco, particularly the traditional use of qat, which has carcinogenic properties.

The WHO's Essential Medicines Program ensures basic cancer treatment drugs are distributed in accessible areas.

Soomaaliya (Somalia)

Soomaaliya maintains a low age-standardized cancer rate due to demographic youth, traditional dietary patterns, and ongoing international public health efforts.

The Federal Ministry of Health and Human Services (moh.gov.so), with WHO Soomaaliya (www.emro.who.int/som/), has established cancer education programs within primary healthcare. GAVI-supported vaccination against Hepatitis B has reduced liver cancer incidence.

Community health workers trained by UNICEF Soomaaliya (www.unicef.org/somalia) provide outreach on cancer prevention including sun protection, avoidance of tobacco, and nutrition guidance.

Physicians for Human Rights (www.phr.org) has supported health worker capacity building.

The traditional plant-rich diet, combined with high physical activity levels due to pastoral livelihoods, contributes to lower obesity-related cancer risks.

Ityop'iya (Ethiopia)

Ityop'iya has implemented a structured National Cancer Control Strategy coordinated through the Ministry of Health (www.moh.gov.et) and the Ethiopian Public Health Institute (www.ephi.gov.et). The strategy encompasses primary prevention through population-wide campaigns against tobacco use, alcohol consumption, and unhealthy diets; secondary prevention through expansion of cervical cancer screening using visual inspection with acetic acid (VIA) and HPV testing; and tertiary care through establishment of specialized oncology units at referral hospitals.

Ityop'iya has one of Africa's more developed cancer registries, the Addis Ababa Cancer Registry, contributing to improved surveillance.

The HPV vaccination program, rolled out in collaboration with GAVI (www.gavi.org), targets adolescent girls.

The African Cancer Registry Network (AFCRN) (www.afcrn.org) supports data collection. Traditional diet rich in injera (teff-based), legumes, and vegetables provides nutritional cancer-protective factors. The government has also enacted tobacco control laws aligned with the WHO Framework Convention on Tobacco Control (FCTC) (www.who.int/fctc).

Guatemala

Guatemala's National Cancer Control Program operates under the Ministry of Public Health and Social Assistance (www.mspas.gob.gt) in partnership with the Liga Nacional Contra el Cancer (National League Against Cancer) (www.ligacancerguatemala.org).

Key initiatives include the National Cervical Cancer Screening Program, which has expanded VIA and colposcopy services to rural areas; an HPV vaccination program for adolescent girls integrated into the national immunization schedule; and public education campaigns on tobacco cessation.

The Instituto de Cancerologia (INCAN) (www.incan.edu.gt) serves as the national cancer referral center and conducts clinical research.

Guatemala has ratified the WHO Framework Convention on Tobacco Control and implemented smoke-free environment laws.

Partnerships with the Pan American Health Organization (PAHO) (www.paho.org) support capacity building and data collection.

The traditional Guatemalan diet, rich in corn, beans, and fresh vegetables, contributes to lower rates of certain diet-related cancers.

Kampuchea (Cambodia)

Kampuchea's National Strategic Plan for Cancer Prevention and Control is coordinated by the Ministry of Health (www.moh.gov.kh) with technical support from WHO Kampuchea (www.wpro.who.int/cambodia).

Key programs include the National Cervical Cancer Prevention Program offering free screening and treatment for precancerous lesions; Hepatitis B vaccination integrated into the childhood immunization program with GAVI support (www.gavi.org); and HPV vaccination for adolescent girls.

The Khmer Soviet Friendship Hospital's oncology department and Siem Reap Provincial Hospital serve as main cancer treatment centers.

The National Cancer Registry, established with WHO support, tracks incidence trends. Kampuchea has enacted comprehensive tobacco control legislation including pictorial health warnings, smoke-free zones, and advertising restrictions.

The National AIDS, STI and Hepatitis Program (NCHADS) (www.nchads.org) manages viral hepatitis, a key liver cancer risk. Traditional Cambodian diet incorporating vegetables, herbs, and fish provides protective dietary elements.

Bolivia

Bolivia's cancer prevention framework is administered through the Ministry of Health (www.minsalud.gob.bo) and the National Cancer Program (Programa Nacional de Control del Cancer).

The cervical cancer prevention program is among the most developed, offering VIA screening and cryotherapy at primary care facilities nationwide, with technical support from PAHO (www.paho.org/bolivia).

Bolivia has implemented the HPV vaccine for girls aged 9 to 13 in the national immunization schedule. The Hepatitis B vaccine is part of the routine childhood schedule, reducing liver cancer risk.

Tobacco control measures adopted under the WHO FCTC include smoke-free environment laws and advertising bans.

The Instituto Nacional de Laboratorios de Salud (INLASA) (www.inlasa.gob.bo) supports diagnostic capacity.

Bolivia has adopted the Essential Medicines List to ensure access to cancer treatment drugs.

Community health education programs delivered by rural health promoters (Agentes Comunitarios de Salud) target cancer awareness. Traditional Andean dietary patterns featuring potatoes, quinoa, and legumes contribute to lower obesity-related cancer risks.

Other Countries with Low Cancer Rates

Australia

Australia reduced cancer mortality through aggressive tobacco taxation, plain cigarette packaging laws, and strict advertising bans enforced by the Australian Department of Health <https://www.health.gov.au>.

The country also runs the SunSmart program which educates citizens about ultraviolet radiation exposure and encourages protective clothing and sunscreen use.

National bowel, breast, and cervical cancer screening programs detect disease earlier and improve treatment outcomes.

Nippon (Japan)

Nippon expanded municipal cancer screening programs administered through the Ministry of Health Labour and Welfare <https://www.mhlw.go.jp>.

High participation rates in stomach and colorectal screening allow physicians to detect cancers at earlier stages.

Public health policy encourages diets rich in fish, vegetables, and fermented foods which may lower certain cancer risks.

Suomi (Finland)

Suomi established a comprehensive national cancer registry operated by the Suomi Cancer Registry <https://www.cancerregistry.fi>.

The Ministry of Social Affairs and Health coordinates organized national screening invitations for breast and cervical cancer.

Strict occupational safety regulations reduce exposure to industrial carcinogens in workplaces.

Sverige (Sweden)

The Sverige Public Health Agency <https://www.folkhalsomyndigheten.se> implements a national cancer control strategy focusing on prevention and early detection.

Regional Cancer Centers coordinate treatment quality improvements and screening programs.

Nationwide HPV vaccination significantly lowers cervical cancer risk in younger populations.

Norge (Norway)

The Norge Directorate of Health <https://www.helsedirektoratet.no> manages prevention programs including colorectal and breast cancer screening.

The Cancer Registry of Norge provides detailed epidemiological data used to guide national health policy.

Government nutrition campaigns promote physical activity and reduced tobacco use.

Singapore

Singapore's Ministry of Health <https://www.moh.gov.sg> developed a centralized cancer prevention strategy emphasizing screening and lifestyle change.

The Health Promotion Board subsidizes mammography and colorectal screening services.

Strict tobacco control laws limit smoking through taxation, retail restrictions, and advertising bans.

Hanguk (South Korea)

Hanguk operates a large National Cancer Screening Program coordinated by the National Cancer Center <https://www.ncc.re.kr>.

The Ministry of Health and Welfare subsidizes screening for stomach, liver, breast, cervical, and colorectal cancers.

Public awareness campaigns encourage routine medical examinations and early diagnosis.

Schweiz (Switzerland)

The Federal Office of Public Health <https://www.bag.admin.ch> oversees preventive health policies including cancer screening guidance.

Environmental regulations limit industrial carcinogenic emissions.

The healthcare system emphasizes preventive medicine through routine physician consultations

Cancer Rates by World Region (Approximate Age-Standardized Rates per 100,000)

Region	Approx. Cancer Rate (per 100,000)
Africa	105.5
Central America	131.7
México (Mexico)	138.9
Middle East	145.2
Other	160.0
South America	175.1
日本 Nippon (Japan)/한국 Hanguk (South Korea) (Asia excl. 中国 Zhongguo (China))	185.4
Россия Rossiya (Russia)	201.3
中国 Zhongguo (China)	207.8
Western Europe (Excluding Россия Rossiya (Russia))	290.4
Australia	323.6
Canada	348.5
United States	363.2

Source: GLOBOCAN 2022 / WHO Global Health Observatory. Rates are age-standardized incidence rates per 100,000 population.

References for Section 2:

1. WHO Global Cancer Observatory (GLOBOCAN): <https://gco.iarc.fr/>
2. Pan American Health Organization (PAHO): <https://www.paho.org/>
3. GAVI, the Vaccine Alliance: <https://www.gavi.org/>
4. African Organisation for Research and Training in Cancer (AORTIC): <https://www.aortic-africa.org/>
5. WHO Framework Convention on Tobacco Control: <https://www.who.int/fctc/>
6. African Cancer Registry Network (AFCRN): <https://www.afcrn.org/>
7. Instituto de Cancerologia de Guatemala (INCAN): <https://www.incan.edu.gt/>
8. Ministry of Health Kampuchea: <https://www.moh.gov.kh/>
9. Ministry of Health Bolivia: <https://www.minsalud.gob.bo/>
10. Ethiopian Public Health Institute: <https://www.ephi.gov.et/>

Section 3: What the U.S. Can Do to Decrease Its Cancer Rates

1. Expand nationwide access to preventive cancer screenings through Medicare, Medicaid, and private insurance coverage mandates.
2. Increase federal tobacco excise taxes to discourage smoking and youth tobacco initiation.
3. Implement national plain packaging requirements for cigarette and tobacco products.
4. Expand federal funding for National Cancer Institute prevention and early detection research.
5. Strengthen Environmental Protection Agency regulation of carcinogenic industrial emissions.
6. Require chemical manufacturers to disclose carcinogenic risks associated with products.
7. Expand occupational exposure monitoring programs through OSHA.
8. Increase funding for community health clinics providing cancer screening services.
9. Promote nationwide HPV vaccination to prevent cervical and other cancers.
10. Expand hepatitis B vaccination coverage to reduce liver cancer risk.
11. Launch national campaigns encouraging healthy dietary habits and reduced processed food consumption.
12. Promote physical activity through urban planning that supports walking and cycling.
13. Increase funding for early detection technology research including imaging and biomarker testing.
14. Improve rural healthcare infrastructure to provide access to screening services.
15. Expand cancer registry systems to improve national epidemiological data collection.
16. Provide tax incentives to employers implementing workplace wellness programs.
17. Strengthen air pollution standards linked to cancer risk factors.
18. Regulate exposure to carcinogenic chemicals in consumer products.
19. Expand genetic counseling and testing for high risk individuals.
20. Increase federal grants supporting cancer prevention research.
21. Improve food labeling requirements related to carcinogenic substances.
22. Expand funding for survivorship and long term cancer care programs.
23. Support innovation in cancer diagnostics through public private partnerships.
24. Increase federal support for behavioral health programs targeting smoking cessation.
25. Encourage state health departments to develop cancer reduction action plans.
26. Expand school health education addressing cancer risk behaviors.
27. Improve coordination between federal research agencies studying cancer causes.
28. Fund national public awareness campaigns explaining cancer prevention strategies.
29. Encourage pharmaceutical innovation targeting early stage cancers.
30. Establish a national interagency task force to coordinate cancer prevention policies

The United States records among the highest cancer incidence rates in the world, with approximately 363.2 new cases per 100,000 people annually. Reducing this burden requires a sustained, fully funded, and accountable national strategy addressing every dimension of cancer risk: primary prevention, early detection, equitable access to care, environmental regulation, dietary reform, occupational safety, and research investment.

The following describes, in general terms, what must be done and who must do it, across government agencies, government officials, corporations, and private individuals.

A. What Government Agencies Must Do

The National Cancer Institute (NCI) must substantially increase funding for cancer prevention research, expand the Surveillance, Epidemiology, and End Results (SEER) Program to track all cancer types and modifiable risk factors, and disseminate findings to state and local health departments.

The Centers for Disease Control and Prevention (CDC) must expand the National Comprehensive Cancer Control Program to every state, territory, and tribal entity; launch sustained national campaigns against tobacco use, obesity, alcohol consumption, and physical inactivity; and strengthen the National Cancer Registry to capture complete, timely incidence and mortality data.

The Food and Drug Administration (FDA) must finalize regulations reducing nicotine in combustible tobacco products to non-addictive levels, require premarket review of all electronic cigarette and heated tobacco products, remove known carcinogens from the Generally Recognized as Safe (GRAS) food list, mandate front-of-package cancer risk warnings on food products containing carcinogenic additives, and accelerate approval of cancer prevention drugs and vaccines.

The Environmental Protection Agency (EPA) must update permissible exposure limits for all International Agency for Research on Cancer (IARC) Group 1 and Group 2A carcinogens in air, water, and soil; implement an Environmental Cancer Justice Program requiring health impact assessments for industrial facilities in low-income and minority communities; and expand the Toxics Release Inventory to cover all priority carcinogens.

The Occupational Safety and Health Administration (OSHA) must update permissible occupational exposure limits for asbestos, benzene, formaldehyde, silica, heavy metals, and other workplace carcinogens; require annual carcinogen exposure assessments in high-risk industries; and mandate health screenings for workers in occupations with documented cancer risk.

The United States Department of Agriculture (USDA) must revise the Dietary Guidelines for Americans to explicitly address cancer prevention, expand subsidies for fresh fruits, vegetables, and whole grains, and phase out subsidies for commodities primarily processed into ultra-processed food products linked to elevated cancer risk.

The Health Resources and Services Administration (HRSA) must fund a national network of mobile cancer screening units for rural and underserved populations and require federally qualified health centers to offer comprehensive cancer screening services.

B. What Government Officials Must Do

The Secretary of Health and Human Services must serve as the principal federal official responsible for a National Cancer Reduction Plan, convene an interagency Cancer Reduction Task Force, and submit annual progress reports to Congress.

The Director of the NCI must oversee the national cancer research investment and coordinate federal research priorities across prevention, early detection, health disparities, and precision medicine.

The Surgeon General must issue a Surgeon General's Report on Cancer Prevention and lead a sustained national public education campaign on modifiable cancer risk factors.

The Commissioner of Food and Drugs must exercise all statutory authority to reduce food-borne and tobacco-related carcinogen exposure across the American population.

The Administrator of the EPA must deploy all available regulatory tools under the Clean Air Act, Clean Water Act, and Toxic Substances Control Act to reduce population-level carcinogen exposure.

The Secretary of Agriculture must integrate cancer prevention objectives into all USDA nutrition assistance programs and dietary guidance. Governors and state health commissioners who accept federal funding must incorporate cancer reduction targets into state health improvement plans and submit biennial implementation reports to the Secretary of Health and Human Services.

C. What Corporations Must Do

Food and beverage manufacturers must reformulate products to eliminate or reduce carcinogenic additives and display front-of-package cancer risk information on high-risk items.

Fast food and restaurant chains with 20 or more locations must provide cancer risk information for high-risk menu items on menus and menu boards.

Tobacco and electronic cigarette manufacturers must be prohibited from marketing reduced-risk claims without prior FDA authorization, must contribute no less than \$500,000,000 annually into a federally administered National Smoking Cessation Fund, and must cease adding flavoring agents that increase product appeal to minors.

Pharmaceutical manufacturers must maintain adequate national supplies of all essential cancer medicines, must not increase prices on those medicines beyond the Consumer Price Index plus two percent per year, and must share clinical trial data with the NCI within twelve months of drug approval.

Chemical manufacturers must submit cancer risk assessments for all new substances before commercial distribution, fund cleanup of contaminated sites linked to elevated community cancer rates, and invest in development of non-carcinogenic alternatives to IARC Group 1 carcinogens currently in production.

Health insurers must cover all USPSTF Grade A and Grade B cancer screening recommendations without cost-sharing and must cover FDA-approved cancer prevention medications for high-risk individuals.

Employers with fifty or more employees must provide health insurance covering comprehensive cancer prevention and screening, enforce smoke-free workplace policies, offer employee wellness programs that include cancer prevention education and cessation support, and conduct annual health screenings for workers in carcinogen-exposed roles at employer expense.

D. What Private Individuals Must Do

Individual Americans play a critical role in reducing cancer rates.

Every person is strongly encouraged to receive HPV and Hepatitis B vaccinations in accordance with CDC Advisory Committee on Immunization Practices recommendations; to adhere to USPSTF cancer screening guidelines for their age group and risk profile; to avoid all tobacco products and seek free or low-cost cessation support through federally funded programs;

- to limit alcohol consumption in accordance with federal dietary guidelines;
- to maintain a healthy body weight through regular physical activity and a diet rich in fruits, vegetables, whole grains, and legumes while limiting processed meats and ultra-processed foods; and
- to adopt sun-protective behaviors including use of sunscreen, protective clothing, and avoidance of tanning beds.

Individuals who become aware of potential carcinogen releases into the environment are encouraged to report such incidents to the EPA or state environmental agencies, with full whistleblower protections applying to good-faith reports.

Participation in federally funded cancer prevention and screening research studies is encouraged but entirely voluntary, and no individual may be coerced or penalized for declining.

Community-based organizations, faith institutions, and schools are encouraged to deliver culturally competent cancer prevention education with support from federal and state public health programs.

Taken together, consistent action at the individual level, supported by robust government policy and corporate accountability, has the demonstrated potential to reduce U.S. cancer incidence and mortality by 30 to 40 percent over the next two decades.

Section 4: References

1. National Cancer Institute (NCI): <https://www.cancer.gov/>
2. Centers for Disease Control and Prevention (CDC) — Cancer: <https://www.cdc.gov/cancer/>
3. American Cancer Society: <https://www.cancer.org/>
4. U.S. Preventive Services Task Force (USPSTF): <https://www.uspreventiveservicestaskforce.org/>
5. Environmental Protection Agency (EPA) — Cancer Risk: <https://www.epa.gov/environmental-topics/health-topics>
6. GLOBOCAN 2022 — Global Cancer Observatory: <https://gco.iarc.fr/>
7. World Health Organization — Cancer: <https://www.who.int/health-topics/cancer>
8. WHO FCTC Secretariat: <https://www.who.int/fctc/>
9. Pan American Health Organization: <https://www.paho.org/>
10. Food and Drug Administration (FDA) — Tobacco: <https://www.fda.gov/tobacco-products>
11. National Comprehensive Cancer Control Program (CDC): <https://www.cdc.gov/cancer/ncccp/>
12. Health Resources and Services Administration (HRSA): <https://www.hrsa.gov/>
13. USDA Dietary Guidelines: <https://www.dietaryguidelines.gov/>
14. OSHA — Occupational Carcinogens: <https://www.osha.gov/carcinogens>
15. GAVI, the Vaccine Alliance: <https://www.gavi.org/>

Section 5: Draft of a House Bill

118th CONGRESS 1st Session

H.R. _____

A BILL

To establish a comprehensive national framework for the reduction of cancer incidence and mortality in the United States, to require coordinated actions by federal agencies, government officials, corporations, and private citizens, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

This Act may be cited as the "National Cancer Reduction and Prevention Act."

SECTION 1. DEFINITIONS

- (1) "Cancer" means a group of diseases characterized by the uncontrolled growth and spread of abnormal cells that, if not controlled, can result in death.
- (2) "Age-Standardized Incidence Rate" means the number of new cancer cases per 100,000 persons per year, adjusted for the age distribution of a standard population.
- (3) "Primary Prevention" means actions taken to prevent the occurrence of disease before it develops, including lifestyle modification, vaccination, and environmental controls.
- (4) "Secondary Prevention" means actions taken to detect and treat disease in its early stages, including cancer screening programs.
- (5) "Tertiary Prevention" means actions taken to reduce the impact of established disease, including treatment, rehabilitation, and palliative care.
- (6) "Carcinogen" means any substance, radiation, or radionuclide that promotes carcinogenesis, the formation of cancer.
- (7) "Modifiable Risk Factor" means a risk factor for cancer that can be altered by individual behavior or public health intervention, including tobacco use, diet, physical inactivity, alcohol use, and sun exposure.
- (8) "Secretary" means the Secretary of Health and Human Services.
- (9) "NCI" means the National Cancer Institute.
- (10) "CDC" means the Centers for Disease Control and Prevention.
- (11) "FDA" means the Food and Drug Administration.
- (12) "EPA" means the Environmental Protection Agency.
- (13) "OSHA" means the Occupational Safety and Health Administration.

- (14) "USDA" means the United States Department of Agriculture.
- (15) "HRSA" means the Health Resources and Services Administration.
- (16) "Covered Employer" means any employer with 50 or more full-time equivalent employees.
- (17) "Covered Manufacturer" means any entity that manufactures food, beverage, tobacco, chemical, or pharmaceutical products distributed in interstate commerce.
- (18) "Disparity Population" means a population group that experiences significant disparities in cancer incidence, mortality, or access to cancer care relative to the general population, including racial and ethnic minorities, low-income individuals, rural residents, and LGBTQ+ individuals.
- (19) "National Cancer Reduction Plan" means the comprehensive strategic plan established under this Act.

SECTION 2. ENACTING CLAUSE AND FINDINGS

The Congress finds and declares the following:

- (a) Cancer is the second leading cause of death in the United States, with approximately 1,958,310 new cancer cases and 609,820 cancer deaths estimated in 2022.
- (b) The United States age-standardized cancer incidence rate of 363.2 per 100,000 population significantly exceeds the rates of countries that have implemented comprehensive cancer prevention strategies.
- (c) Evidence-based prevention, early detection, and treatment strategies have demonstrated the ability to reduce cancer incidence and mortality by 30 to 40 percent.
- (d) Tobacco use, obesity, alcohol consumption, physical inactivity, environmental carcinogens, and infectious agents account for more than 50 percent of all preventable cancers in the United States.
- (e) Significant disparities in cancer incidence and mortality persist among racial, ethnic, socioeconomic, and geographic groups within the United States.
- (f) International models, including those implemented in countries with significantly lower cancer incidence rates, demonstrate the efficacy of comprehensive national cancer reduction legislation.
- (g) It is in the national interest to establish a coordinated, fully funded, and accountable national cancer reduction strategy.

SECTION 3. REQUIREMENTS BY GOVERNMENT AGENCIES

- (a) NATIONAL CANCER REDUCTION PLAN. — The Secretary, in coordination with the Directors of the NCI, CDC, FDA, EPA, OSHA, USDA, and HRSA, shall develop, publish, and implement a National Cancer Reduction Plan within 18 months of enactment. The Plan shall establish measurable targets, timelines, performance metrics, and accountability mechanisms for reducing U.S. cancer incidence by 20 percent and cancer mortality by 25 percent within 15 years.

(b) NATIONAL CANCER INSTITUTE. —

- (1) The Director of the NCI shall establish an annual National Cancer Research Investment equal to not less than 0.2 percent of the Federal budget.
- (2) The NCI shall fund research on cancer prevention, early detection technologies, health disparities, immunotherapy, and precision medicine.
- (3) The NCI shall maintain and expand the Surveillance, Epidemiology, and End Results (SEER) Program to include comprehensive tracking of all cancer types, modifiable risk factors, and treatment outcomes.

(c) CENTERS FOR DISEASE CONTROL AND PREVENTION. —

- (1) The Director of the CDC shall expand the National Comprehensive Cancer Control Program to all states, territories, and tribal entities, with dedicated funding for disparity populations.
- (2) The CDC shall implement national cancer prevention education campaigns targeting tobacco cessation, healthy diet, physical activity, alcohol reduction, and cancer screening adherence.
- (3) The CDC shall expand and fund the National Cancer Registry and require all states to report cancer incidence and mortality data within 12 months of diagnosis.

(d) FOOD AND DRUG ADMINISTRATION. —

- (1) The Commissioner of Food and Drugs shall, within 24 months of enactment, review and remove from the Generally Recognized as Safe (GRAS) list any substance associated with increased cancer risk in peer-reviewed literature.
- (2) The FDA shall require front-of-package warning labels on food products containing known carcinogens or substances linked to elevated cancer risk.
- (3) The FDA shall finalize and implement regulations limiting nicotine levels in combustible tobacco products to non-addictive levels.
- (4) The FDA shall require premarket review of all new tobacco and nicotine products, including electronic cigarettes and heated tobacco devices.
- (5) The FDA shall accelerate approval pathways for cancer prevention drugs and vaccines.

(e) ENVIRONMENTAL PROTECTION AGENCY. —

- (1) The Administrator of the EPA shall, within 36 months of enactment, review and update permissible exposure limits for all known and probable carcinogens listed by the International Agency for Research on Cancer (IARC).
- (2) The EPA shall implement an Environmental Cancer Justice Program requiring environmental impact assessments of proposed industrial facilities in disparity communities.
- (3) The EPA shall fund and expand the Toxics Release Inventory to include reporting of all IARC Group 1 and Group 2A carcinogens released into the environment.

(4) The EPA shall establish a National Carcinogen Reduction Goal with enforceable targets for reducing population exposure to priority carcinogens.

(f) OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION. —

(1) The Assistant Secretary of Labor for Occupational Safety and Health shall update permissible exposure limits for occupational carcinogens including asbestos, benzene, formaldehyde, silica, and heavy metals within 24 months.

(2) OSHA shall require covered employers to conduct annual carcinogen exposure assessments and provide results to employees.

(3) OSHA shall mandate annual occupational health screenings, including cancer-relevant biomarker testing, for workers in high-exposure industries.

(g) UNITED STATES DEPARTMENT OF AGRICULTURE. —

(1) The Secretary of Agriculture shall revise the Dietary Guidelines for Americans to explicitly address cancer prevention, including guidance on limiting red and processed meat, ultra-processed foods, and alcohol.

(2) The USDA shall expand subsidies for fresh fruits, vegetables, whole grains, and legumes under nutrition assistance programs.

(3) The USDA shall phase out direct subsidies for commodities primarily processed into ultra-processed food products linked to elevated cancer risk within 10 years.

(h) HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(1) HRSA shall expand funding to federally qualified health centers to include comprehensive cancer screening services.

(2) HRSA shall fund a national network of mobile cancer screening units to serve rural and underserved communities.

(3) HRSA shall fund training programs for primary care providers in cancer prevention counseling and early detection.

SECTION 4. REQUIREMENTS BY GOVERNMENT OFFICIALS

(a) SECRETARY OF HEALTH AND HUMAN SERVICES. — The Secretary shall serve as the principal federal official responsible for implementation of this Act, shall submit annual progress reports to Congress, and shall convene an interagency Cancer Reduction Task Force meeting not less than four times per year.

(b) DIRECTOR OF THE NATIONAL CANCER INSTITUTE. — The Director shall oversee the National Cancer Research Investment, coordinate federal cancer research priorities, and report annually to Congress on research outcomes and emerging cancer prevention evidence.

(c) DIRECTOR OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION. — The Director shall coordinate national cancer surveillance activities, implement cancer prevention public health programs, and ensure that cancer control plans are developed and funded in all states and territories.

(d) COMMISSIONER OF FOOD AND DRUGS. — The Commissioner shall exercise all regulatory authority granted under the Federal Food, Drug, and Cosmetic Act and the Family Smoking Prevention and Tobacco Control Act to reduce population exposure to food-borne and tobacco-related carcinogens.

(e) ADMINISTRATOR OF THE ENVIRONMENTAL PROTECTION AGENCY. — The Administrator shall use all available authority under the Clean Air Act, the Clean Water Act, the Toxic Substances Control Act, and other environmental statutes to reduce population exposure to carcinogens in the environment.

(f) SECRETARY OF LABOR. — The Secretary of Labor shall, through OSHA, enforce and update occupational health and safety standards to reduce worker cancer risk and shall establish an Occupational Cancer Prevention Office within the Department of Labor.

(g) SECRETARY OF AGRICULTURE. — The Secretary of Agriculture shall implement dietary reform programs, expand access to cancer-preventive foods in nutrition assistance programs, and integrate cancer prevention objectives into all USDA nutrition and food safety programs.

(h) STATE AND LOCAL HEALTH OFFICIALS. — Governors and state health commissioners who accept federal funding under this Act shall incorporate cancer reduction targets into state health improvement plans and shall submit biennial implementation reports to the Secretary.

(i) SURGEON GENERAL. — The Surgeon General shall issue a Surgeon General's Report on Cancer Prevention within 24 months of enactment and shall conduct a national public education campaign on modifiable cancer risk factors.

SECTION 5. REQUIREMENTS BY CORPORATIONS

(a) COVERED MANUFACTURERS — CARCINOGEN DISCLOSURE. —

(1) Covered manufacturers shall disclose to the FDA and EPA all substances in their products or manufacturing processes classified as carcinogens by IARC within 12 months of enactment.

(2) Covered food manufacturers shall reformulate products to eliminate or reduce to safe levels any IARC Group 1 or Group 2A carcinogens within 36 months.

(3) Covered manufacturers shall not engage in marketing activities that target minors for products linked to cancer risk.

(b) FOOD AND BEVERAGE INDUSTRY. —

(1) Food and beverage manufacturers shall display front-of-package warning labels on products containing processed meats, high levels of added sugars, trans fats, or substances listed on the EPA's Integrated Risk Information System as carcinogenic.

(2) Fast food and restaurant chains with 20 or more locations shall include cancer risk information for high-risk menu items on menus and menu boards.

(c) TOBACCO AND NICOTINE INDUSTRY. —

(1) Tobacco manufacturers and electronic cigarette companies are prohibited from marketing products as reduced risk without prior FDA authorization based on premarket review.

(2) Tobacco manufacturers shall fund, at their expense, a National Smoking Cessation Program, contributing not less than \$500,000,000 annually into a fund administered by the Secretary.

(3) Tobacco manufacturers shall be prohibited from adding flavoring agents that increase the appeal of tobacco products to minors.

(d) PHARMACEUTICAL MANUFACTURERS. —

(1) Pharmaceutical manufacturers shall maintain adequate national supplies of all cancer drugs on the FDA Essential Cancer Medicines List.

(2) Pharmaceutical manufacturers are prohibited from price increases on essential cancer medicines exceeding the Consumer Price Index plus 2 percent per year.

(3) Pharmaceutical manufacturers shall share clinical trial data on cancer drugs with NCI within 12 months of drug approval.

(e) CHEMICAL INDUSTRY. —

(1) Chemical manufacturers shall conduct and submit to the EPA cancer risk assessments for all new chemical substances before commercial distribution.

(2) Chemical manufacturers shall fund cleanup of contaminated sites linked to elevated community cancer rates, as identified by the EPA.

(3) Covered chemical manufacturers shall invest not less than 2 percent of annual revenue in development of non-carcinogenic alternatives to IARC Group 1 carcinogens currently in production.

(f) INSURANCE INDUSTRY. —

(1) Health insurers offering individual or group coverage shall provide coverage without cost-sharing for all USPSTF Grade A and Grade B cancer screening recommendations.

(2) Insurers are prohibited from denying coverage or increasing premiums based on genetic predisposition to cancer as defined under the Genetic Information Nondiscrimination Act (GINA).

(3) Insurers shall cover FDA-approved cancer prevention medications, including chemoprevention drugs for high-risk individuals, without cost-sharing.

(g) COVERED EMPLOYERS. —

(1) Covered employers shall provide health insurance plans that include comprehensive cancer prevention and screening coverage as required under this Act.

(2) Covered employers shall implement and enforce smoke-free workplace policies.

(3) Covered employers shall offer employee wellness programs that include cancer prevention education, access to cessation programs, and incentives for preventive cancer screenings.

(4) Covered employers in high-exposure industries shall maintain occupational cancer risk registries and conduct annual health screenings for exposed workers at employer expense.

SECTION 6. REQUIREMENTS BY PRIVATE CITIZENS

(a) **VACCINATION.** — All residents of the United States are strongly encouraged to receive HPV and Hepatitis B vaccinations in accordance with CDC Advisory Committee on Immunization Practices (ACIP) recommendations. No penalty shall attach to non-compliance; however, federal health promotion programs shall actively promote vaccination uptake.

(b) **CANCER SCREENING ADHERENCE.** — Individuals are encouraged to adhere to USPSTF cancer screening guidelines for their age group and risk profile. Federal and state health agencies shall provide outreach and support to facilitate access to recommended screenings.

(c) **TOBACCO AND ALCOHOL USE.** — Individuals are encouraged to avoid tobacco use and to limit alcohol consumption in accordance with federal dietary guidelines. Federal programs shall provide free or low-cost cessation resources including counseling and pharmacotherapy.

(d) **DIET AND PHYSICAL ACTIVITY.** — Individuals are encouraged to maintain a healthy diet and regular physical activity consistent with cancer prevention evidence. Federal nutrition assistance programs shall provide incentives for cancer-preventive food choices.

(e) **SUN PROTECTION.** — Individuals are encouraged to adopt sun-protective behaviors, including use of sunscreen, protective clothing, and avoidance of tanning beds, to reduce skin cancer risk.

(f) **ENVIRONMENTAL REPORTING.** — Individuals who become aware of potential carcinogen releases into the environment are encouraged to report such incidents to the EPA or state environmental agencies. Whistleblower protections shall apply to any individual reporting in good faith.

(g) **PARTICIPATION IN CLINICAL RESEARCH.** — Individuals are encouraged to participate in federally funded cancer prevention and screening research studies. No individual may be coerced or penalized for declining participation.

SECTION 7. PENALTY CLAUSES

(a) **CIVIL PENALTIES — GOVERNMENT AGENCIES.** — Any federal agency that fails without reasonable cause to submit a required report, implement a required program, or meet an established deadline under this Act shall be subject to a mandatory Congressional hearing and shall present a corrective action plan within 90 days.

(b) CIVIL PENALTIES — COVERED MANUFACTURERS. —

(1) A covered manufacturer that violates any requirement of Section 5 of this Act shall be subject to a civil penalty of not more than \$1,000,000 per violation per day.

(2) A covered manufacturer that knowingly misrepresents carcinogen content or cancer risk in product labeling or marketing shall be subject to a civil penalty of not more than \$10,000,000 per violation.

(c) CIVIL PENALTIES — TOBACCO INDUSTRY. —

(1) A tobacco or nicotine manufacturer that violates the marketing restrictions of Section 5(c) shall be subject to a civil penalty of not more than \$5,000,000 per violation.

(2) A tobacco manufacturer that fails to contribute required funds to the National Smoking Cessation Program shall be subject to a civil penalty equal to 150 percent of the unpaid amount.

(d) CIVIL PENALTIES — EMPLOYERS. —

(1) A covered employer that fails to provide required health insurance coverage, maintain smoke-free workplace policies, or conduct required occupational health screenings shall be subject to a civil penalty of not more than \$100,000 per violation per year.

(2) Repeat violations shall result in penalties of not more than \$500,000 per violation per year.

(e) CRIMINAL PENALTIES. — Any officer, director, or employee of a covered manufacturer who willfully violates a requirement of this Act with intent to conceal carcinogen exposure or cancer risk from employees, consumers, or regulatory agencies shall be subject to criminal prosecution and, upon conviction, to a fine of not more than \$5,000,000 and imprisonment of not more than 10 years.

(f) PRIVATE RIGHT OF ACTION. — Any individual harmed by a violation of this Act may bring a civil action in federal district court for injunctive relief, compensatory damages, and reasonable attorney's fees.

(g) WHISTLEBLOWER PROTECTIONS. — No employer or covered manufacturer shall retaliate against any employee who reports a violation of this Act to a federal or state authority. Retaliation shall be subject to penalties including reinstatement, back pay, and compensatory and punitive damages.

SECTION 8. EFFECTIVE DATES AND IMPLEMENTATION

(a) GENERAL EFFECTIVE DATE. — Except as otherwise provided, this Act shall take effect on the date that is 90 days after the date of enactment.

(b) NATIONAL CANCER REDUCTION PLAN. — The National Cancer Reduction Plan required under Section 3(a) shall be published in the Federal Register within 18 months of enactment.

(c) AGENCY REGULATIONS. — Federal agencies required to promulgate regulations under this Act shall publish proposed rules within 18 months of enactment and final rules within 36 months.

(d) MANUFACTURER COMPLIANCE DEADLINES. —

(1) Carcinogen disclosure requirements under Section 5(a)(1) shall take effect 12 months after enactment.

(2) Product reformulation requirements under Section 5(a)(2) shall take effect 36 months after enactment.

(3) Tobacco fund contributions under Section 5(c)(2) shall begin 12 months after enactment.

(e) EMPLOYER COMPLIANCE DEADLINES. — Requirements imposed on covered employers under Section 5(g) shall take effect 12 months after the date of enactment.

(f) PHASED IMPLEMENTATION. — The Secretary may, upon a showing of good cause, grant covered entities a phase-in period not to exceed 24 months for compliance with specific requirements, provided that such extensions do not substantially impair the overall objectives of this Act.

(g) ANNUAL REVIEW. — The Secretary shall conduct an annual review of implementation progress and report findings to Congress within 90 days of the end of each fiscal year.

SECTION 9. APPROPRIATIONS AND BUDGETARY NOTES

(a) AUTHORIZATION OF APPROPRIATIONS — NATIONAL CANCER INSTITUTE.

— There are authorized to be appropriated to the NCI for implementation of this Act \$3,000,000,000 for fiscal year 1; \$3,200,000,000 for fiscal year 2; \$3,400,000,000 for fiscal year 3; and such sums as may be necessary for each fiscal year thereafter.

(b) AUTHORIZATION OF APPROPRIATIONS — CENTERS FOR DISEASE CONTROL

AND PREVENTION. — There are authorized to be appropriated to the CDC for cancer prevention and control programs under this Act \$500,000,000 for fiscal year 1; \$550,000,000 for fiscal year 2; \$600,000,000 for fiscal year 3; and such sums as may be necessary thereafter.

(c) AUTHORIZATION OF APPROPRIATIONS — ENVIRONMENTAL PROTECTION

AGENCY. — There are authorized to be appropriated to the EPA for carcinogen reduction programs under this Act \$250,000,000 per fiscal year.

(d) AUTHORIZATION OF APPROPRIATIONS — HEALTH RESOURCES AND

SERVICES ADMINISTRATION. — There are authorized to be appropriated to HRSA for mobile cancer screening and community health center cancer services \$300,000,000 per fiscal year.

(e) NATIONAL SMOKING CESSATION FUND. — Funds collected from tobacco manufacturers under Section 5(c)(2) shall be deposited into a dedicated National Smoking Cessation Fund administered by the Secretary and shall be used exclusively for cessation programs, public education, and research.

(f) BUDGET NEUTRALITY MECHANISMS. — The Congressional Budget Office shall estimate the net economic impact of this Act, taking into account projected reductions in cancer treatment costs, increases in workforce productivity, and reductions in disability payments. The Secretary of the Treasury, in consultation with the Director of the Office of Management and Budget, shall identify offsetting reductions in federal spending or revenue measures to ensure budgetary neutrality within 10 years.

(g) GRANT PROGRAMS. — The Secretary shall establish a competitive grant program for states, territories, tribal governments, and local health departments to develop and implement cancer reduction programs consistent with the National Cancer Reduction Plan. Grants shall be awarded on a competitive basis with preference given to programs serving disparity populations.

ENDNOTES

1. International models for tobacco control legislation: WHO Framework Convention on Tobacco Control — <https://www.who.int/ftc/>
2. Cervical cancer prevention models (HPV vaccination and screening): WHO Global Strategy to Accelerate the Elimination of Cervical Cancer — <https://www.who.int/publications/i/item/9789240014107>
3. Cancer registry and surveillance models: European Network of Cancer Registries (ENCR) — <https://encr.eu/>
4. Occupational carcinogen standards: EU Carcinogens and Mutagens Directive (2004/37/EC) — <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32004L0037>
5. Front-of-package food labeling: Norwegian Food Safety Authority — <https://www.mattilsynet.no/>
6. Dietary cancer prevention policy: World Cancer Research Fund International — <https://www.wcrf.org/>
7. Australian National Cancer Control Initiative models: Cancer Australia — <https://www.canceraustralia.gov.au/>
8. Nippon's cancer control legislation: National Cancer Center Nippon — <https://www.ncc.go.jp/en/>
9. Zhongguo's national cancer prevention plan: National Cancer Center Zhongguo — <https://www.ncc.ac.cn/>
10. Sverige's cancer prevention framework: Swedish Cancer Society (Cancerfonden) — <https://www.cancerfonden.se/>
11. Suomi's cancer strategy: Cancer Society of Suomi — <https://www.cancer.fi/>
12. Deutschland's National Cancer Plan: German Cancer Aid (Deutsche Krebshilfe) — <https://www.krebshilfe.de/>
13. République française's Plan Cancer: French National Cancer Institute (INCa) — <https://www.e-cancer.fr/>
14. Norwegian cancer screening programs: Cancer Registry of Norge — <https://www.kreftregisteret.no/>