

Cross-Cutting Issues in Cancer Control and Prevention

A number of cross-cutting issues exist which must be addressed in order for the prevention and control of cancer to receive the attention it needs in Kansas. The issues are often complex with interlocking concerns and unclear surrounding aspects. These include:

Disparity – A number of disparate issues and differences in the burden of cancer exist because of differences in age, sex, socio-economic, race, ethnicity, geography, and other factors. These barriers often mean individuals who develop cancer are not screened early enough and often lack access to and the ability to pay for medical care. Patients also must overcome treatment and recovery issues that may be life altering.

Age/Sex – The median age of the Kansas population is 35.5 years, however, in the 65 or older age group, where cancer is most prevalent, there were 356,229 Kansans according to the 2000 census.¹ This represents 13.3 percent of Kansas' total population, a small decrease compared to recent years. In the over age 85 age group, there were more than 52,000 individuals representing 1.9 percent of the population, with Kansas having a slightly higher percentage of such older citizens than the U.S. average of 1.5 percent. By gender, the state has nearly the same amount of males (1.343 million) as females (1.372 million).

Call to Action – With an aging population the incidence of cancer will continue to rise. Of the 11,465 cases of cancer diagnosed in 2002, more than 9,770 were individuals over the age of 50. Of those 9,770 cases, 6,753 occurred in those 65 and older.² With early screening and diagnosis, it is expected that the number of cancer cases will continue to rise and that those living with cancer will continue to increase. Cancer prevention becomes the key to managing this increasing health burden.

Socio-economic/Financial – The financial burden of cancer is staggering and issues of uninsured and underinsured individuals must be addressed. Uninsured Kansans live sicker and die younger than those who have insurance.³ However, with the economic downturn beginning in 2001 and increases in the cost of insurance as high as 28 percent, many individuals have lost their employer-provided health insurance or were unable to afford coverage.⁴ Low-income and ethnic populations felt the biggest impact. Changes in health insurance also have made co-pay amounts and high deductibles areas that need further study and consideration. Changes in the health care laws and regulations must be addressed. Insurance policies should cover screening and early detection tests to further reduce the burden of cancer in the state.

The per capita personal income in Kansas was \$28,565 in 2002, slightly below the national average of \$30,472.⁵ Socio-economic factors contribute to the disparities in health care and can include measures of income, wealth, education, poverty level, occupation and composite measures that include variables such as employment status and access to a car.⁶ The Kansas Health Insurance Study documented that more than 10 percent of all Kansans under 65 years of age are without insurance. Of those uninsured Kansans nearly 21 percent are Hispanic/Latino and 8.5 percent are African-American.

Call to Action – Individuals and organizations are currently committed to cancer control and prevention and awareness of that effort needs to be recognized and expanded. The identification of current resources to fight cancer will help determine if they are allocated correctly. Those resources need to be estimate and identified and the best sources of revenue found. Funding sources beyond government dollars need to be identified.

Race/ Ethnicity – Minority and ethnic individuals represent a small portion of the Kansas population, but have a disproportionate amount of the cancer diagnosis. Kansas' population data indicate that about 90 percent of Kansans are White, 6.4 percent are African-American, 2.2 percent are Asian or Pacific Islanders and 1.1 percent are American Indian. Ethnicity breaks out as 92.4 percent Non-Hispanic and 7.6 percent Hispanic.⁷ Estimates also indicate an upward trend in other races and ethnicities in the population, especially in the proportion of the Hispanic population. Health issues and concerns for some individuals may be exacerbated by a number of factors including limited access to health care, no insurance coverage or high deductibles and co-insurance payments.

Minority health disparities exist in Kansas with different races and ethnicities experiencing a variety of issues related to cultural competency and sensitivity. For example, some Asian cultures have medical traditions that do not emphasize preventive medical services. Asian/Pacific Islander women are 16 percent less likely to receive a Pap smear test for cervical cancer than the general population. Language and cultural competency barriers also may contribute to this pattern.⁸ American Indians also have increased health risk factors with a greater percentage of their population who are obese and smoke, factors which contribute to a high rate of lung cancer.⁹ Studies indicate that Hispanic cultures view chronic diseases as inevitable and unavoidable, which hampers efforts to introduce early prevention for diseases.¹⁰ The overall cancer death rate is 28 percent higher among African-Americans than the total population in Kansas.



Virginia-
Cancer Survivor

I had returned from bowling on a league and just didn't feel right. Later that evening I blacked out in the bathroom and fell into the bathtub. When I finally came to, I called 911 and emergency medical personnel arrived and transported me to the hospital. The ER staff found I had bleeding ulcers and advised me to stay overnight so they could administer more tests the next day. During an endoscope, a biopsy was taken and sent off to Mayo Clinic for further testing. I was released a day or so later, but asked to come back for second biopsy that was requested by Mayo.

About a week later, my primary care physician requested I come in and recommended a referral to an oncologist. The oncologist informed me my biopsy was malignant – a low-grade lymphoma. This was in August 1999 and I was filled with shock, fear and many other emotions. I had known of no family member who had cancer and I rejected the thought of having it. I went through a denial stage for about three weeks, but then started treatment at the end of the month.

I spent the next four months taking chemotherapy treatments. I finished my first round in December 1999. Then in January 2000 I was hospitalized to receive a new medication for treatment. I went through my chemo treatment first and then decided I would deal with whatever problems came later.

I hesitated notifying my mother who was 94 years old then. She worried a lot and I did not want her to worry any more than she had to. I let my daughter and sister know several days after I was diagnosed. My oncologist said my chances of survival were 80/20 and I had prepared a will about 10 years...

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...ago that would apply in case I didn't survive.

I have gone back frequently for check ups. During the first year it was every three months, the second year every six months and since then I am checked every year during my annual visit to the doctor. My primary care doctor encourages me to keep up with the tests.

I would encourage anyone to take advantage of any early screening tests for cancer. In my case, it was another health problem that led to the detection of my cancer, but I was lucky to receive such good care and treatment.

I am thankful for the medical and scientific professionals who spend the time on research and development of a cure for cancer.

landmass that comprises the metropolitan areas. The other 45 percent of the population lives in the remaining 90 percent of the geographic areas in the state, mainly the rural counties, particularly in western Kansas.¹³ While the urban areas house state-of-the-art medical facilities and a good doctor-patient ratio, individuals in rural areas must often drive long distances to access medical care. Health care providers in the rural areas are also lacking and the medically underserved in those areas often receive less timely medical care with longer waits for treatment.

Capacity – The capacity of the medical system in Kansas is currently challenged in the area of the underserved individuals. And as more people are screened and diagnosed with cancer, health/medical professionals may be taxed to provide timely and thorough treatment and care. Data also indicates that the population of Kansas is aging, but at a slower pace than the rest of the United States.¹⁴ That is good news when it comes to incidence since cancer occurs more often in those over the age of 50. However, the system will continue to face challenges to provide quality cancer screening, detection and care for Kansans.

Data – The ability to measure the disease of cancer and morbidity and mortality factors is critical to making an impact. This includes being able to measure the effectiveness of intervention methods and the access to care. The Kansas Cancer Registry (KCR) provides an important tool to collect and analyze cancer cases in the state and will serve as a vehicle for successful comprehensive cancer prevention and control. The KCR has identified objectives toward this pursuit including: continued data management and surveillance, hospital, physician, laboratory and radiation reporting and emphasis toward case completeness, data quality and information dissemination. The Behavioral Risk Factor Surveillance Survey (BRFSS) also is an important tool in gathering information from the public. KDHE currently uses data collected by the Environmental Protection Agency during a national study in 1998-99 of radon levels, however, additional study and data collection is needed.

Call to Action – The addition and modification of questions related to comprehensive cancer control will start with the 2005 BRFSS survey in order to begin gathering and

African-American male adults have the highest rates of prostate, lung and colorectal cancer compared to the general population.¹¹

In general, late diagnosis and poorer outcomes from treatment contribute to higher mortality that characterizes minority health with respect to cancer.

Call to Action – In 2002, more than 5,300 deaths were attributed to cancer. Of those, data indicates that more than 350 were in individuals where race was indicated as African-American or other.¹² In order to address the disparity issue, an understanding of how cultures look at the disease of cancer is needed.

Geographic – Kansas has a particular challenge when dealing with the urban versus rural issue. Fifty-five percent of the 2.7 million people in Kansas live in the 10 percent of

analyzing the data needed. This data collection will help determine the scope, nature and extent of the cancer problem in Kansas. The Partnership also will look at other data collection opportunities particularly in accordance with stated strategies and supports the need for the Kansas Cancer Registry to follow up with patients to collect additional information. The Partnership intends to work toward an annual release of data identifying the status of cancer in Kansas.

Public Information/Education – Increasing the knowledge of the general public and coordinating current efforts through education and information is critical to the prevention and screening efforts to detect cancer at its earliest stages and provide prompt treatment. Those individuals affected by cancer demand direct, accurate, and current information readily accessible through the Internet, local libraries or media sources. A wealth of information on cancer currently is available on cancer in written and electronic form. However, coordination of this information in a comprehensive format is critical to avoid duplication of efforts and ensure that those seeking information will be able to obtain it quickly and reliably. A comprehensive media campaign, using coordinated messages and a logo/slogan concept, also would benefit the state effort by raising awareness of the general public through marketing and media efforts.

Call to Action – The development and promotion of a common theme to raise awareness about cancer and the options available to cancer patients is needed. “Quality cancer care in Kansas – Close to home” will provide the basis for a public information/education and medical advocacy program. A statewide information access point is needed which draws from entities providing cancer information including, but not limited to, the American Cancer Society, Susan G. Komen Breast Cancer Foundation, US TOO, National Cancer Institute, hospital cancer centers and others. This effort should be comprehensive to provide easy utilization and support.

Professional Education – Health care professionals need additional education and training to adequately manage cancer and its risks. A systematic approach to disseminating newly identified cancer strategies to Kansas’s doctors, nurses, dentists and other allied health care professionals is needed. Providers are often unaware of the prevention methods and screening guidelines for the disease and clinical treatment trials available for their clients and patients. Other improvements in communication methods for professionals also are needed in the state.

Call to Action – Programs at medical and nursing schools should cover the full spectrum of the cancer continuum including end of life needs. Training for health professionals in cultural competencies, including disparities in education and literacy levels of patients is needed. Primary care physicians should be engaged in the spectrum of cancer prevention and the continuity of care.

Resources – The risk, occurrence, suffering and death from cancer must be minimized by making sound societal decisions and utilizing resources to deal with this important public health issue. Existing resources must be used wisely and additional sources of revenue, opportunity and collaboration must be explored.

Call to Action – The partnership will support each other and their respective organizations in the implementation of the cancer plan, consistent with the goals and objectives outlined. A clear commitment is needed along with the identification of resources including grants, additional funding and in-kind services.

Research – New knowledge and new tools must be pursued for cancer risk reduction and cancer care. Although there is a downward trend in the mortality rates from cancer, with early detection and treatment, the number of individuals living with this disease will continue to rise. Being a rural state, Kansas has the risk of carcinogens linked to agriculture, and also has a risk from radon in homes and businesses.

Call to Action – Additional research is needed for screening and early detection services. And research is needed into new cancer drugs and treatment, which offer the best hope to those afflicted with the disease. Coordination with health care providers is recommended for screening and treatment trials. Continued scientific study is needed in the area of environmental carcinogens to reduce exposure and to educate the public about possible risk.

Advocacy/Policy – Many groups, individuals, survivors, organizations and companies support the cause of cancer prevention, control and treatment. A number of organizations participated in and contributed to the input for this plan. Health professionals, cancer advocates, medical centers, associations, legislators, foundations, and state departments contributed their time and talent to researching and studying the problem of cancer along the continuum of care. Each realizes that a comprehensive approach to the problem of cancer prevention and control is needed.

Call to Action – A clear call to action is needed by advocates who support a comprehensive and collective approach to reducing the burden of cancer in the state. This includes a visible effort with an established agenda for organizations, health care professionals, the public sector and private businesses. The partnership supports the increase in tobacco taxes for prevention efforts, health care coverage for the medically underserved and programs to reduce cancer risks. Cancer needs to be raised as a priority issue in the health care arena.

References:

- ¹ U.S. Census Bureau and the National Center for Health Statistics
- ² Kansas Cancer Registry, 2002
- ³ Kansas Insurance Department, State Planning Survey, May 2004
- ⁴ Center for Studying Health System Change
- ⁵ State Policy Report, September 2002, U.S. Department of Labor
- ⁶ Institute of Medicine, Guidance for the National Healthcare Disparities Report, 2002
- ⁷ U.S. Census, 2000
- ⁸ Minority Health Disparities in Kansas, Kansas Institute of Health, January 2003
- ⁹ Behavioral Risk Factor Surveillance Survey, 1993-2000
- ¹⁰ Minority Health Disparities in Kansas, Kansas Institute of Health, January 2003
- ¹¹ Minority Health Disparities in Kansas, Kansas Institute of Health, January 2003
- ¹² Kansas Cancer Registry, 2002
- ¹³ Kansas Department of Health and Environment, Office of Local and Rural Health
- ¹⁴ U.S. Census