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African American Breast Cancer Health Disparities

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AFRICAN AMERICAN BREAST CANCER HEALTH DISPARITIES

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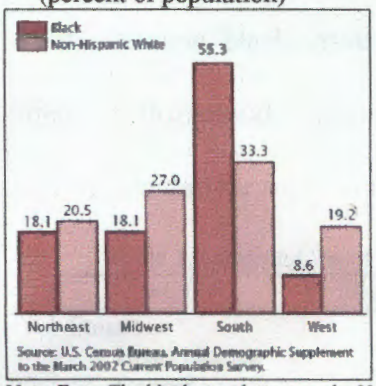
Health disparities are "the differences in the incidence, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the United States" (National Cancer Institute [NCI], 2002). Racial and ethnic minorities experience serious disparities in health access and outcomes. Disparities in the burden of death and illness experienced by African Americans in particular, as compared with our nation's population as a whole, are particularly striking. There are a variety of factors contributing to these inequalities. The purpose of this report is to examine these factors and the consequential effects on the African American's overall health status through a thorough analysis of current studies and reports. An especially discerning case of a health disparity is this population's higher overall cancer incidence and mortality rates when compared to the white population. This report will place particular emphasis on the breast cancer health disparities faced by the women in this minority group. Additionally, programs and initiatives working towards the disappearance of these disparities will be identified and evaluated.

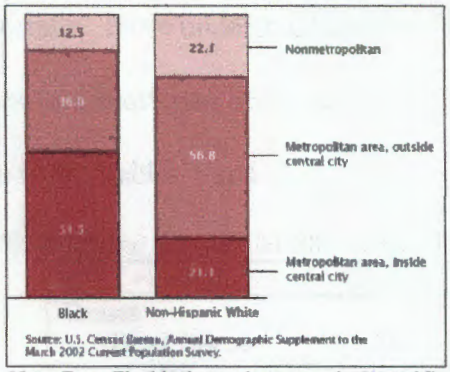
In order to understand the problems faced by African Americans, it is helpful to have a basic understanding of the group's general demographic information. The U.S. Census Bureau (2003) reports that of the approximately 37 million people in the United States, more than 13% of the total population, are black. As diagrammed in Figures 1 and 2, the majority of blacks live in the South and inside the central city of metropolitan areas.

Figure 1, Region of Residence by Race: 2002 (percent of population)



Note: From *The black populations in the United States: March 2002* by J. McKinnon, 2003, United States Census Bureau.

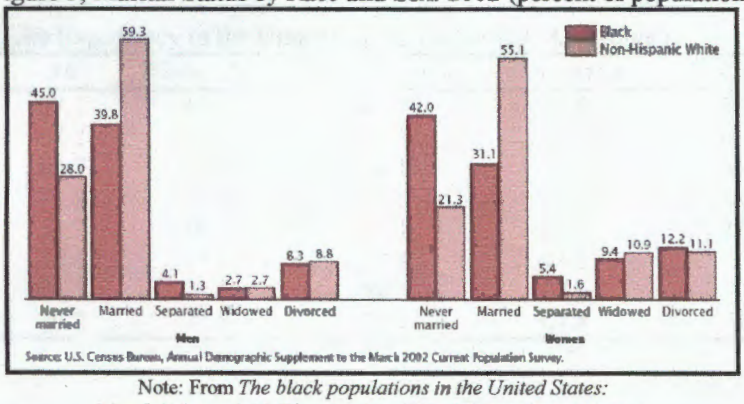
Figure 2, Metropolitan and Non-metropolitan Residence by Race: 2002 (percent of population)



Note: From *The black populations in the United States: March 2002* by J. McKinnon, 2003, United States Census Bureau.

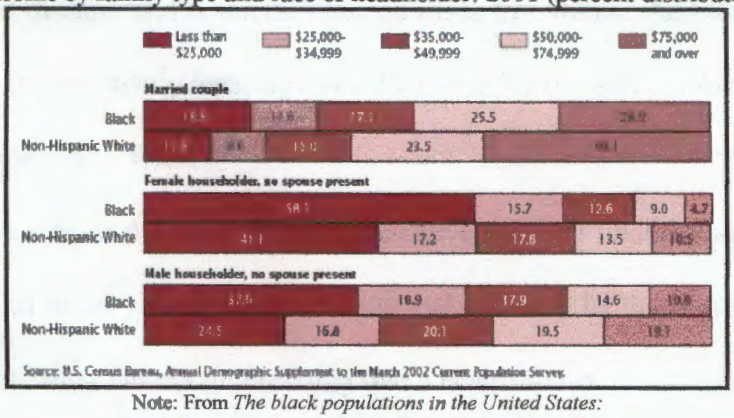
Additionally, there are more single-parent families and the majority of these families are poverty stricken. This information is revealed in Figure 3.

Figure 3, Marital Status by Race and Sex: 2002 (percent of population)



Note: From *The black populations in the United States: March 2002* by J. McKinnon, 2003, United States Census Bureau.

Figure 4, Family income by family type and race of headholder: 2001 (percent distribution of families)



Note: From *The black populations in the United States: March 2002* by J. McKinnon, 2003, United States Census Bureau.

There are several major differences in the health of black and white Americans. As an overview, blacks have higher infant mortality, more undetected diseases, higher infectious disease rates, more chronic diseases, and shortened life expectancies. Budrys (2003) summarizes some of these differences in the Tables 1 and 2.

Table 1. Leading Causes of Death by Race/Ethnicity and Sex per 100,000 Persons, 1998.

Males	*White*	*Black*	*Females*	*White*	*Black*
Causes			Causes		
Heart Disease	333	408	Heart Disease	218	292
Cancer	247	343	Cancer	168	200
Stroke	58	86	Stroke	57	75
Lung Disease	55	45	Lung Disease	37	22
Accidents	22	26	Accidents	10	10
Suicide	21	11	Suicide	5	2
Assault	6	38	Assault	2	8
HIV	5	34	HIV	<1	12
Total Deaths	1036	1413	Total Deaths	726	955

Note: From *Unequal Health* by G. Budrys, 2003, p. 38.

Table 2. Life Expectancy in the United States, 1900-1999, According to Sex and Race.

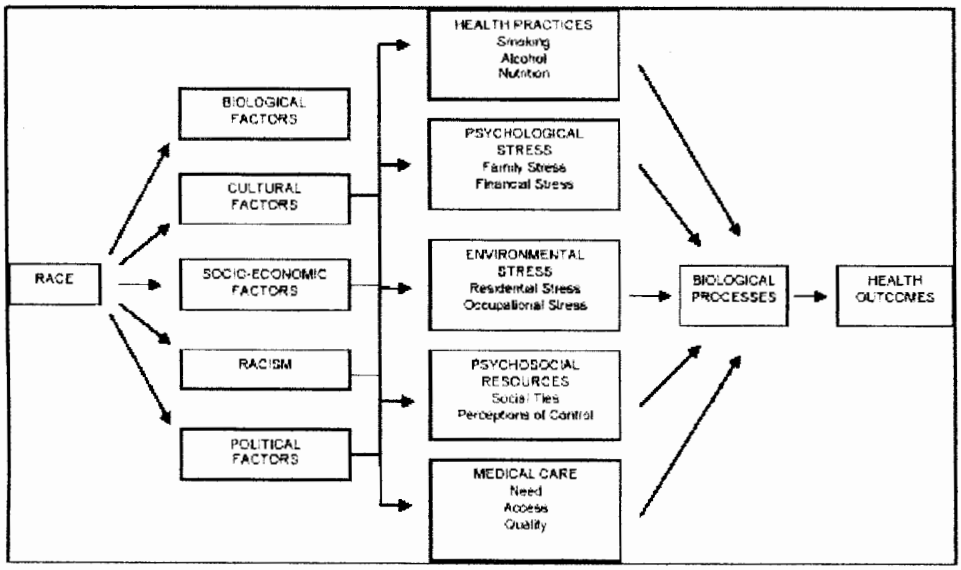
Year	*All*	*White Male*	*White Female*	*Black Male*	*Black Female*
1900	57.3	46.6	48.7	32.5	33.5
1950	68.2	66.5	72.2	58.9	62.7
1960	69.7	67.4	74.1	60.7	65.9
1970	70.8	68.0	75.6	60.0	68.3
1980	73.7	70.7	78.1	63.8	72.5
1990	75.4	72.7	79.4	64.5	73.6
1998	76.7	74.5	80.0	67.6	74.8
1999	76.7	74.6	79.9	67.8	74.7

Note: From *Unequal Health* by G. Budrys, 2003, p. 28.

The incidence of disease and mortality rates for blacks from many conditions (cancer, HIV/AIDS, heart disease, and homicide) exceed those for whites. Additionally, the life expectancies have consistently been significantly lower for the African American racial group when compared to Whites.

There are various models that have been developed for understanding the basis of this unequal health status. Figure 5 reveals a model provided by the National Institute of Health (2002) revealing factors determining one's health status.

Figure 5. A framework for understanding the relationship between race and health.



Note: From NIH (2002), p.15.

As seen in this classification scheme, race influences and determines one's biological make-up, culture, socio-economic status, racist perspective, and political life. Each of these main factors is intertwined within one's daily life and influences other health-determining factors. As seen in Figure 5, these secondary factors include health practices, psychological stress, environmental stress, psychosocial resources, and medical care. Each of these plays a prominent role on the biological processes of the human body and ultimately affect the health status of the individual. As destructive as each of one these of these factors is individually, when inevitably intertwined as they are, these factors can afflict the people effected by the disparities. A thorough investigation of these factors is required in order to gain a complete understanding of the disparities at hand.

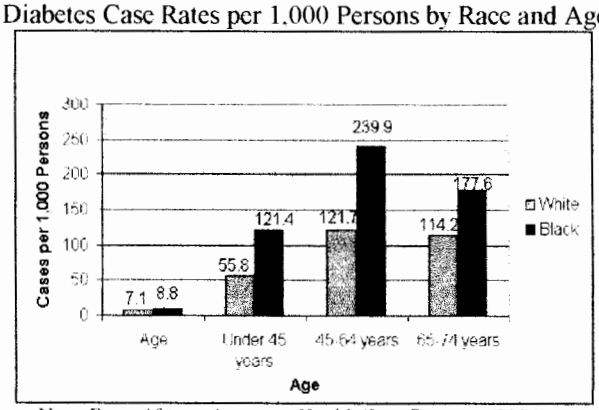
According to the United States Department of Health and Human Services [HHS] (2000), "Biology refers to the individual's genetic make-up (those factors with which he or she is born), family history (which may suggest risk for disease), and the physical and

mental health problems acquired during life." The general population of our society places a great deal of emphasis on genetics as a determinate factor of one's health. There are several diseases in which genetics do, in fact, play a role regarding the health of African Americans. These include type-2 diabetes and sickle cell anemia. On the subject of the increased incidence of diabetes,

> Some researchers believe that African Americans inherited a 'thrifty gene' from their African ancestors. Years ago, this gene enabled Africans, during 'feast and famine' cycles to use food energy more efficiently when food was scarce. Today, with fewer such cycles, the thrifty gene that developed for survival may instead make the person more susceptible to developing type-2 diabetes (National Diabetes Information Clearinghouse, 2002).

Figure 6 reveals the increased rates of diabetes among blacks.

Figure 6. Diabetes Case Rates per 1,000 Persons by Race and Age – 1995.



Note: From *African American Health Care Statistics* (2004).

Moreover, sickle cell disease is the most common genetic disorder among this minority group and is determined largely by genetics. The disease affects approximately one out of every 500 African Americans (Cohen, 2003). The reasoning behind this genetic difference may stem from previous malaria outbreaks in African. People with the sickle cell trait were more likely to survive than others. Thus, it is believed that the sickle

cell trait evolved as means of protection against malaria. However, this "protection" is no longer needed in today's world and the sickle-cell trait serves no purpose but to cause health problems.

Based on information such as this, it is tempting to assume that other diseases such as hypertension, increased cancer rates, and lower general health, can be attributed to genetics. However, when considering the specific example of increased hypertension rates, Budrys (2003) argues that "the problem with this conclusion is that the majority of African Americans come from the sub-Saharan region of Africa, where the population typically has low blood pressure, which translates into low levels of hypertension" (p. 80).

Although the genetic components of these diseases are very real, the genetic makeup of an individual is not the determinate factor of one's health. There are so many other differences in health outcomes that genetics play only a trivial role. Very few health problems have a singularly genetic cause. Usually, multiple risk factors play a role in the one's health status as confirmed in the aforementioned model of health disparities

The socio-economic status may be the most influential determinate of one's health. A higher proportion of blacks, compared to any other racial groups, are living below the poverty level. Table 3 reveals the relationship between poverty and race.

Table 3. Percentage of Persons below the poverty level, 1999.

Race/Ethnicity	*All Persons*	*Children <18*	*Children <18 in Female-headed Households*
All races	11.8	16.3	41.9
White	9.8	12.9	35.5
Black	23.6	32.7	51.7

Note: From Unequal Health by G. Budrys, 2003, p. 71

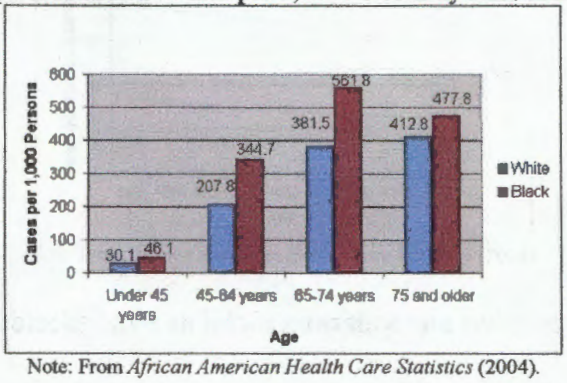
Fortunately, the 24% poverty rate for the blacks is as low at is has ever been. Budrys (2003) reports "it was over 50 percent during the 1960's and roughly 30 percent over the

last few decades" (p. 71). However, it should be noted that about half of black households are single parent, female headed households. These families experience a much greater degree of poverty than the rest of the black population. The fact that such a high percentage of blacks are poor may provide some insight into the effects that poverty has on one's health. The low economic, and thus social, status of this racial group lays the foundation for many of the other factors that influence health.

The cultural customs of African Americans may also play a role in their health status. Traditional beliefs about an individual's place in his or her community, belief in alternative methods of healing, and perception of the patient-physician relationship will directly cause many of the secondary factors in the identified model. The economic and social deprivation experienced by a large percentage of African Americans effects the lifestyle and health behaviors of this racial group, which in turn effects its overall health status.

Additionally, the consequences and the legacy of racism and racial discrimination are serious matters. The leading causes of death among blacks of all ages are chronic, stress-related diseases. In particular, heart disease as an effect of hypertension and high blood pressure has a devastating effect on the African American population.

Figure 7, Hypertension Case Rates per 1,000 Persons by Race and Age – 1995.

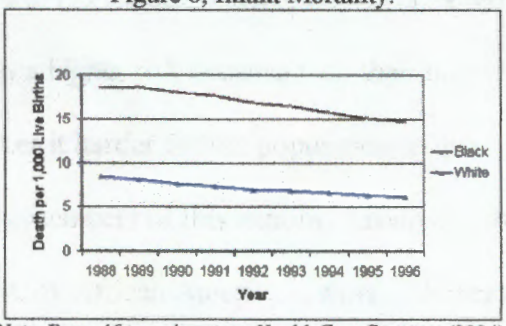


Note: From *African American Health Care Statistics* (2004).

The increased stress is correlated with racist perspectives. This racism, whether perceived or physically acted upon, creates barriers to health care access. There appears to be a clear connection between the increased blood pressure and self-reported experiences of discrimination or unfair treatment. A study by Krieger and Sidney (1996) found that blood pressure is lower among blacks that reported they challenged unfair treatment than those who reported they accepted racial discrimination as an unchangeable part of U.S. society. Dealing with the barriers and racial insults from others contributes to stress-related health problems.

Each of these primary factors is associated with one's daily life and predictably affects the secondary factors listed in the diagram. These secondary factors include health practices, psychological stress, environmental stress, psychosocial resources, and medical care. The socioeconomic status and cultural practices of this group affects their health practices. Living in poverty is associated with poor nutrition because it is cheaper to buy non-healthy, high-fat foods than it is to buy nutritional fruits and vegetables. Malnutrition plays a role in the onset of a wide variety of poor medical conditions and increases the risk of problems during pregnancy and infant development.

Figure 8, Infant Mortality.



Note: From *African American Health Care Statistics* (2004).

Figure 8 illustrates that blacks have an infant mortality rate twice as large as that of whites. Additionally, it should be noted that many traditionally African American foods

are not high in nutritional content. Therefore, the diets of a large percentage of the group who can afford adequate amounts of food are still unhealthy because of the poor nutritional quality of the food they traditionally enjoy. Kumanyika and Odoms (2001) report "Nutritional monitoring data indicate that the average intake of some essential nutrients are still below recommended levels in the African American population. Food insecurity (that is, the sense of not having enough to eat) is also more common in blacks than whites"(p. 419).

The use of tobacco should also be considered when examining one's lifestyle. African Americans are lighter or less intense smokers than whites. Headen and Robinson (2001) provide several reasons for this discrepancy,

> "First, the cigarette brands preferred by African Americans are higher in nicotine and may satisfy the addiction with fewer cigarettes. Second, the economic disparity that exists between blacks and whites may reduce African Americans' ability to smoke large numbers of cigarettes" (p. 357).

Interestingly, however, both incidence and mortality rates for lung cancer in African Americans are significantly higher than the rates among whites. Perez-Stable and colleagues (as cited in Jones, Hernandez-Valero, Esparaza, & Wilson, 2001) concluded that this group might be at a higher risk because they their body responds differently to nicotine in a way that makes it harder for the population to quit smoking.

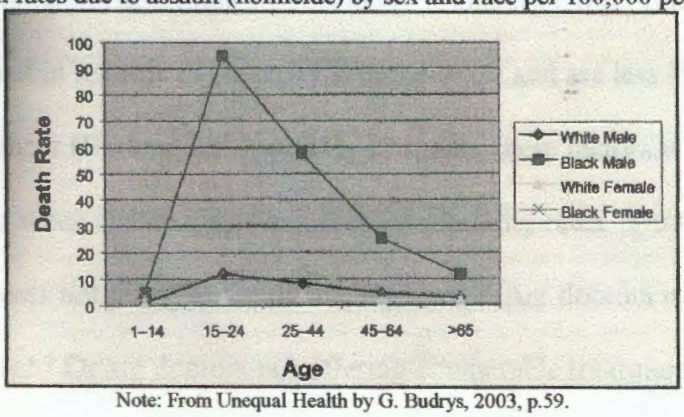
Additionally, many members of this minority group are challenged with powerful environmental stresses. Many African Americans work in lower level, low-wage jobs. Blacks working in these low-wage jobs are often subject to hazardous work environments. Having to do such laborious work under unsafe conditions is extremely

dangerous and detrimental to one's health. These workers are exposed to a variety of harmful chemicals and other work-related illness and injuries.

Poverty is not only correlated with unsafe working conditions, but also unhealthy living environments. Poor, black neighborhoods often consist of older houses and overcrowding. The people living in these neighborhoods are subjected to increased exposure to lead paint poisoning, fire hazards, air pollution, etc. Additionally, communicable diseases are easily spread throughout these communities due to the close proximity and overcrowding of the people in these neighborhoods.

The socio-economic status, cultural, and racism factors are also correlated with one's dilapidated psychosocial resources. Socially inflicted trauma is a large component of the African American health status, particularly that of young black males. The tremendous difference between the rates of violent crime involving young black men compared to young white men is seen in Figure 9.

Fig. 9, Death rates due to assault (homicide) by sex and race per 100,000 persons, 1999.



Note: From Unequal Health by G. Budrys, 2003, p.59.

While living in the dilapidated, poor, communities people begin to believe that "they cannot do anything to improve their living conditions, which include high crime rates, vandalism, graffiti, drugs, and so on" (Budrys, 2003, p. 198). As the number of unemployed adults increases, the youth have less reason to believe that their fate will be

any different. Young people, especially young men, find it harder to find social support in such a depressed environment, which explains, in part, why they turn to gangs. Involvement with gangs, drugs, and alcohol has obvious, very important, health consequences on those participating in these acts and on the community as well. Those not directly involved in these acts can be hurt in accidents caused by people under the influence. Also, these acts effect the future generations because this social cycle is continuous. Children grow up with these things around them and will most likely follow in the footsteps because they don't see any other hope for themselves or because it is the only thing they know how to do.

Each and every one of the primary resulting from race effects one's need, access, and quality of medical care. There are also disparities seen in the medical care received by African Americans as compared to that of white Americans. Dr. Alcena (1994) reports "two-thirds of the deaths in the black community are due to poor health care delivery" (p. 11). African Americans are less likely to undergo appropriate diagnostic testing and treatment in regards to coronary artery disease and are less likely to undergo surgery for lung cancer (Budrys, 2003, p. 81). Forgoing these factors would obviously be considered a factor when considering the increased mortality rates. Do these problems arise from the patients not going to the doctor regularly? Are doctors not diagnosing the diseases early enough? Or are doctors not offering comparable treatment?

There is a critical need for greater health education and preventative health care in the black communities. Many blacks get little or no preventative care and access to health care is a primary concern. The lack of health insurance and lack of neighborhood health care facilities are at the root of this problem. Many do not have the time available

to leave work, transportation, or funding needed to get to the doctor. Budrys (2003) explains that poor blacks are not prevented from receiving high quality care at the point of crisis when the patient must go to the emergency room, but the disparities in medical care affect everything that happens before and after that point (p. 123). They seek care at a later stage of disease because they lack insurance and the funding to seek care earlier. Additionally, they lack funds to buy the necessary medications and follow the prescribed treatment regimen after a critical event, such as taking time off work.

However, even when insurance and funding are available, blacks consistently undergo fewer diagnostic procedures, are diagnosed at a later stage in the disease process, have less surgery, etc. Their health care is substandard. Potential explanations for these healthcare choices/consequences may be cross-cultural miscommunication, lack of trust, differing preferences, and discrimination on both the sides of the patient and/or physician. There is a desperate need for the educational services of health promotion specialists in black communities in order to distinguish these misconceptions.

The multi-factorial framework diagramed in the abovementioned model assists in understanding the relationship between race, health, and the origin of health disparities. The disparities in cancer health are particularly striking. Blacks have an overall higher cancer incidence and mortality rates than whites. The HHS (2000) reports that, overall, blacks are 34% more likely to die of cancer than are whites." Table 4 reveals the increased burden of cancer faced by African Americans.

Table 4. Overall cancer incidence and mortality race by sex and race.

Incidence[a]

	Rate 1997-2001 Rate per 100,000 persons		
	Total	Males	Females
RACE/ETHNICITY			
All Races	470.3	554.3	424.4
White	479.6	556.5	429.8
White Hispanic[b]	360.2	429.1	318.5
White Non-Hispanic[b]	490.9	563.2	443.7
Black	515.8	689.2	400.1

Mortality[a]

	Rate 1997-2001 Rate per 100,000 persons		
	Total	Males	Females
RACE/ETHNICITY			
All Races	199.8	251.1	166.7
White	196.9	245.5	165.5
White Hispanic[b]	139.7	177.8	114.4
White Non-Hispanic[b]	206.1	249.7	167.9
Black	252.5	347.3	196.5

Note: From National Cancer Institute, *SEER Cancer Statistics Review*.

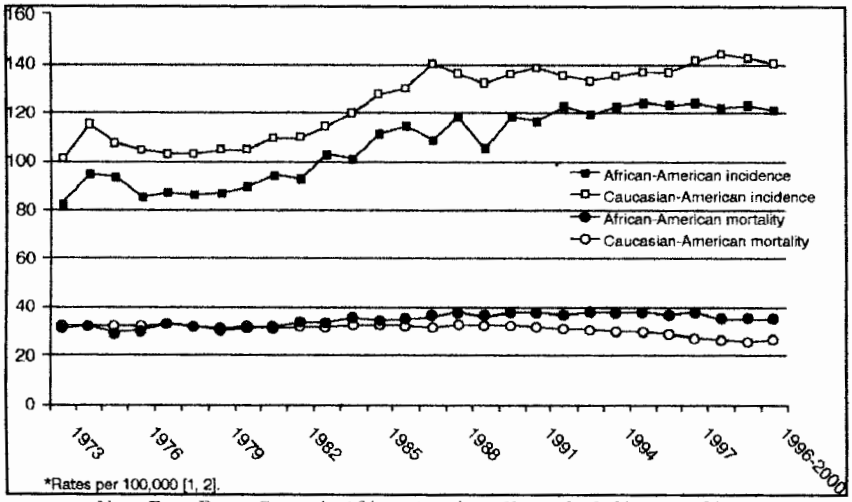
In recent years, as the NIH reports, there have been measurable declines for overall cancer death rates reflecting progress in the prevention, early detection, and treatment of cancer. "However, racial and ethnic disparities suggests that not all segments of the US population have benefited equally from such advances" (Jemal et al., 2004, p. 4). The cancer health disparities are undoubtedly the results of the factors discussed earlier. Additionally, and more specifically, there are other barriers effecting cancer-related care. The NCI (2005) identifies several of these as "financial, physical, lack of education, and barriers related to cultural differences and biases in cancer care."

A cancer diagnosis often foresees bankruptcy as patients struggle to pay the enormous expenses of the various aspects of their cancer care, even those lucky enough to have insurance. Additionally, African Americans are less likely to have a regular doctor than whites (20% compared to 30%, respectively) and more likely to have difficulty communicating with doctors (23% compared to 16%) (NCI, 2005, April 12). The NCI (2005, April 12) reports, "Much of the disparities in cancer outcome is a reflection of type, timeliness, and continuity care rather than the disease itself."

African Americans are faced with an increased burden of cancer, but the breast cancer health disparities are particularly discerning. Breast cancer is the most common type of cancer in women. Within this disease, an interesting health disparity is

manifested. Black women experience a lower incidence of breast cancer than white women, but the mortality rate turns out to be consistently higher, as illustrated in Figure 10.

Figure 10, Breast cancer incidence and mortality in African and Caucasian Americans.



Note: From Breast Cancer in African-American Women by L. Newman (2005).

Additionally, as with the other leading cancers, there has been a stable decrease in breast cancer mortality in the last decade "Despite the recent decreases in breast cancer mortality rates, significant survival disparities exist between races and the gap is widening between breast cancer rates for African American and white women" (Joslyn, 2002, p. 1759). The stark disparities in breast cancer between races are revealed in Tables 5 and 6 through the annual percent change rates.

Table 5. SEER Incidence Rates and Trends by Race/Ethnicity for 1992-2001.

	All races			**Whites**			**Blacks**		
Cancer site	*Rank*	*Rate*	*APC*	*Rank*	*Rate*	*APC*	*Rank*	*Rate*	*APC*
Breast	1	132.5	0.6	1	138.3	0.8	1	120.3	-0.3

APC: annual percentage change

Note: From Annual Report to Nation on Cancer and Survival by Jemal, et.al. (2004).

Table 6. U.S. Death Rates and Trends by Race/Ethnicity for 1992-2001.

	All races			**Whites**			**Blacks**		
Cancer site	*Rank*	*Rate*	*APC*	*Rank*	*Rate*	*APC*	*Rank*	*Rate*	*APC*
Breast	2	28.8	-2.4	2	28.3	-2.6	2	36.4	-1.2

APC: annual percentage change

Note: From Annual Report to Nation on Cancer and Survival by Jemal, et.al. (2004).

The incidence rate for white women has increased, "due in part to increased screening by physical examination and mammography" (Joslyn, 2000, p. 14), but the incidence rates for African Americans have actually decreased. This reiterates the higher incidence of breast cancer in white women compared to African American. Alarmingly, however, the death rates show almost an opposite trend. Each race reveals a decrease in death rates, but the white women have experienced a decline almost twice that of African American women. These trends directly reveal the consequences of the multifactorial origin of health disparities. Overall, African Americans have "poorer prognosis" when diagnosed with breast cancer (Joslyn, 2002, 1760).

Several current studies are of particular interest. A study by Wells and Horn (1992) analyzed the stage at diagnosis of breast cancer between the differing races in a large population study. There are several stages in the progression of disease. The stage describes the size of the tumors and/or how far the cancerous cells have spread from their original site to other parts of the body (NCI, 2005, April 14). The data was gathered from the United States National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program which collects information on all cases of cancer diagnosis among geographically defined subjects of the United State's population" (Wells & Horn, 1992. p.1383). The results of their study are shown Table7.

Table 7. Stage Distribution of Breast cancers among women, by race and census tract indicators of Education, Three Areas*

	In Situ		Localized		Regional		Distant		Other		Total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Under 12 y												
Black	48	(3.9)	466	(37.2)	529	(42.3)	180	(14.4)	29	(2.3)	1252	(100.0)
White	85	(4.3)	902	(45.7)	770	(39.0)	171	(8.7)	47	(2.4)	1880	(100.0)
High school												
Black	64	(4.3)	654	(43.8)	590	(39.5)	142	(9.5)	42	(2.8)	1492	(100.0)
White	455	(4.6)	4583	(46.0)	4007	(40.2)	694	(7.0)	221	(2.2)	9960	(100.0)
13 y and over												
Black	14	(6.4)	110	(50.0)	80	(36.4)	9	(4.1)	7	(3.2)	220	(100.0)
White	377	(5.4)	3429	(49.5)	2623	(37.8)	371	(5.4)	131	(1.9)	6931	(100.0)
Total												
Black	126	(4.2)	1230	(41.5)	1199	(40.4)	331	(11.2)	78	(2.6)	2964	(100.0)
White	917	(4.9)	8914	(47.2)	7400	(39.2)	1236	(6.6)	399	(2.1)	18 866	(100.0)

Note: The results of the Spearman rank-correlation test of association between education and stage of disease were as follows: Black, $t = -5.92$, $P < .001$, and White, $t = -6.32$, $P < .001$.
*The three areas are San Francisco–Oakland, Detroit, and Atlanta.

Note: From Wells & Horn (1992).

In summary of Figure 11, only 45.7% of Black women diagnosed in the more curable localized and in situ stages compared with 52.1% of White women. Over 11% of the Black women and less than 7% of Whites had breast cancers that had already metastasized beyond localized or regional into distant stage.

There are also racial differences in the treatment for early stage breast cancer (Joslyn, 2002). Her large population-based study consisted of African American and white women diagnosed between 1988 and 1998 with Stage I, IIA, or IIB breast carcinoma as reported in the NCI. The treatment variable of her study "describes the first course of treatment received by subjects, including only type of surgery and use of follow-up therapy" (Joslyn, 2002, p.1760). Many patients choose to have a surgery in order to attack the disease. Breast conserving surgery is the most common and involves "an operation to remove the cancer but not the breast itself" (NCI, 2005, April 14). Another type of surgery is mastectomy, in which the whole breast is removed in attempts to rid the body of the cancerous cells. Her study revealed that there are significant differences in the type of surgery between the races. As seen in Table 7, out of the

"women diagnosed with early-stage breast carcinoma who received BCS, African-American women were significantly less likely to receive follow-up radiation" (Joslyn, 2002, p.1762).

Table 8. Percent of Subjects Receiving BCS and, of Those Receiving BCS, Percent of Subjects Receiving Follow-Up Radiation Stratified by Age Category and Race for Women Diagnosed with Stage I, IIA, IIB, Breast Carcinoma, SEER Database 1988-1998

	White		**Black**	
Age Category (yrs)	*BCS (%)*	*Radiation (%)*	*BCS (%)*	*Radiation (%)*
<35	43.3	78.4	43.3	67.8
35-44	46.2	80.7	47.4	72.3
45-54	49.6	83.0	48.2	74.9
55-64	46.0	84.3	44.9	76.1
65-74	41.9	80.7	42.8	71.9
75-84	40.0	62.5	43.4	53.5
85+	47.1	22.4	52.1	24.4

BCS: breast-conserving surgery

Note: From Joslyn (2002).

Overall, these breast cancer health disparities are the consequences of the barriers on cancer care and the determinant factors of one's health status. Public health efforts to reduce these disparities are needed. The studies discussed above call for increased cancer screening programs, especially among the black populations of lower socioeconomic status and assuring equality in cancer care, including increased rates of radiation therapy. Additionally, increased research objectives are imperative to "understanding of the development and progression of diseases and disabilities that contribute to health disparities in minority populations" (NIH, 2002, p.23).

The Department of Health and Human Services and the National Institute of Health have developed extensive initiatives to reduce and ultimately eliminate health disparities. *Healthy People 2010* is a national health promotion and disease prevention initiative involving several federal agencies which "sets forth the Nation's health objectives for the next decade, which include a major goal for eliminating health

disparities among differing segments of the population" (NIH, 2002, p.19). The program focuses on improving the health status of the overall person. Their goals in breast-cancer related health issues are of particular interest. Their goals consist of a 20% decrease in breast cancer deaths, increase the proportion of physicians who counsel patients about cancer screening (from the current 37% to target goal of 85% in 2010), and "increase the number of states that have a statewide population-based cancer registry that captures case information on at least 95% of the expected number of reportable cancers" (HHS, 2000).

Additionally, the National Cancer Institute has requested increased resources in order to "better understand and address the causes of cancer health disparities" (NCI, 2004). The budget increases are outlined in Figure 11.

Figure 11. Overcoming Cancer Health Disparities Budget Increase Request for Fiscal Year 2006

Determining the causes & extent of cancer health disparities	**$19.00 M**
Evaluating promising new interventions	**10.50 M**
Collaborating for research, translation, & application	**10.50 M**
Training minorities for cancer care & research	**3.00 M**
Management & Support	**.65 M**
Total	**$39,15M**

Note: From NCI (2004).

Over half of this increased funding is directed towards determining the causes and extent of cancer health disparities. These focused research objectives will be of crucial

importance to the ultimate reduction of disparities. Only through increased cancer surveillance, development of improved methods of detection and treatment, and increased knowledge behind the biology of the disease can improvements in cancer health care occur. It is imperative that a large number of minorities be included in these studies in order to gain a representative sample of this population.

Communicating the scientific and health information gained from research about health disparities is of principal importance. The knowledge gained must not be discussed only in laboratories. Rather, the results gathered and any other pertinent information needs to be conveyed to the wide variety of people working towards improving the overall health of our nation and the elimination of health disparities through comprehensive and widespread outreach programs.

In conclusion, there is a multifactorial foundation of one's health status. One's race influences his or her biological make-up, cultural traditions, socio-economic factors, racist perspective, and political life which individually, and collectively, effect one's health status. African Americans are experiencing harmful health disparities. Specifically, this minority group faces overall increased cancer incidence and mortality rates when compared to whites. Alarmingly, more whites get breast cancer, but more blacks die from the disease. The reduction of these disparities is a major goal of several national initiatives, including the Healthy People 2010 campaign. Finally, there is call to arms of public health officials for greater health education and preventative health care in the black communities. It is only through education and personalized care can equality in health status be attained.

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