

A Cancer Policy Agenda for North Carolina

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Public health approaches to cancer focus on 3 areas: prevention, early detection, and elimination of health disparities. All have significant state policy applications and implications. While considerable emphasis is placed on federal policy, states play a significant role in influencing federal policy. Nearly every major policy initiative considered by Congress in the last decade was designed, tested, and improved through state experimentation. In order to further North Carolina's cancer policy agenda, we offer the following 5 areas of emphasis.

Increase Preventive Efforts

Reducing exposure to tobacco products in our society is arguably the most promising preventive intervention currently available.¹ Tobacco use is the most potent risk factor for cancer. It has been causally linked to more than 10 different types of cancer, and it is the primary cause of lung cancer, the leading cause of cancer death in both men and women.² The policy agenda for tobacco has been well-defined by the public health community. Based on sound science, recommended policy interventions include: (1) increasing the unit price of tobacco products, (2) funding comprehensive state tobacco programs, (3) providing support for those who want to quit, and (4) banning smoking in all worksites and public places.

Tobacco excise taxes are a revenue source for state governments that are strongly supported by the public, and studies have shown a public health benefit when the tax is raised by at least 10%.^{3,4} At 35 cents per pack, North Carolina currently has the sixth lowest tobacco tax in the nation.⁵ Raising this tax to the national average of \$1.14 per pack would have a profound affect on cancer rates across the state. Studies in other states have shown that for every 10% increase in the cost of cigarettes there is a 4% decrease in smoking in the general population and a 7% decrease in smoking among youth.⁴ Based on this formula, a 79 cent tax increase would decrease youth smoking rates by 17% and generate an additional \$360 million in new tax

revenues. A portion of this could be used to fund a comprehensive tobacco control effort in the state. The Centers for Disease Control and Prevention recently recommended that North Carolina increase its current level of tobacco funding by \$87 million to maximize efforts in tobacco prevention and control.⁶

In 2006, the 29th Surgeon General's Report found unequivocal evidence that regular secondhand exposure to environmental tobacco smoke increases cancer risks and is a significant occupational health hazard.⁷ Among nonsmoking restaurant and

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bar employees, rates of lung cancer are 20 to 30 times higher than in the general public.⁷ Restaurant employees are far less likely than other workers to be protected by smoke-free workplace policies, are more likely than other employees to have these policies violated where they do exist, and are more likely to be exposed to high levels of secondhand smoke on the job.⁷ While current North Carolina law has banned smoking in state-owned buildings and schools, it does not cover employees in high-risk occupations such as restaurants and bars. Current state law also preempts policy change at the local level. Communities are explicitly constrained from enacting nonsmoking ordinances by statute. North Carolina should join the 22 states that have now passed comprehensive statewide worksite smoking bans.⁸

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Tobacco is a highly addictive product that has been extensively grown, manufactured, and marketed in North Carolina. North Carolina tobacco users should be treated with compassion and supported in their efforts to quit. In 2006, 57% of North Carolina smokers made a quit attempt.⁹ State tobacco quit lines, when combined with the use of smoking cessation medications, have been shown to triple successful quit rates.¹⁰ The US Public Health Service recommends state quit lines should serve 4-6% of smokers.¹⁰ North Carolina was one of the last states to implement a quit line in 2006, and funding is available to serve less than 1% of all smokers. Most state quit lines also provide smoking cessation medications to callers. Providing additional funding for the quit line to reach more callers and allowing the quit line to provide over the counter cessation medicines would allow the state to better meet the needs of North Carolina tobacco users who are trying to quit.

Increase Early Detection

Breast, colorectal, and prostate cancers are the second and third causes of cancer death in men and women.¹¹ Breast and colorectal cancers are highly treatable when detected early using cost-effective screening tests. Access to cancer screening is highly dependant on access to a regular health care home that is affordable, convenient, and trusted. While universal access to comprehensive health care is outside the reach of most states, states are capable of providing universal access to cost-effective cancer screening tests. The federal Breast and Cervical Cancer Control Program (BCCCP) provides grants to states to provide breast and cervical cancer screening to women who are poor and uninsured. Women who are found to have cancer are automatically eligible for Medicaid coverage to assure they get treatment. The federal program provides services for about 10% of eligible women, and at least 14 states have expanded the federal program with state appropriations to reach more of the eligible population. In 2007, North Carolina expanded the NC BCCCP program by \$2 million, allowing an additional 8000 women to be served. Ultimately these services could be provided as an entitlement, assuring access to any women who seek screening services.

North Carolina could also follow the lead of a few states that have expanded the BCCCP program to include screening for colorectal cancer and have included colorectal cancer and prostate cancer in the Medical Treatment Act, making Medicaid coverage of treatment available to those diagnosed by health care providers who participate in the screening program. Funding for the Purchase of Medical Care for Cancer program, described elsewhere in this issue, could also be expanded with a more focused mandate to assure that treatment is available for cancers identified through recognized screening programs.

Eliminate Health Disparities

Racial and ethnic minorities are more likely to be diagnosed with cancer at a later stage, suffer higher rates of complications from their treatments, and die from the condition.¹³

Differences in access to care are one important cause of these disparities. Expansion of the screening programs discussed previously can improve early detection of treatable cancers among minorities. However these programs often fail to reach minority communities because of physical barriers, limited health literacy, fear, and mistrust. Funding for targeted outreach, social marketing, expansion of rural and urban health centers, incentives for practice in underserved areas, and recruitment of minority health professionals can help increase participation in screening programs.¹⁴ Culturally competent care practices improve knowledge, trust, and self-management skills in minority patients, increasing their adherence to recommendations for additional follow-up or treatment. Federally-funded providers are required to meet 4 Culturally and Linguistically Appropriate Services (CLAS) standards. State policy could be created to develop minimum standards and encourage their use through incentives.

Reduced access to care explains some but not all health disparities. It is clear that differences in the quality of care provided to racial and ethnic minorities also play a role in cancer disparities.¹³ Health care providers must have access to good data on utilization of services and clinical outcomes in racial and ethnic groups in order to engage in quality improvement efforts to identify and address disparities. North Carolina data on health care utilization among racial and ethnic minorities are limited. State surveillance of health disparities is currently only available from birth, death, and behavior survey data. Only 55% of North Carolina hospital discharge data currently have complete race and ethnicity fields. With the exception of Medicaid and Medicare, North Carolina insurers do not routinely collect data on enrollees' race and ethnicity. Self-reported race and ethnicity data are accurate and reproducible, and North Carolina recently joined a number of states that have mandated hospital reporting of these data. Race and ethnicity reporting must be improved among all North Carolina health care providers so that disparities in cancer utilization and quality of care indicators can be identified and addressed.

Support Cancer Survivors

Early detection of treatable cancers and medical advances in treatment have improved cancer survival rates considerably. However, a cancer diagnosis is a frightening experience, especially when compounded by the inadequacies of our health care system. Many individuals who have survived cancer find themselves unable to obtain health insurance either because they are ruled ineligible or because they are unable to secure affordable policies. Many states have established high risk insurance pools so patients with preexisting or chronic medical conditions can still obtain health insurance. In 2007, North Carolina passed legislation to establish a high risk pool by 2009. However, the premiums for these policies will be substantial and potentially beyond many peoples' means. The state could increase the number of people covered in the high risk pool by providing subsidies for low-income enrollees.

Balance Investment Priorities

Health services researchers, policy experts, and health leaders place great emphasis on the importance of prevention as a well-established strategy to reduce human suffering and decrease health care costs.¹⁵ However only a small portion of every health care related dollar is spent on prevention. North Carolina has aggressively pursued federal funding to develop nationally recognized preventive health programs and become a leader in public health research. State funding has also been an important component of this success. In 2001, the state established the North Carolina Health and Wellness Trust Fund (HWTF) and directed 25% of the Tobacco Master Settlement Agreement funds to develop and implement public health and preventive interventions across the state. This resource has been an invaluable asset for state efforts in tobacco control, obesity, health disparities, and access to medications. In 2004, HWTF funds were used to support the debt burden for several new medical facilities, including a new cancer center at the University of North Carolina at Chapel Hill. This resource will be invaluable to improving cancer treatment options for North Carolinians. However, this has also reduced the limited state resources available to invest in preventive

“12 year survivor. Thank God, and to Him I give all the praise. Complete remission.”

— Bobby
Prostate Cancer

health interventions by as much as \$350 million over the next 25 years. Efforts must be made to address this.

Despite our progress, cancer has now surpassed heart disease as the leading cause of death in North Carolina.¹⁶ Policy makers and health leaders need additional information, options, and resources to impact the underlying causes of cancer and eliminate disparities. In 2007, the North Carolina General Assembly funded a historic initiative to support and expand cancer research in the state's academic institutions. In developing policy for this research agenda, academic leaders must balance investments in developing new medical treatments with increased attention to expanding the evidence base for preventive interventions and exploring additional options for screening and early detection. Such an agenda would guide our future efforts to assure a progressive public health policy agenda for cancer in North Carolina. **NCMJ**

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