

health
disparities

lung cancer

breast cancer

cancer

cultural

awareness

childhood:teens:twenties:thirties:middle:prevention

health check

prostate

melanoma

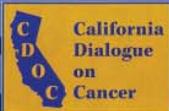
colorectal
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COMPREHENSIVE CANCER CONTROL IN

CALIFORNIA

2004



This publication was prepared by:

California Dialogue on Cancer
P.O.Box 2061
Oakland, CA 94604
(916) 449-5536

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**Prepared by
California Dialogue on Cancer**

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FOREWORD FROM THE CALIFORNIA DIALOGUE ON CANCER

An estimated 138,000 Californians will be diagnosed with cancer in 2004 and 53,800 will die from the disease. In the coming years, cancer is expected to strike three out of four California families. The diverse populations in our state bring additional challenges in combating the disease.

Comprehensive cancer control is based on the idea that people and organizations working together to identify problems and develop solutions will lead to better use of limited resources and generation of new resources through new partnerships.

Comprehensive cancer control will reduce the cancer burden on all California citizens by integrating and coordinating approaches for reducing the incidence, morbidity, and mortality of cancer through effective prevention, early detection, treatment, rehabilitation, and palliation efforts.

The California Dialogue on Cancer (CDOC) was formed to provide guidance for comprehensive cancer control activities in California. The development of the state plan is the first step in the ongoing process of implementing comprehensive cancer control. CDOC will be the lead organization in implementation of the plan via working committees specifically formed to address specific strategies and tactics as well as cross-cutting issues.

The California Comprehensive Cancer Plan is a strategic plan of action, developed by dedicated individuals and organizations concerned with the burden of cancer on California citizens. In particular, the American Cancer Society and the California Department of Health Services have assisted in coordinating the process that led to this plan.

This process included:

- I Establishing a Steering Committee for initial guidance in determining overarching issues and the plan's framework.
- II Developing an outline of the plan which resulted in a first rough draft.

III Following completion of the first draft of the plan, convening a meeting of cancer control stakeholders in California to further develop the plan. This stakeholders group was comprised of individuals with expertise in the field and representatives from a broad spectrum of government, health care, business, labor, and community-based organizations. This meeting was attended by over 175 individuals representing more than 75 organizations. This was the process of building our strategic partnerships.

IV The document resulting from this stakeholders meeting was distributed to participants for further review, revision, and finalization. In addition, cross-cutting issues were identified and to be addressed during the implementation process.

This formal plan blends community participation with the science of cancer control, examines the barriers and gaps in cancer control efforts and identifies measurable goals, strategies and tactics needed for the future. The impact of cancer is greater on some people than others. Therefore, recognition of the state's multicultural population is a primary component of this plan of action.

Successful implementation requires the continued support and assistance of many different partners including the state legislature, state and local health agencies, community-based organizations and grassroots efforts. Additional resources will also be needed to support of plan strategies.

We are extremely thankful for all those individuals and organizations who have assisted in developing this agenda for the future. This plan is an end product of the planning process and an important milestone toward reducing the cancer burden on Californians; however, it is just one step in a longer, sustained, comprehensive cancer control process. Every partner organization involved is vital to continuing successful implementation of California's Cancer Control plan, and we look forward to working together on this critical endeavor.

EXECUTIVE SUMMARY

California Confronts Cancer

Cancer is second only to heart disease as a cause of death in California across all population groups, except for Asian/Pacific Islander women where it is the leading cause of death. In the coming years, cancer is expected to strike three out of four California families.

Significant talent and resources have been directed into the effort to control cancer in our state. As a result, California has created a world-class cancer surveillance system and registry. Although encouraged by its progress in controlling cancer, the state is at an important juncture where a comprehensive plan can coordinate control efforts and optimize resources during difficult financial times. A comprehensive plan will also engender greater collaboration and consensus among stakeholders as to what could and should be achieved.

In March 2003, California convened the California Comprehensive Cancer Control Plan Stakeholders Meeting with over 200 participants including state leaders, members of the public, not-for-profit organizations, health, medical, and business communities, the research community, national leaders, survivors, caregivers, and advocates. This meeting resulted in development of the initial draft of California's plan.

The meeting was an inaugural event sponsored by the California Dialogue on Cancer (CDOC), the overarching organization that will take on issues of structure, growth, and outcomes for cancer control in California.

The Cancer Burden in California

Mirroring the rest of the nation, the burden of cancer does not fall equally on all Californians. Californians who are poor, lack health insurance, and lack access to adequate cancer care carry an unequal burden of cancer. The risk of developing cancer varies considerably by race/ethnicity.

Measures of cancer incidence, mortality, survival, and other pertinent data are used as a resource to originate and evaluate comprehensive cancer control as an evidence-based public health program. Evidence-based programs ensure that limited resources are directed toward efforts that will lead to the most meaningful and applicable results.

Cross-Cutting Issues in Cancer Control

In order to implement the comprehensive cancer control plan and achieve its goals, cross-cutting issues, which cut across the full spectrum of cancer control, are highlighted.

- › Access to Quality Care
- › Prevention
- › Survivorship, Palliative Care, and Quality of Life
- › Surveillance and Evaluation
- › The Cost of Cancer
- › Public Policy and Legislation
- › Research
- › The Environment and Cancer

The Unequal Burden of Cancer

California's large multicultural and diverse population also often encounters barriers to optimal cancer care. Disparities exist in knowledge, access, treatment, and survival and result in risk of high cancer incidence, mortality, poor cancer survival, and poor quality of life. Efforts specifically directed to the state's diverse and low-income populations will continue to overcome gaps in its cancer control programs.

Top Strategies to Achieve Goals and Objectives

Key strategies and tactics for making progress in California's efforts to control cancer were developed by participants at the March 2003 Stakeholders Meeting described above. Listed below are the top strategies identified for colorectal, breast, prostate, and lung cancer as well as for the two leading risk factors for cancer overall, i.e. tobacco use, poor nutrition and physical inactivity.

Colorectal Cancer - Top Strategies to Achieve Goals and Objectives

1. By January 1, 2006, develop and support proactive colorectal cancer advocacy groups that will, in turn, support community, state, and national agendas for increasing awareness of colorectal cancer issues.



2. By January 1, 2006, develop and support evidence-based, culturally sensitive public awareness campaigns that focus on the importance of colorectal cancer screening, prevention, and early detection through media, community outreach, and through a collaboration among health care providers and community and voluntary organizations.
3. By January 1, 2006, work toward universal insurance coverage for colorectal cancer screening and treatment.

Breast Cancer - Top Strategies to Achieve Goals and Objectives

1. By January 1, 2006, begin to conduct statewide tracking of women's breast cancer health care.
2. By January 1, 2006, provide education for health professionals, policy makers, and consumers, including diverse populations, regarding breast cancer risk assessment and risk reduction through a variety of materials and mechanisms developed to increase cultural competency and communication skills.
3. By January 1, 2006, develop a coordinated system and resources to provide access for patients to breast cancer detection, diagnosis, and treatment services which ensures quality of life throughout the continuum of cancer care including recovery and palliative care.

Prostate Cancer - Top Strategies to Achieve Goals and Objectives

1. By January 1, 2006, educate the public, health professionals, and policy makers regarding major issues relating to prostate cancer including its risks, treatment options and associated quality of life issues, fears, beliefs and perceptions about the cancer and its treatment, lack of trust in the health care system among diverse groups, the need for easier access to prostate cancer detection and care, and lack of accurate, unbiased information conveniently accessible to men within and outside the health care system.
2. By January 1, 2006, increase state funding for prostate cancer control research that includes basic, translational, clinical, and health services, quality of life, and outcomes research.
3. By January 1, 2006, ensure consistent funding of existing prostate cancer mandates and programs for the low income, uninsured, and underinsured, and ensure that programs are culturally and linguistically appropriate for ethnic communities.

Lung and Oral Cancer and Tobacco Control - Top Strategies to Achieve Goals and Objectives

1. Prevent or control tobacco use by funding and implementing the Tobacco Education and Research Oversight Committee Master Plan to strengthen the California Tobacco Control Program structure (community-based and school-based programs and tobacco-related disease research).
2. Integrate evidence-based and efficacious smoking and smokeless tobacco cessation services into the state's school systems, community-based organizations, public health programs, and health care plans and institutions.
3. Improve current and develop new technologies for screening, early diagnosis, and treatment of lung, oral cancer, and other tobacco-related cancers (e.g. cervical, stomach, pancreatic), and improve the quality of life measures at all stages of the patient's health care and balance of life.

Nutrition, Obesity, Physical Activity, and Cancer - Top Strategies to Achieve Goals and Objectives

Based on the model provided by the successful tobacco prevention campaign in California, identify current funding streams and mobilize new resources to at least a comparable level of California's Tobacco Control Program. Create a similar statewide infrastructure to change state norms regarding healthy dietary and physical activity behaviors as follows:

1. Develop a statewide infrastructure that provides leadership, management, planning, information and intervention dissemination, resource development training, and coordination.
2. Institute environmental and policy change.
3. Implement mass communication strategies.

The individuals and organizations who have contributed to this end product of the planning process are welcomed as a partner in developing this agenda into the future.

This process of building partnerships continues with The California Dialogue on Cancer (CDOC) providing guidance for comprehensive cancer control implementation activities in California via working committees specifically formed to address specific strategies and tactics as well as cross-cutting issues.



CHAPTER I
COMPREHENSIVE CANCER CONTROL
IN CALIFORNIA

COMPREHENSIVE CANCER CONTROL IN CALIFORNIA

GOALS

1. By 2010, reduce the cancer mortality rate by 40 percent in California, from a baseline of 178.3 deaths per 100,000 persons.
2. By 2010, reduce the cancer incidence rate by 20 percent in California, from a baseline of 445.5 new cases per 100,000 persons.

California Confronts Cancer

California has made enormous strides in cancer control over the past twenty years, particularly during the last decade as cancer incidence and mortality rates have declined, in some cases dramatically.

Between 1988 and 1999, overall California cancer mortality rates decreased 17 percent among men and 12 percent among women. The relatively smaller decline among women is likely driven by a lag in reducing their lung cancer-related mortality.



During 1988-1999, Cancer Mortality Rates in California Decreased Significantly Among African Americans (11 Percent), non-Hispanic Whites (13 Percent), Hispanics/Latinos (12 Percent), and Asian/Pacific Islanders (15 Percent).

Much, however, remains to be done. An estimated 138,300 Californians will be diagnosed with cancer in 2004 and 53,700 will die from the disease (1). Cancer is second only to heart disease as a cause of death in California across all population groups, except for Asian/Pacific Islander women where it is the leading cause of death. In the coming years, cancer is expected to strike three out of four California families. The population is aging, births and population migration are growing, and even now California has the highest percentage of uninsured residents in the U.S., (nearly 25 percent). These are large, albeit surmountable, barriers to saving lives from cancer.

There are more cancer survivors alive now than ever. Nearly 885,000 Californians are alive today who have a personal history of cancer, and this is not by chance. Vast talent and resources have been directed into the effort to control cancer in our state. As a result, California has created a world-class cancer surveillance system and registry. Concurrently, research, clinical, and public health cancer control programs recast research findings into practical interventions to benefit all Californians.

What is a Successful Cancer Control Program?

California's Tobacco Control Program, certainly a model for the rest of the nation, demonstrated what is needed to control and ultimately eliminate cancer, in this case lung and other tobacco-related cancers. California has experienced a dramatic decline in lung cancer deaths compared to the rest of the U.S. over the past 15 years (1). However, when the full impact of the program hits in the future (because cancer does take some time to develop), the decline in lung cancer incidence and mortality will be nothing less than awesome.

What Makes this Program Work?

Number one, it is comprehensive. The program is organized at the grass roots level across the state and involves coalitions in every county and the three cities in the state that have a health department, as well as a broad spectrum of government, voluntary, health care, business, labor, and community-based organizations. Recognition of and sensitivity to the state's multicultural population is crucial, and the program's ethnic networks are essential partners that participate throughout the program.

Secondly, public policy, particularly at the local level, is a major intervention tool that brings about social change. Third, an aggressive media campaign frames the issues and helps to focus and legitimize program efforts in the public's eye. Fourth, multiple strategies are used to get the job done.

To sustain the program, a viable infrastructure emphasizes both vertical (state and local) and horizontal connections (training, technical assistance, clearinghouse, ethnic networks, cessation helpline, evaluation, media and public relations) that benefit the entire program. This horizontal and vertical integration is key to its success. Highly skilled staff and courageous

leadership at all program levels provide the program's support.

Programs like this, as with all cancer control programs, cannot be done with a minimal and uncertain budget. Political and social will are essential to fund and sustain programs at necessary levels if results are expected. Sustainability of adequate program funding is difficult as it fluctuates with the ebb and flow of legislative decisions and budget constraints. (See Chapter 7, "Lung and Oral Cancer and Tobacco Control," for more detailed information on California's tobacco control program.)

California's Plan

Although California should be and is encouraged by its progress in controlling cancer, the state is at an important juncture where a comprehensive plan can coordinate control efforts and optimize resources during difficult financial times. In addition, many of the strategies and tactics presented in this plan will have health benefits extending far beyond cancer to additional leading causes of mortality such as heart disease and diabetes.

A comprehensive plan will also engender greater collaboration and consensus among stakeholders as to what could and should be achieved. These stakeholders include state leaders, members of the public, not-for-profit organizations, health, medical, and business communities, the research community, national leaders, survivors, caregivers, and advocates, all who will help create this visionary blueprint for California.

Developing a comprehensive cancer control plan is a tall order for California whose urban-rural mix, ethnic diversity, and geographic size have resulted in a complex population larger than that of the country of Canada. California, must be up to the challenge.

Overarching Principles of California's Plan

California's plan is about science, delivery, and impact, in other words, what we know must be applied to what we do, and if we don't know, we must find out. When the California Comprehensive Cancer Control Steering Committee met in June of 2002, members deliberated on these issues and resolved that the following ten core principles be considered in creating the plan.

The committee felt this plan must address:

- 1) Cancer in general, and selected site-specific areas.
- 2) Equal access to quality care for all resulting in minimal disparities in cancer outcomes.
- 3) Quality cancer surveillance and data collected across all population sub-groups.
- 4) Culturally appropriate awareness, information, and interventions that span the diversity of California
- 5) Continued and expanded investment in research across the research continuum from prevention to applied public health (translational) research.
- 6) Greatly expanded funding needed to achieve successful cancer control outcomes.
- 7) The relationship of poverty and the environment to the development of cancer.
- 8) All aspects of the cancer continuum from prevention and risk reduction to palliative care, survivorship and end of life considerations including physical, psychological, social, and spiritual dimensions that are crucial to cancer patients and their families.
- 9) Strong collaboration among cancer control groups that include both traditional and non-traditional partners.
- 10) Focus on opportunities and interventions that will have the biggest impact for the greatest number of people.

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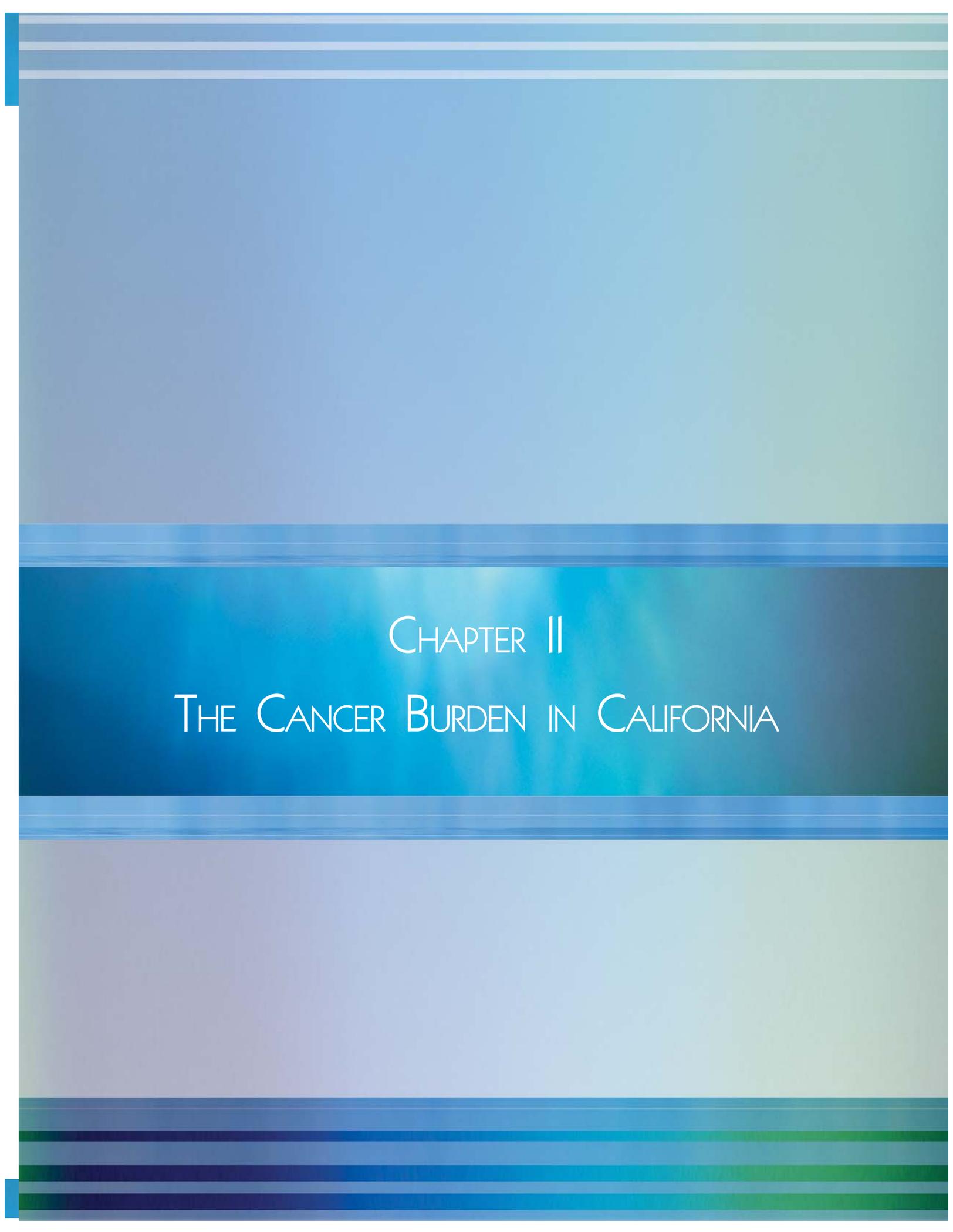
The California Dialogue on Cancer

In 2002, two leading California cancer control organizations that have collaborated over many years spearheaded the beginning of the planning process: the California Division of American Cancer Society and California Department of Health Services (DHS). Although California already has major, individual cancer control programs in place, no formal comprehensive plan has been developed since 1983.

A Comprehensive Cancer Control Steering Committee was organized and met June 7, 2002, to begin the planning process which would ultimately lead to the development of a draft plan. This distinguished committee was composed of numerous and diverse representatives from academia, corporate California, health care and insurance industries and institutions, consumer and advocacy groups, and others with an interest in cancer control. (See Appendix A)

In March 2003, California convened the California Comprehensive Cancer Control Plan Stakeholders Meeting to introduce the Steering Committee's thoughts on a draft plan to a large statewide coalition, to gain constituent participation, and to begin a massive reconstruction effort for cancer control program growth. Over 200 meeting participants examined the science of cancer control, its practice, funding, assets, gaps in cancer control efforts, barriers to close the gaps, and then identified priority strategies and tactics needed to overcome the barriers and produce successful cancer control outcomes. This meeting was the inaugural event sponsored by the California Dialogue on Cancer, the overarching organization that will take on issues of structure, growth, and outcomes for cancer control in California.

This plan is the first step.



CHAPTER II

THE CANCER BURDEN IN CALIFORNIA

THE CANCER BURDEN IN CALIFORNIA

Comprehensive cancer control programs, should, as should all public health-oriented programs, be evidence-based to ensure that limited resources are directed toward efforts that will lead to the most meaningful and applicable results.

Key characteristics of evidence-based programs include:

- › Intervention approaches developed are based on the best possible scientific information.
- › Problem solving is multi-disciplinary.
- › Theory and systematic planning approaches are followed.
- › Sound evaluation principles are followed.
- › Results are disseminated to others who need to know.

California has the ultimate resource to base its plan of action on and to use for evaluating the plan in the California Cancer Registry (CCR) and the Cancer Surveillance Section's Survey Research Group. In order to set the stage for the remainder of this plan, pertinent data from the Registry and the Survey Research Group are summarized below.

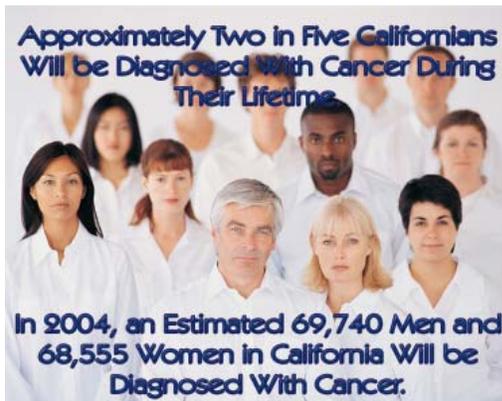
Table 1 shows the expected number of new cases per year for the ten leading causes of cancer. Among men, the most frequently diagnosed cancer is prostate, while breast cancer is the most frequently diagnosed cancer among women. Lung and colorectal cancers are second and third most frequently diagnosed cancers among both men and women.

**Table 1—
Estimated Number of New Cancer Cases per Year, by Gender and Site (Ten Leading Causes of Cancer Incidence), California, All Race/Ethnicity Groups Combined, 2004-2010**

Cancer Site	Annual Number of New Cases	
	Men	Women
Breast	135	22,415
Prostate	22,265	-
Lung	9,300	8,215
Colon	5,030	5,310
Urinary bladder	4,215	1,360
Melanoma	3,355	2,345
Non-Hodgkins Lymphomas	3,035	2,520
Uterine corpus	-	3,520
Rectum	2,320	1,825

Source: California Cancer Registry (11/02)
Prepared by the California Department of Health Services, Cancer Surveillance Section.

Cancer in California



6

Cancer is the second leading cause of death among all Californians, and one in four deaths in California is attributable to cancer. Among Asian/Pacific Islander women, however, cancer is the leading cause of death in California. While overall cancer mortality rates have been declining, the absolute number of cancer-related deaths is expected to increase because California's population is aging and growing in size. During 2004, approximately 27,080 men and 26,610 women will die from cancer in this state (1).

COMPREHENSIVE CANCER CONTROL IN CALIFORNIA, 2004

Table 2
Estimated Number of Cancer Deaths per Year, by Gender and Site (Ten Leading Causes of Cancer Death), California, All Race/Ethnicity Groups Combined, 2004-2010

Cancer Site	Annual Number of Deaths	
	Men	Women
Lung	7,530	6,445
Female breast	-	4,195
Prostate	2,925	-
Colon	2,165	2,250
Pancreas	1,395	1,525
Non-Hodgkins Lymphomas	1,175	1,000
Leukemias	1,205	935
Ovary	-	1,515
Liver	945	460

Source: California Cancer Registry (11/02)
 Prepared by the California Department of Health Services, Cancer Surveillance Section.

Table 2 shows the annual expected number of deaths for the most frequent causes of cancer death. Lung cancer will kill more California men than prostate and colon cancers combined, and as many women as breast cancer and colon cancer combined.

Mirroring the rest of the nation, the burden of cancer does not fall equally on all Californians, and the risk of developing cancer varies considerably by race/ethnicity. Among men, African-American men have the highest incidence and mortality from cancer, followed by non-Hispanic whites. Among women, non-Hispanic white women have the highest incidence of cancer, but African-American women have the highest mortality. Although Hispanic and Asian/Pacific Islander men and women are at lower risk of developing many cancers, they have higher rates of other cancers, including liver, stomach and cervical cancer. Asian/Pacific Islanders and Hispanics are two to three times more likely than non-Hispanic whites to develop stomach cancer, and are from two to five times more likely to develop liver cancer. Hispanic women also have twice the risk of being diagnosed with invasive cervical cancer relative to non-Hispanic white women.

In most race/ethnic groups, prostate, lung and colorectal cancer are among the top four cancers for males, while breast, lung and colorectal cancer are among the top four cancers for females. Risk varies considerably among the four-race/ethnic groups and variation exists even within Asian subgroups.

Table 3 and 4 show the five most common cancers and number of new cases for the period 1996-2000, among men and women, respectively. Prostate cancer was the most common cancer for men in most ethnic groups, but lung cancer was the most common cancer for Cambodian and Vietnamese men. Lung cancer also was the most frequently diagnosed cancer among Korean men.

Table 3
Five Most Common Cancers and Number of New Cases by Detailed Race/Ethnicity, California, 1996-1999, Men

Rank	Men				
	1	2	3	4	5
African American	Prostate 8,443	Lung 3,801	*C&R 2,291	**NHL 691	Oral 754
American Indian	Prostate 56	Lung 50	*C&R 41	Kidney 16	Stomach 14
Asian Indian	Prostate 305	*C&R 93	**NHL 68	Lung 67	Leukemia 64
Cambodian	Lung 44	Liver 38	*C&R 22	**NHL 16	Leukemia 13
Chinese	Prostate 1,337	*C&R 984	Lung 969	Liver 497	Oral 343
Filipino	Prostate 1,720	Lung 1,126	*C&R 700	**NHL 302	Liver 235
Hawaiian	Prostate 46	Lung 31	*C&R 27	Bladder 12	**NHL 10
Hispanic	Prostate 11,214	*C&R 4,221	Lung 3,771	**NHL 2,291	Leukemia 1,861
Japanese	Prostate 807	*C&R 577	Lung 386	Stomach 230	Bladder 165
Korean	Lung 293	Stomach 273	*C&R 262	Prostate 192	Liver 176
Laotian	Liver 53	Lung 41	Stomach 23	*C&R 16	Oral 14
Non-Hispanic White	Prostate 67,413	Lung 35,371	*C&R 26,203	Bladder 17,456	Melanoma 13,220
Vietnamese	Lung 408	Liver 343	Prostate 277	*C&R 238	Stomach 147

Source: California Cancer Registry (11/02)
 *C&R = Colon and Rectum
 **NHL = Non-Hodgkin's Lymphoma
 Prepared by the California Department of Health Services, Cancer Surveillance Section.

COMPREHENSIVE CANCER CONTROL IN CALIFORNIA, 2004

Table 4 — Five Most Common Cancers and Number of New Cases by Detailed Race/Ethnicity, California, 1996-1999, Women

Women					
Rank	1	2	3	4	5
African American	Breast 5,865	Lung 2,503	*C&R 2,485	Uterus 816	Pancreas 647
American Indian	Breast 77	Lung 39	*C&R 31	Uterus 24	Ovary 19
Asian Indian	Breast 373	Ovary 64	*C&R 61	Uterus 58	**NHL 44
Cambodian	Breast 48	Cervix 28	Lung 24	Thyroid 19	*C&R 15
Chinese	Breast 1,774	*C&R 901	Lung 649	Ovary 289	Stomach 263
Filipino	Breast 2,427	*C&R 606	Lung 470	Thyroid 400	Uterus 386
Hawaiian	Breast 70	Lung 29	Uterus 19	*C&R 18	Ovary 8
Hispanic	Breast 11,216	*C&R 3,384	Cervix 2,836	Lung 2,587	Uterus 2,071
Japanese	Breast 1,211	*C&R 587	Lung 337	Stomach 199	Uterus 192
Korean	Breast 415	*C&R 249	Stomach 181	Lung 149	Cervix 108
Laotian	Lung 31	Breast 30	Cervix 23	Stomach 16	*C&R 16
Non-Hispanic White	Breast 78,061	Lung 32,283	*C&R 25,868	Uterus 13,471	Ovary 9,369
Vietnamese	Breast 519	*C&R 215	Lung 194	Cervix 158	Thyroid 121

Source: California Cancer Registry (11/02)
*C&R = Colon and Rectum
**NHL = Non-Hodgkin's Lymphoma
Prepared by the California Department of Health Services, Cancer Surveillance Section.

for Cambodian, Chinese, Korean, Laotian, and Vietnamese men. Stomach cancer is one of the top five cancers for American Indian men, Chinese women, Japanese men and women, Korean men and women, Laotian men and women, and Vietnamese men.

Although not among the top five sites, African-American men and women have twice the risk of developing multiple myeloma, and cancers of the stomach or liver compared to non-Hispanic whites. African-American women have a 50 percent higher risk of developing invasive cervical cancer, and African-American men are 60 percent more likely to be diagnosed with prostate cancer compared to non-Hispanic whites.

Chances of Being Diagnosed Early and Surviving Cancer Also Vary by Race/Ethnic Group in California.

Similarly, breast cancer is the most frequently diagnosed cancer among all women except Laotian women, among whom lung cancer is the most frequent cancer. Cancer of the cervix does not appear among the top ten cancers for all California women combined, but is among the top five cancers for Cambodian, Hispanic, Korean and Laotian women.

Similarly, liver cancer is not one of the top cancers for all California men combined, but is one of the top five cancers

Table 5 shows the proportion of Californians diagnosed with early stage (*in situ* or localized) breast, prostate, cervix, colorectal cancer and

Table 5 — Percent of Cancers Diagnosed at Early Stage, by Race/Ethnicity, California, 1999

	Percent Early Stage			
	African American	Asian Pacific Islander	Hispanic	Non-Hispanic White
Breast (female)	61	69	62	70
Prostate (male)	64	70	70	71
Cervix (female)	41	46	50	53
Colorectal (male)	41	41	40	43
Colorectal (female)	41	39	36	41
Melanoma (male)	--	80	80	90
Melanoma (female)	--	84	89	92

Source: California Cancer Registry (11/02)
Prepared by the California Department of Health Services, Cancer Surveillance Section.

melanoma, by race/ethnicity during 1999. Through screening, these cancers can be diagnosed at an early stage. Yet fewer than half of colorectal cancers are diagnosed early in men and women of all race/ethnic groups, and fewer than half of cervix cancers in African-American and Asian women, despite the availability of effective screening programs. Incidence rates of more advanced breast cancer (Stages III and IV) were higher among African-American women than among non-Hispanic white women.

Survival from Cancer Varies by Type, but for Most Cancers Survival is Associated With Stage at Diagnosis.

Table 6 shows the relative survival from cancer by stage at diagnosis. Women diagnosed with breast cancer at an early stage have a 97 percent probability of surviving five years, but this drops considerably for women diagnosed with more advanced disease. Similar results can be seen for other cancers.

In the U.S., many minority groups experience poorer cancer survival than whites. For California, statewide survival rates by race/ethnicity are not currently available but race-specific and socioeconomic status (SES)-specific life tables are being developed in order to better characterize survival among individuals of the four largest race-ethnic groups in California.

Although cancer remains a major cause of illness and death, incidence rates for most

Table 6
Five-Year Relative Survival by Stage at Diagnosis, California, 1993-1999

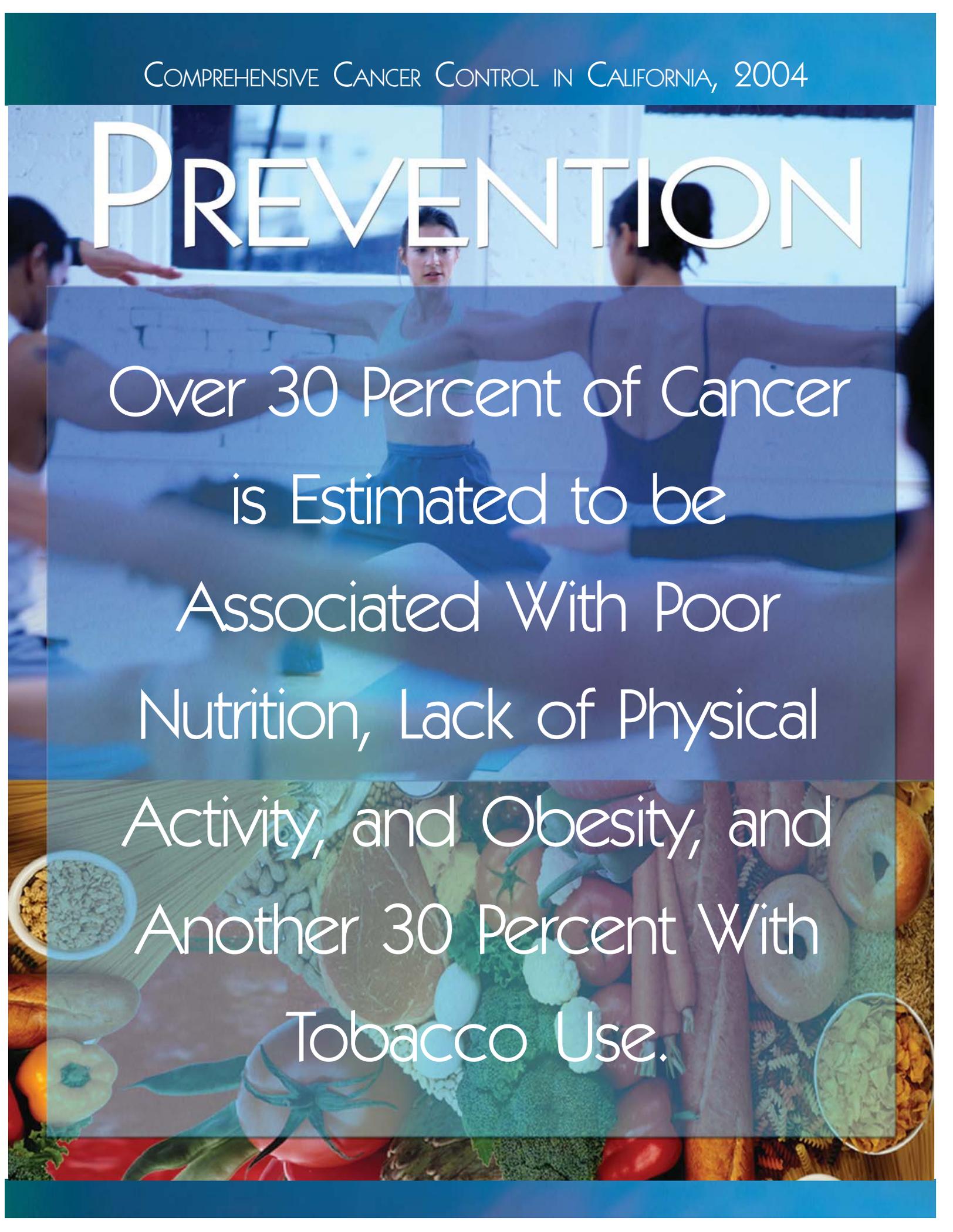
Cancer Type	All Stages	Localized	Regional	Distant
Female breast	87%	97%	77%	18%
Cervix uteri	70%	91%	52%	13%
Uterus	86%	96%	67%	18%
Ovary	54%	95%	79%	32%
Prostate	98%	100%	94%	33%
Testis	94%	99%	95%	69%
Oral & Pharynx	59%	79%	49%	28%
Colon & Rectum	63%	91%	66%	9%
Pancreas	5%	15%	6%	2%
Lung & Bronchus	14%	48%	20%	3%
Melanoma	88%	93%	52%	14%
Bladder	68%	80%	36%	7%
Hodgkin's Disease	82%	--	--	--
NHL**	52%	--	--	--
Leukemia	44%	--	--	--
Childhood (0-19)	73%	--	--	--
Adult (20+)	38%	--	--	--

Source: California Cancer Registry (11/02)
Follow-up is through December 2000
**NHL = Non-Hodgkin's Lymphoma
Prepared by the California Department of Health Services, Cancer Surveillance Section.

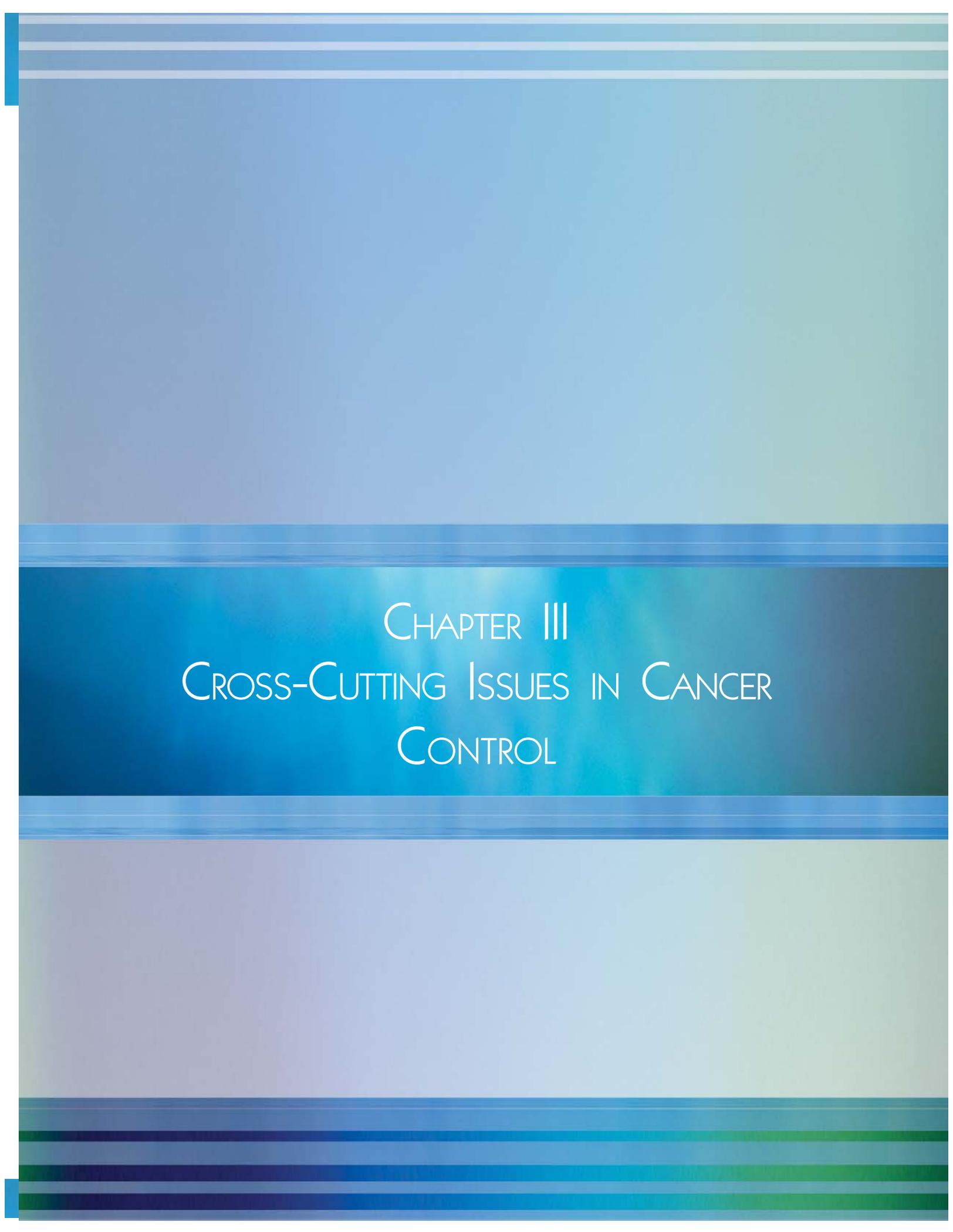
common cancers have declined among both men and women since statewide cancer reporting became mandatory in 1988. Much of this decline is the result of significant decreases in smoking-related cancers such as lung and bronchus, oral cavity, larynx, pancreas, stomach, cervix, uterus, and bladder. Yet smoking remains a significant problem among some groups and among young people of California.

Declining cancer incidence and mortality among non-Hispanic white men and women is not always apparent among the other race/ethnic groups in California. Continued research is needed to explore the unequal burden of cancer among Californians who are poor, lack health insurance, and lack access to adequate cancer care, factors which affect the cancer incidence, mortality, and survival.

PREVENTION



Over 30 Percent of Cancer
is Estimated to be
Associated With Poor
Nutrition, Lack of Physical
Activity, and Obesity, and
Another 30 Percent With
Tobacco Use.



CHAPTER III
CROSS-CUTTING ISSUES IN CANCER
CONTROL

CROSS-CUTTING ISSUES IN CANCER CONTROL

Certain issues cut across the full spectrum of cancer control. Although many of them are also discussed within each cancer site-specific or risk factor-specific chapter that follows, several are given special emphasis here to highlight their importance in implementing this plan and achieving its goals. Disparities in cancer burden, one of the paramount cross-cutting issues in cancer control, is addressed in the next chapter, "The Unequal Burden of Cancer."

Access to Quality Care

Access to health care is a leading national health indicator, and strong predictors of access includes having health insurance, a higher income, and a regular source of ongoing health care. Equal access to quality cancer care should ensure that all people diagnosed with cancer have access to appropriate treatment and follow-up, resulting in minimized disparities in treatment outcome.

The barriers to accessible quality cancer care, however, are enormous. Individuals with inadequate health insurance, low-income populations, and the working poor are at higher risk for increased cancer incidence and mortality rates and poorer cancer survival. This is also true for MediCal and Medicare recipients who are unable to get the care they need from physician groups, hospitals, or health care plans because of low reimbursement rates or gaps in coverage.

Access to care does not mean just getting in the door. What happens to people after they get into primary care can defeat the best of health care provider intentions and desires of their patients. Cultural, linguistic, and gender differences may impede communication and

understanding, resulting in additional barriers to quality care.

Prevention

According to the National Cancer Institute (NCI) and other cancer experts, prevention is a key strategy to reduce the nation's cancer burden. In the U.S., four cancers - lung, breast, prostate, and colorectal - account for 55.9 percent of all cancer cases and 52.7 percent of all cancer deaths. If California expects to reduce its cancer trends further, aggressive preventive strategies must be employed to reduce the cancer burden. For example, two of the most critical determinants affecting future cancer rates are the ability to reduce tobacco use and to increase healthier eating and physical activity in all populations. Over 30 percent of cancer is estimated to be associated with poor nutrition, lack of physical activity, and obesity, and another 30 percent with tobacco use.

The answers are clear where program priorities should lie. California must put limited resources where they will have the greatest impact for the largest number of people. This, however, is easier said than done. Academicians may prefer the investment be made supporting research in diagnostic and treatment advances, clinicians may prefer to focus on adequate compensation for clinical services rendered, and the public health constituency will likely look to primary prevention as the optimal strategy. A consensus of choices is needed as to where California makes its investments in cancer control in these lean fiscal times.

Survivorship, Palliative Care, and Quality of Life

The 2001 Annual Report to the Nation on the Status of Cancer states, "Although it is encouraging that overall cancer incidence and death rates continue to decline in the U.S., measures to sustain this progress must address the entire spectrum of prevention, early detection, and improved treatment and quality of life and must be aimed at reducing mortality among all populations."

"Quality of life" is really the optimum of what can be achieved to enhance the physical, psychological, social, and spiritual dimensions of cancer survivors' lives from the time of diagnosis through their balance of life. As the number of cancer survivors continues to grow and, in fact, survive to increasingly older ages, quality of life measures at each phase of the cancer continuum become a major concern.

Quality of life issues related to the needs of cancer patients, their families, friends, and caregivers include the following:

- › Control and relief of pain, fatigue, nausea, and other side effects of treatment.
 - › Amelioration of cancer's impact on physical appearance and body image.
 - › A support network of family, friends, social and cancer survivor groups, and a culturally competent and caring health care team.
 - › Socioeconomic support to help patients deal with financial, employment, and insurance barriers, and access to quality treatment and follow-up care.
 - › Care or referral to services that can assist the patients' and their families' psychological, emotional, and spiritual needs.
 - › Health care givers knowledgeable about and sensitive to their patient's culture and language and able to provide quality care and referral to support services.
- › The Institute of Medicine (IOM) and the National Research Council (NRC) in their report, "Improving Palliative Care for Cancer," tell us that, "Improvements in the development and delivery of symptom control and other aspects of palliative care needed in the late stages of cancer...have not kept pace with the medical advances that have allowed people to live longer."
 - › Palliative care may not currently be a higher priority within the health care system for several reasons, for example: lack of insurance reimbursement; inadequate skill of health care workers with poor, if any, training in symptom management; poor public sector investment in palliative care research and training; lack of standards of care and accountability in the care of dying and suffering patients; lack of public information resources for people dealing with end of life care; lack of reliable data on quality of life and care; and disparities in care for ethnic and low-income populations, even when that care is available.
 - › The IOM-NRC report cites several recommendations regarding palliative care that include: adequate reimbursement for palliative care by public and private insurers; culturally relevant adult and child patient oriented educational materials that give comprehensive, accurate information on palliative care; standards of care dictated by best practices guidelines for physical and psychological symptoms and encouraged by accreditation bodies; and enhanced data systems through cancer control registries, core quality measures, and support for research or demonstration projects in cancer care.

Surveillance and Evaluation

Cancer surveillance data provide the background and make the case for priorities and programs in cancer control. NCI states that a truly comprehensive cancer surveillance system would embrace the entire life cycle from birth to death and would include cancer data regarding healthy people, the newly diagnosed, patients receiving treatment, and those living with and dying of the disease.

The goal of surveillance data is to identify and prioritize at-risk populations for prevention strategies, early-detection programs, and research. Data are also crucial to determine access to the best treatment and to improve quality of life throughout the continuum of cancer and at the end of life.

California's greatest resource for cancer data is the CCR. The data it collects, compiles, and publishes helps to paint a clear picture of where our program priorities must lie, where disparities exist, and what populations California must reach. CCR data are essential to monitor the progress of this plan and the CCR requires adequate funding to do it.

Evaluation answers the question, "What works?" Evaluation must determine a cancer control program's progress, impacts, and outcomes and demonstrate (or not demonstrate) linkage between a program and its observed impacts and outcomes. Evaluation is based on what a program is expected to achieve and requires measurable program objectives. Unexpected achievements are also important to capture, therefore, both quantitative (e.g. number of deaths) and qualitative (e.g., impact on quality of life) methodologies are required. Evaluation is not only integral to this plan but to the objectives and strategies it generates between now and 2010.

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The Cost of Cancer

The National Institutes of Health (NIH) estimated overall U.S. costs for cancer in the year 2000 at \$180.2 billion which included \$60 billion for direct medical costs (all health expenditures); \$15 billion for indirect morbidity costs (lost productivity due to illness); and \$105.2 billion for indirect mortality costs (cost of lost productivity due to premature death). Allowing that California has at about 12 percent of the U.S. population and also the highest uninsured population (25 percent), it is easy to see that California's cancer costs are considerable.

Prostate Cancer: For prostate cancer alone, Max, et al., estimated that the total cost of prostate cancer in California in 1998 was \$360 million - divided equally between direct (health care) and indirect (premature death and lost productivity). Prostate cancer costs are expected to rise in the future as populations age.

Gynecologic Cancers: Max, et al., looked at the 1998 economic burden of gynecologic cancers that included cervical, ovarian, and uterine cancer. Direct medical costs were derived from California patient discharge data and the 1997 Medical Expenditure Survey. Indirect mortality costs were derived from the numbers of deaths and expected value of female future earnings.

The three gynecologic cancers in California cost a total of \$624 million. Direct costs, of which hospitalization was about half, were \$200 million. Indirect costs were over twice that amount at \$424 million. Ovarian cancer was the most costly at an estimated \$292 million, then cervical cancer at \$206 million, and uterine cancer at \$126 million.

Obesity: The "Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity: Economic Consequences," calculated

the year 2000 cost of obesity in the U.S. at more than \$117 billion. These costs do not bode well for California that has an overweight and obesity rate over 54 percent among adults and an overweight rate of 22 percent among teens 12-17 years of age (15, 16).

A Recent California Study Has Already Found That the Cost of Cancer-Related Health Care in California Attributable to Obesity Was \$15 Million While the Cost Associated With Physical Inactivity Was \$34 Million.

Lung Cancer and Tobacco: In California, the care and treatment for illness caused by smoking reached an estimated \$8.7 billion in 1993 (19). Other cost details related to lung cancer and tobacco are discussed in the chapter specifically addressing lung cancer.

Public Policy and Legislation

Cancer control constituencies must continue to address policy and legislative issues in order for progress to be made in controlling cancer in California. In framing issues, California must declare how serious the cancer problem is, how serious we are to solve it, that there is something we can do about it, and that the resources to solve the problem are insufficient. For example, social and political will and a lot of hard work made two huge advances possible to reduce the cancer burden in California: the 1988 Tobacco Tax Initiative, or Proposition 99 as it is commonly called, and the California smoke free workplace law that also included bars - a first in the U.S.

This same social and political will is needed to enact policies and legislation that, for example:

- › End disparities in cancer care and outcomes.
- › Institutionalize quality of care, quality of life, and pain management standards.
- › Protect Californians from environmental risks and determine the linkage of environmental factors with the development of cancer.
- › Reduce or eliminate chemical, physical, and biological exposures.
- › Ensure access for everyone to quality cancer prevention, early detection, and treatment programs as well as the entire cancer control continuum.
- › Ensure adequate funding for cancer research that includes translational research and technology transfer.
- › Fund population-based programs to curb obesity, overweight and physical inactivity among adults and youth and increase consumption of fruits and vegetables.
- › Protect school children from access to junk food on school campuses.
- › Defeat policies and legislation that maintain health disparities in California's multicultural population.

Research

In order to truly control cancer, sustained support for cancer research is paramount and must span across the entire research continuum, i.e., from basic/molecular/genetic research through epidemiologic and clinical research to translational research which focuses on the transfer of current technology from the academic cancer centers to the larger communities of both providers and consumers.

Increased funding for research is imperative and research results must be translated into cancer

control policies and practice. There are unacceptable lengthy lag times between scientific understanding of prevention and control measures and the widespread application of those measures in the community.

The result is tragic numbers of unnecessary deaths. For example, the Pap test was perfected in 1943, but not widely used until the early 1970s, mammography was available in the late 1950s, but not widely promoted until 1985. And the 1964 Surgeon General Report that warned about the link between smoking and cancer did not result in the application of comprehensive population-based tobacco control interventions until the late 1980s.

The first major National Academy of Science report on diet, physical activity and cancer was published in 1982. Today, however, several thousand more peer reviewed articles later, we are yet to see the systematic allocation of federal or state funds for diet and physical activity interventions as we have seen in tobacco control.

Over the years there has been a major emphasis on basic biomedical research at the federal level to the significant exclusion of support for more applied public health-oriented research. If California wants to accelerate its control of cancer in a timely manner, the type of research funded needs to be broadened. Primary prevention, early detection, innovative treatment, public issues and policies, health communications, and palliative and end of life care research all should be considered.

Future funding of research should include:

- › nutritional, physical activity, epidemiologic, and behavioral research,
- › diffusion, translational, and technology transfer research, and
- › health-delivering cancer control services research that examines societal barriers.

The need for systemic and fundamental social changes that are invariably connected to effective cancer control interventions is now recognized. The unequal burden of cancer in the U.S. is the most dramatic example that we must address. California, with its mainstream multicultural population, is in an important position to take on the kind of practical research that could help to eliminate disparities in cancer control.

In the meantime, California has not only tapped national and various foundation sources, it has made a major investment in its own comprehensive state-based cancer control research programs such as:

- › DHS' gender-based Cancer Research Program that provides the research and development base (100 million dollars) for many of the state's cancer control interventions;
- › The University of California's (UC) Tobacco-Related Disease Research Program that has funded (approximately 225 million dollars) a variety of research including basic, community-based and policy, and the UC Breast Cancer Research Program which has funded (about 115 million dollars) similar research focusing on breast cancer.

The downside to California's cancer research picture is that many still think research has more than adequate funding. California research initiatives supported to date represent a miniscule investment toward a disease that

continues to cost the State over 10 billion dollars a year. Expansion of this prudent investment would benefit not only Californians, but also the nation as a whole.

The Environment and Cancer

The 2002 International Summit on Breast Cancer and the Environment defined the environment as including "...the totality of living and working conditions as well as the physical, biological, social and cultural responses to those conditions." The Summit was primarily concerned with environmental exposures "involving activities that subject people to agents that they, as individuals, cannot control such as pesticides, dioxins, passive tobacco smoke and other chemicals, and ionizing and non-ionizing radiation." Environmental carcinogens of this type may be in air, food, water, and soil, and exposure can occur in the home, school, workplace, health care facilities, and many other places. Exposures are often influenced by social, economic, and cultural factors and may be chronic or acute. Science has long known of the linkage of certain cancers with the environment such as exposure to second hand smoke, asbestos, excess sunlight, and certain chemicals.

One of the Earliest Cancers
Linked With the Environment Was
Scrotal Cancer Among Chimney
Sweeps in 1775.

Currently there are more questions than answers as to how environmental factors influence the development of cancer, and finding areas of agreement among scientists is indeed a

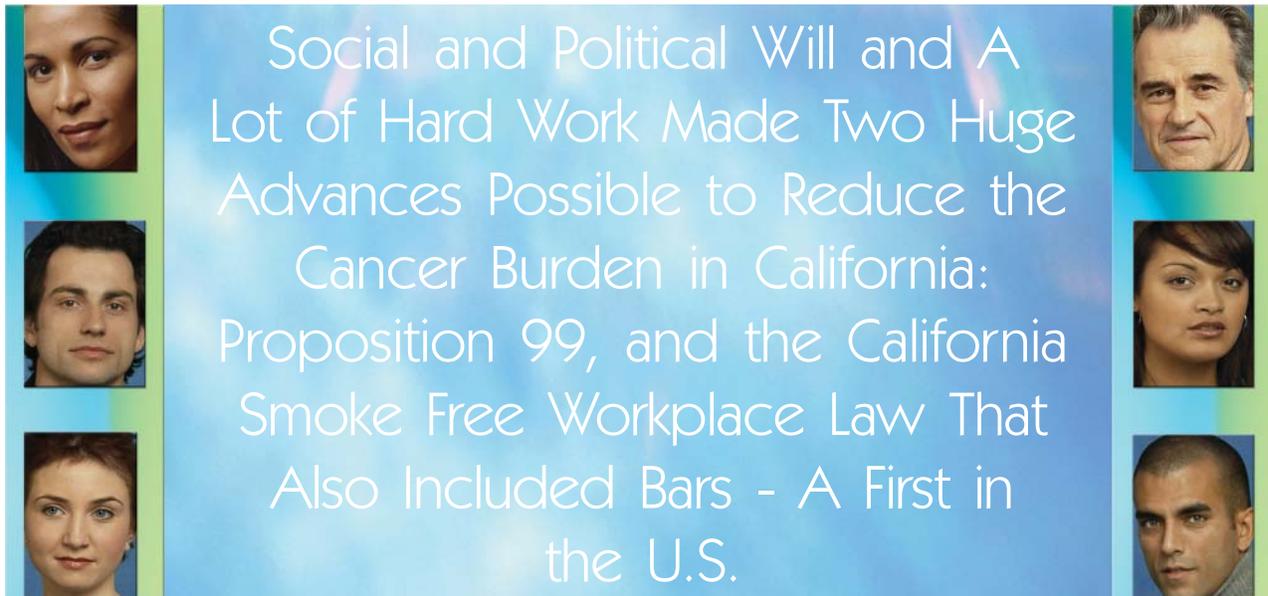
challenge. Studies suggest, for example, that there are dietary influences on cancer, and that specific foods and their components may reduce cancer risk.

The effects of "environmental" influences in poor communities such as tobacco promotions, excessive numbers of liquor stores, lack of affordable healthy food, unsafe streets and playgrounds require new study and broader approaches. Certain employees low in the corporate hierarchy may suffer increased exposure to certain occupational carcinogens, and migrant farm workers and their families are more vulnerable to high pesticide exposures and other potentially carcinogenic agents. Studies are also needed to explain to what extent country of residence vs. country of origin plays a role in the predisposition of cancer. The list of unanswered questions is long.

Major progress has been made in survival following diagnosis of cancer, yet the incidence of some cancers is on the rise, most notably the epidemic of breast cancer which cannot be totally explained by increasing screening rates. Current knowledge about the link between breast cancer and the environment is uncertain at best and more research is definitely needed. The link between long-term hormonal therapy with breast cancer only recently came to light and obesity is now an acknowledged breast cancer risk.

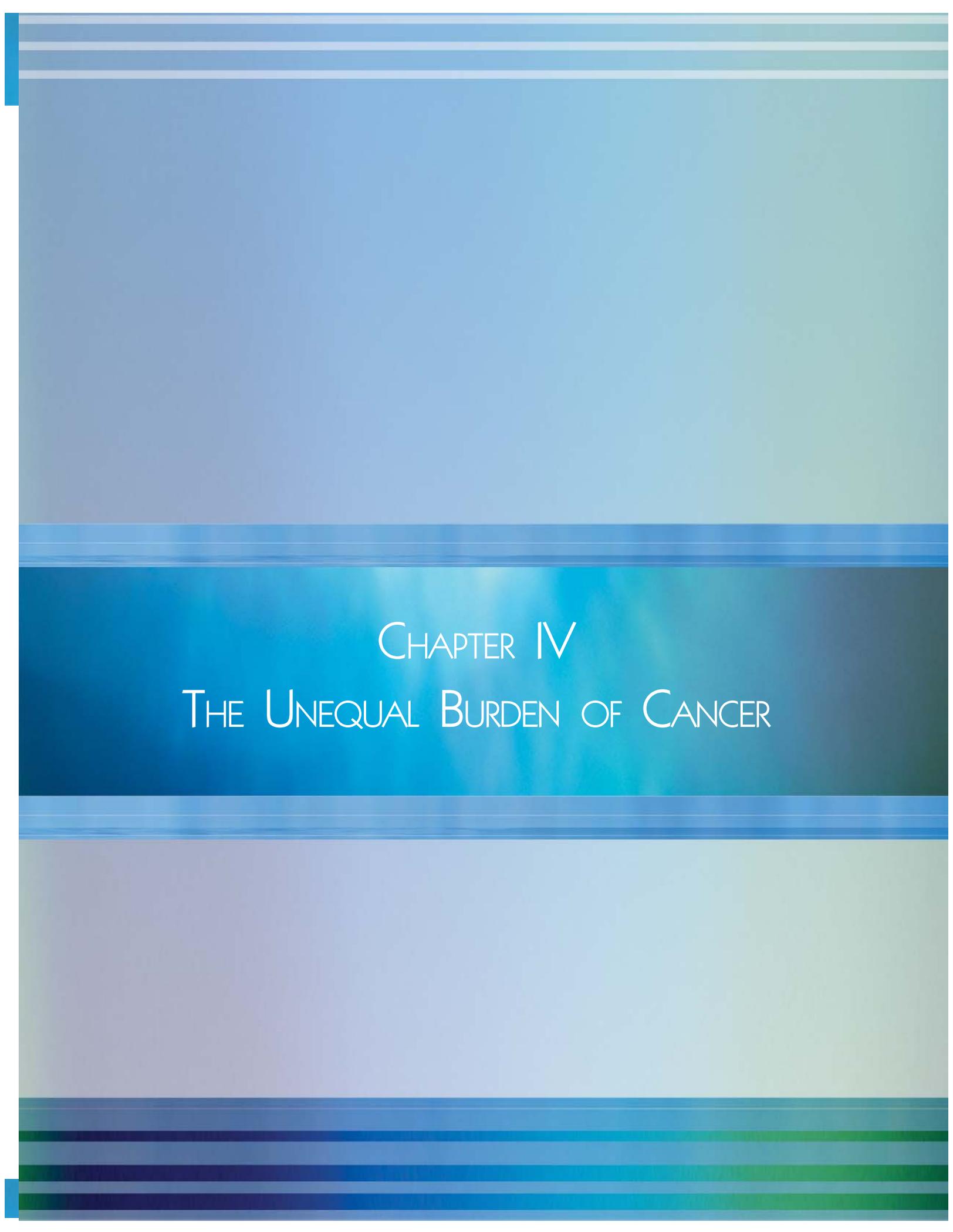
Although, the International Summit was largely concerned with the environment and breast cancer, some of its recommendations about research, community education, policy needs can apply more broadly to all cancers. The Summit participants recommended improved exposure assessment in population studies, identification of better biomarkers indicative of exposure, and that more cohort and collaborative studies should be funded.

Also identified as needed were studies of the interplay between timing of events and chronic exposure, linkage of cancer registries to occupational data, large multi-center epidemiological studies to look at breast cancer international differences and environmental exposures, how the estrogen receptor status of tumors is related to causes of breast cancer, and inclusion of all ages in future breast cancer research. Additional research is certainly warranted in this controversial and important area.



Social and Political Will and A Lot of Hard Work Made Two Huge Advances Possible to Reduce the Cancer Burden in California: Proposition 99, and the California Smoke Free Workplace Law That Also Included Bars - A First in the U.S.

The graphic features a central text box with a blue background and white text. On either side of the text box are three small, square portraits of individuals, arranged vertically. The portraits are set against a light blue and green background.



CHAPTER IV
THE UNEQUAL BURDEN OF CANCER

THE UNEQUAL BURDEN OF CANCER

GOAL

By 2010, all populations in California will have access to quality cancer care across the entire continuum of cancer with no disparity in outcomes.

OBJECTIVES

1. By 2010, eliminate disparities in cancer incidence, morbidity, mortality, survivorship, and quality of life.
2. Provide equal access to optimal cancer care along the entire cancer care continuum (including prevention, screening, early detection, treatment, and palliative care) for everyone by providing comprehensive, culturally competent, language appropriate health care regardless of race or ethnicity, gender, age, income, insurance status, geographical location, sexual orientation, housing status, occupation, physical or developmental or mental ability, or immigration status.
3. Eliminate institutional racism, classism, sexism, and other related barriers in the delivery of optimal cancer care where they exist.
4. Increase the diversity of the health care workforce.
5. Eliminate late-stage cancer presentation at diagnosis in ethnically diverse Californians.
6. Develop a set of consistent guidelines for cancer screening for health care providers.

Background and Barriers to Achieving Goals and Objectives

Disparities in California

"Disparities" is the common term used to describe a population-specific difference in the presence of disease (in this case cancer), health outcomes, and access to the continuum of cancer care (which includes prevention, screening, early detection, treatment, rehabilitation, and palliative care). In other words, a disparity usually refers to a difference in

what happens to a racial, ethnic, low-income, underserved, rural, or disabled population in contrast to the comparison group, which is, in most reports, non-Hispanic whites.

Disparities in cancer prevention and control are usually found among those who encounter barriers, not necessarily of their choosing, to optimal cancer care (education, prevention, detection, treatment and rehabilitation).

The term underserved includes, but is not limited to: Individuals and their children who are indigent; working poor without adequate medical insurance; elderly; homeless; those who have limited education; those who have limited literacy or language ability; persons with physical and/or mental disabilities, and those whose cultural beliefs and practices are not supported by Western biomedicine.

Since over half of California's population is non-white, addressing health disparities is of monumental importance to reduce the incidence, morbidity, and mortality of cancer and to improve the quality of life in this state. California has no population majority and is unique as the most diverse state in the U.S.

The 2000 U.S. Census shows that of California's total 33.9 million people, 47 percent are non-Hispanic white, 32 percent Hispanic/Latino, 11 percent Asian, 7 percent African American, 1 percent American Indian, and 0.3 percent Native Hawaiian and other Pacific Islander.

California has the largest Asian population group in the U.S. and approximately 70 percent are first generation immigrants. In addition, California has large low-income, uninsured, and rural populations.

Disparities and Cancer

Cancer is the second leading cause of death across all populations (except Asian-American females, for whom cancer is the leading cause of death) and the four major cancers - lung, breast, colorectal, and prostate - make up over 50 percent of cancer incidence and mortality. The risk of developing cancer, however, varies by

ethnicity. The underserved are often diagnosed at later stages and with a higher incidence of cancers with higher mortality, such as lung cancer.

The reasons for this variability are not fully understood. In California, for example, African-American men have the highest overall cancer rates, and though African-American women are less likely to have a cancer diagnosis than non-Hispanic white women, they are more likely to die from it. African-Americans have higher rates of stomach, liver, and multiple myeloma cancer than non-Hispanic whites, and are 50 to 80 percent more likely to have cancer of the prostate and larynx (48).

Asian, Native Hawaiian and other Pacific Islanders, and Hispanic/Latinos have higher rates of stomach and liver cancer than non-Hispanic whites. In fact, liver cancer mortality is second only to lung cancer for Cambodian, Hmong, Laotian, and Vietnamese males. Lung cancer is rising among recently immigrated Cambodian and Vietnamese men, who also have among the highest smoking rates of all ethnic groups. American-Indian males have high smoking rates as well, and suffer from high lung cancer rates.

Poverty, Disparities, and Access to Care

Disparities exist in knowledge, access, treatment, and survival among California's diverse, low-income, rural, and disabled populations. Strong predictors of access to care, for example, includes having a higher income, health insurance, and a regular source of on going health care. Since a significant number of Californians do not have health insurance, and this certainly includes ethnically diverse groups, their access to quality care or even care at all is

clearly limited. As a result the uninsured are at risk for high cancer incidence, mortality, poor cancer survival, and poor quality of life.

Early in the 1990s, Harold P. Freeman, MD, current Director of the Center to Reduce Cancer Health Disparities, National Cancer Institute, declared poverty as a carcinogen. Poverty not only acts as a barrier to prevention, screening, and treatment services, it can contribute to the development of cancer through social and physical environments in which the low-income live and often work. While SES is not a substitute for ethnicity, the reality is that many ethnic groups live in lower SES neighborhoods. The consequences to cancer care are many, including higher incidence, more advanced stage of cancer at presentation/diagnosis, inadequate treatment, and hence greater mortality rates.

Gaps

California must continue to work hard to overcome gaps in its cancer control programs with efforts specifically directed to the state's many diverse and low-income populations.

Gaps include:

- › lack of health insurance for critical services that can prevent, detect, treat, rehabilitate and support quality of life for cancer survivors;
- › lack of funding for the CCR to provide surveillance data and monitoring for smaller populations groups such as the many Asian, Native Hawaiian, and other Pacific Islander nationalities and American Indians;
- › lack of health care providers who reflect the diversity of this state and who have cultural competency to communicate with their patients and diverse co-workers;

- › lack of assistance for patients to navigate their health care and receive quality of life support;
- › lack of access to social support services;
- › lack of facilities with appropriate equipment to accommodate people with physical and/or sensory disabilities;
- › costs of medications not covered by insurance;
- › the need for scientists to involve the community in research, particularly translational research;
- › lack of knowledge of available services by both patients and providers; and
- › a lack of appropriate cultural and linguistic skills in education and delivery of cancer services.

Calls for Action

Disparities in the burden of cancer are discussed in each chapter of this plan and are imperative for California to solve in the face of the state's large multicultural and diverse population. Fifty-three percent of California's total of 33.9 million people equals an ethnically diverse population of almost 18 million, and this figure does not include all of the low-income and uninsured.

Three calls for action on this issue have gone out from the IOM, a fourth from the U.S. Department of Health and Human Services (DHHS), and a fifth from the U.S. Centers for Disease Control and Prevention (CDC).

Two reports from the IOM specifically cite the disparate care provided to ethnic minorities in the U.S. The 1999 IOM Report on Unequal Burden of Cancer for Racial and Ethnic Minorities, and the 2002 IOM Report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," which reported minorities are more likely to receive lower quality health care

regardless of income and insurance coverage. The DHHS national health objectives for 2010 set as its second of two goals to eliminate health disparities among racial and ethnic populations within the U.S. CDC followed, stating "Differences in cancer death rates result from a combination of factors such as behaviors (e.g., smoking and poor nutrition); access to preventive, diagnostic, therapeutic, and screening services and aggressiveness of treatment. If these factors were modified, more than half of the cancer deaths could be prevented and most racial-ethnic disparities in cancer death rates could be eliminated."

Herein lies the challenge to California.

THE UNEQUAL BURDEN OF CANCER — STRATEGIES AND TACTICS

Strategies to Achieve Goals and Objectives:

Strategy 1 ————— Increase Cancer Health Disparities Research. Within the Next Two Years:

- › Enhance the funding for California-based special population networks toward increasing clinical trial participation and for cancer disparities research.
- › Advocate for private and corporate donors to fund cancer disparities research
- › Support community-based participatory research.
- › Advocate and recruit community-based organizations and community-based providers for participation and/or collaboration in research and clinical trials.
- › Provide funding for support services for participants in diverse and low-income communities to participate in clinical trials, e.g., transportation and childcare, and cost of added ancillary treatment required due to participation in clinical trials.
- › Increase the awareness of community oncologists of the need for participation of diverse groups in clinical trials by encouraging those efforts in oncology associations.

Strategy 2

Increase the Capacity of Agencies, Institutions, and Community-Based Organizations to Work With Diverse Communities. Within the Next Two Years:

- › Identify existing barriers to working with diverse populations in community-based organizations, agencies, and institutions.
- › Increase the capacity for in-depth, comprehensive and substantive diversity training in state medical and educational institutions and the development of measurable behavioral outcomes. This should include information regarding language access requirements, an education campaign to inform the public regarding laws relating to meaningful access, identifying organizations that could provide this training, and identifying best practices and advance replicated models to the entire state.
- › Participate in existing and future governmental and community-based network meetings and forums.

Strategy 3

Increase Surveillance Data, Especially for Population Subgroups. Within the Next Two Years:

- › Increase awareness and lobby the Department of Finance for intercensus population estimates for smaller populations other than the major five groups specified by OMB Directive 15.
- › Educate staff in hospitals who enter patient information to include more definitive patient data regarding diversity, including socioeconomic information.

- › Gather data on immigrant status and add more identifiers such as “rural,” first generation or second generation acculturation indicators, and disability status.
- › Increase and sustain funding for the CCR.
- › Improve population, racial/ethnic classification techniques.

Strategy 4

Provide Universal Health Care Coverage.

- › Promote and support legislation to make this a reality.

Strategy 5

Enforce Existing Laws, Including, but not Limited to, Americans with Disabilities Act and Language Access Laws, Such as:

- › Title VI Civil Rights Act of 1964
- › Executive Order 13166, Year 2000, requires “meaningful access” to all federally funded programs, including medical institutions
- › KOPP Act, California Health and Safety Code, Section 1259
- › Dymally-Alatorre Bilingual Service Act