

Personal health depends upon multiple factors, many of which an individual can control and some of which he or she cannot. Genetic predisposition to disease, improper nutrition as a child, and inadequate education about healthy lifestyles affect a person's health for his or her entire life but lie outside the control of the individual. Just as doctors cannot always identify the cause of a disease in a patient, it is often difficult to separate the ways in which a person's socioeconomic status, race, and lifestyle affect his or her physical health. Given that health insurance provides access to health services, it too affects health outcomes. Often, individuals have little control over access to health insurance. In particular, people of low socioeconomic status may have difficulty in receiving health insurance, or cannot obtain it at all.

The majority of non-elderly adults obtain health care through employer-sponsored insurance; less common forms of insurance include privately purchased plans or Medicaid. In between this framework of coverage options, many go entirely uninsured. About 18% of women ages 18 to 64, have no form of insurance. Yet many of these women are working full or part-time. Families with at least one part or full-time worker constitute 79% of the total number of uninsured women (Kaiser Commission,1).

Recent studies attempt to analyze the relationship between insurance status and personal health. However, in order to prove a direct causal relationship between a particular level of insurance coverage and health outcomes, researchers must consider whether "unobserved differences between uninsured and insured individuals, rather than the difference in insurance coverage, explain both insurance status and the differences in medical care use and health outcomes"(Hadley, 1073).

To isolate and examine the consequences of insurance coverage, we can study how insurance impacts a patient's access to medical information and treatment. Although we most

often think of medicine in terms of intervention (i.e. seeing a doctor or getting a prescription after falling ill) we interact with the healthcare system in a variety of ways. In the U.S. healthcare includes health education and preventative medicine. Public education provides most individuals with basic information regarding hygiene and healthy living. After childhood, the amount of knowledge which adults access regarding disease may vary based upon insurance status. Likewise, a patient's access to preventative treatment and screening procedures may change depending upon insurance coverage. We can study the overall impact of health insurance status on the individual by considering the availability of healthcare services at each of these levels: education, screening for early diagnosis, and treatment.

This study considers non-elderly women with breast cancer. Despite the plethora of different kinds of health insurance, we will limit ourselves to considering three broad groups of women: those without any insurance, women on Medicaid, and women with either employer-based or private insurance. All women are at risk of developing breast cancer, and must have at least a basic understanding of the disease. Furthermore, we know that early detection can make a tremendous difference in patient outcomes. Therefore preventative medicine plays an important role in determining the effectiveness of treatment. Insurance status influences when and how these patients become informed about risk factors for the disease, regularity of screening, stage of the disease at diagnosis, and the treatment options available.

Outcomes are worse for Medicaid recipients and uninsured women with breast cancer (Figure 1). Although this paper focuses on how insurance status contributes to those poor outcomes, we will address other possible causes for disparities among patients. Many factors including race, weight, and environment play known but uncharacterized roles. Therefore, we must be careful to consider these factors before asserting causal relationships between health

insurance status, access to treatment, and the effectiveness of that treatment. Ultimately we would like to determine what changes to the current system of healthcare, including but not limited to insurance coverage, will help improve outcomes for uninsured and underprivileged populations.



Figure 1. Breast Cancer Survival Rates by Race and Insurance Status.

*Patients aged 18 to 64 years diagnosed from 1999 to 2000; excluded from the analysis: unknown stage; race/ethnicity other than White, African American, or Hispanic; missing information on stage, age, race/ethnicity, or zip code.

Data Source: National Cancer Data Base.

(Ward, Figure 13).

Breast Cancer as a Threat to Women's Health

Breast cancer remains a highly lethal disease, one which can be fatal for young and otherwise healthy patients. More women die each year of heart disease than breast cancer. But while heart disease is “the leading cause of death only for women over the age of eighty...breast cancer strikes at earlier ages with more lethal results” (Knopf-Newman, 21). In 2002, the National Cancer Institute's Surveillance, Epidemiology, and End Results Program (SEER) concluded that breast cancer was the greatest cause of death for women between 20 and 59 years of age (Knopf-Newman, 21). As a result, a breast cancer diagnosis has significant implications, not just for the patient, but also for her family.

Starting in the Victorian Age, the breast has been associated with the foundation of family. In the 1800's, most women concealed a diagnosis of breast cancer. The disease demanded secrecy because it “could destroy the nuclear family” (Knopf-Newman, 7). While the need to keep the disease private eroded with the feminist movement, breast cancer continues to create turmoil for patients and their families. A surge in the number of support groups for motherless children reflects the “increasing mortality rates for younger women, who are often younger mothers” (Knopf-Newman, xiii). Watching one's mother struggle through the experiences of diagnosis, treatment, and early death, profoundly affects a child.

Public perception of breast cancer has changed, but not all populations of women understand the disease to the same extent. Initial efforts educate the public about breast cancer targeted affluent society. The Women's Field Army, created in 1935, educated women about screening procedures for early detection and treatment options. However, the group consisted primarily of “white, middle-class housewives” (Knopf-Newman, 17). Although the Army collaborated with groups such as the National Association of Colored Women, and a Jewish

organization called Hadassah, the “women running the organization did not effectively leave behind their segregated lives as they reached out to communities of color and poor communities” (Knopf-Newman, 17). For the large part of the century, most considered breast cancer a disease of affluence, and many women of lower socioeconomic status went uninformed.

Recently, factors such as race and class entered the discussion of breast cancer. In the 1970’s over 5,000 studies were conducted on breast cancer, but few “even mentioned race as a category to be taken into consideration in research. Linking race and breast cancer, or thinking comprehensively about that relationship did not become substantive and commonplace until the mid-1990’s”(Knopf-Newman, 125). Research advocates such as Audre Lorde found this dearth of information inexcusable. They drew the public’s attention to the possibility that low-income, minority breast cancer patients face different challenges than wealthy, white women (Knopf-Newman, 125).

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Higher rates of breast cancer among poor women remain unexplained; there is insufficient evidence to conclude that these rates are the result of toxic environments, diet, or insurance status. While causation is difficult to establish, most social scientists concur that how women experience this disease relates directly to social, economic, and insurance status. Rather than try to sort through the various causes of the breast cancer and explain the inequity of breast cancer rates across class, this paper will consider how insurance status affects what women know about the disease, how frequently they undergo screening, and what treatment they receive. Proposals for delivery of more equitable healthcare services for women will address not only issues of insurance, but also additional barriers to access and use which are related to socioeconomic status.

What do women know about breast cancer? Knowledge of Risk Factors

Knowledge is power; a woman who is well-informed about breast cancer and understands her risk status can make better decisions. Therefore, educating women is the first step of preventative care. The average American woman has a 1 in 8 chance, or a 12.3% likelihood, of developing breast cancer over the course of her life (American Cancer Society, 9). However, personal risk factors can make an individual much more likely to develop the disease. Risk of developing breast cancer increases with age. In addition, women with two or more close relatives with the disease, a personal history of breast cancer, or genetic predisposition to the disease are at high risk for developing breast cancer (American Cancer Society 2008, 9-10).

Campaigns to increase public awareness of breast cancer are a relatively recent development. The American Cancer Society formed in 1913, and twenty-two years later, the first organization devoted solely to issues surrounding breast cancer was established (Knopf-Newman, 18). Today, women can access information from websites maintained by organizations such as the American Cancer Society, National Institute of Health, National Cancer Institute, and Susan G. Komen Foundation. In addition to these online resources, books ranging from personal memoirs of breast cancer survivors to collections of primary research articles discuss the topic of breast cancer. Yet only women with the resources and capacity to obtain and digest the material benefit from the information.

Even for those with access, it is difficult to interpret the data and make informed decisions. Experts disagree about the causes of and treatments for breast cancer; for a lay person without scientific or medical training the information can be confusing. Contradictory evidence and inadequate public education lead to misconceptions regarding breast cancer. For example,

many women understand that genetics affect a woman's risk of developing breast cancer, but incorrectly believe that only breast cancer on the maternal side of the family can put them at risk (Vuckovic, 50). Interestingly, mammography clinics in many states ask women to list the incidence of breast cancer on their maternal side only (Nat. Cancer Inst., online). Little data has been collected on how and when women obtain information about breast cancer. More information is needed to determine how best to reach women who are ill-equipped to study their disease on their own.

Awareness of Personal Risk: Who has access to genetic counseling services?

Genetic mutations in BRCA1 and BRCA2 genes create a higher risk of breast cancer. Although these defects are present in less than 1% of the general population, they dramatically increase the risk of disease for women that have them. Women with the BRCA1 mutation have a 65% risk of developing breast cancer before they turn 70, and women with a BRCA2 mutation have a 45% risk (American Cancer Society, Breast Cancer Facts and Figures). Given these statistics, there is an obvious advantage to identifying women with these genetic characteristics. Women who undergo genetic screening and learn that they have one or both mutations can take preventative measures such as more frequent screening or prophylactic surgery. However “genetic counseling and testing for heritable susceptibility to breast cancer caused by mutations in BRCA genes are largely unavailable to underserved women in the United States” (Lee, 306). This is due in part to the high cost of the service; genetic counseling requires multiple visits to a trained specialist, and it may take 2-3 months to test and advise a patient (Lee, 308).

In 2002, the San Francisco General Hospital (SFGH) received funding from the Avon Foundation to provide genetic counseling services to poor and underserved women. Doctors at

SFGH identified women at high risk of carrying the genetic mutation by examining family history of the disease. By requiring women to complete a thorough questionnaire as to their family history, physicians could identify women at high risk of carrying the genetic mutation. Unlike many other registries, this program asked patients to describe occurrences of cancer on both sides of their family. An estimated 40% of patients who received genetic counseling services through this program were identified based upon information regarding a history of breast cancer in their paternal line (Lee, 309). Over a three year period, genetic counselors at SFGH worked with more than 350 patients from diverse backgrounds (Lee, 309).

Despite the efficiency of recruitment methods, encouraging women to undergo genetic testing required physicians to overcome “psychological, cultural, and financial barriers” (Lee, 309). The outreach program at SFGH achieved success after gaining sufficient cooperation and communication between “referring physicians...surgeons, radiologists, and oncologists” (Lee, 310). The program proved difficult to implement, but it yielded results. Five women tested positive for a mutation of the BRCA1 gene and an additional twelve women tested positive for a BRCA2 gene mutation (Lee, 309).

Access to genetic counseling may not be enough to encourage women to participate. A study conducted on women with HMO insurance in Portland, Oregon uncovered many misconceptions of and opposition to genetic counseling. Many women who participated did not understand that genetic testing assessed likelihood of developing breast cancer rather than diagnosing the disease. In addition, there were misunderstandings about how the test is performed. However, the main objection women had to undergoing genetic counseling stemmed from a fear of the social consequences of a positive test result. These women were not persuaded by the idea that genetic counseling would allow them to take precautions to protect their health.

Instead, they believed that they would worry incessantly about developing breast cancer if they learned that they carried the mutation. This issue was brought up repeatedly among women of different ages and races, indicating that insurance status alone is not enough to encourage genetic testing (Vuckovic, 48-52).

However, all women should have the opportunity to obtain genetic counseling services regardless of their insurance status. Currently, only wealthy members of society can afford these services. The population of women counseled through the SFGH program was much more ethnically diverse and had a lower level of education compared to groups of women who sought out genetic counseling at private offices (Lee, 306).

Detecting Breast Cancer Early: The Importance of Regular Screening

Outcomes for women diagnosed with breast cancer are substantially better when the illness is identified at an early stage (ACS, Breast Cancer: Early Detection). Women who are screened regularly stand the best chance of catching the disease at its earliest and most treatable form. A mammogram, a type of x-ray, can detect breast cancer years before symptoms appear. Mammography is sensitive enough to detect “about 80%-90% of breast cancers in women without symptoms” (ACS, Breast Cancer Facts and Figures). The American Cancer Society (ACS) recommends that women have a mammogram performed every year after the age of 40 (ACS, Breast Cancer: Early Detection). Given the importance of this procedure, private health insurance plans as well as Medicaid and Medicare cover mammograms (ACS, Breast Cancer Facts and Figures).

Historically, researchers attributed lower rates of screening among the African American population to racial and cultural norms. Yet the most recent report published by the Cancer

Journal for Clinicians in 2006 concludes that mammography use varies more by insurance status than race. The “current overall usage of mammography is similar among White and African American women” (Smigal, 178). Additional studies conclude that health insurance status influence how likely a women is to have a mammogram. A National Health Interview Survey (NHIS) conducted in 2005 showed that women without insurance were much less likely to have a mammogram. Only 38.1% of uninsured women between 40 and 64 years of age had a mammogram in the past 2 years, compared to 56.1% of women with Medicaid insurance and 74.5% of privately insured women (Ward, 20-21). When controlling for other factors associated with insurance status, such as race and level of education, insurance continued to correlate with breast cancer screening. These trends regarding insurance status are present in data collected the following year, despite a decrease in the total number of women receiving mammograms. In 2006, only 33.2% of uninsured women had a mammogram in the past two years, versus 69.8% of women with insurance (Ward, 22).

Poor workers, defined as adults with incomes within 200% of the federal poverty line, are less likely to receive employer-based health insurance (Ross, 254). Yet a lack of health insurance is not the only barrier to care which women face. Poor working women who have health insurance may still struggle with limited access to preventative services. A comparative study analyzed the primary care available to poor and non-poor workers with employer-based health insurance. Although all the women included in the study had health insurance, the working poor were less likely to be screened for breast cancer than non-poor women (Ross, 255).

Possibly this disparity results from inadequate health coverage provided by low-paying jobs. If a patient’s health insurance will not cover breast cancer screening, the cost of mammograms will prohibit poor women from getting them. Evidence collected by researchers

comparing rates of mammography to rates of cervical cancer screening support this hypothesis. Mammograms can cost up to \$150 for women without insurance. Cervical cancer screening is less costly, and generally even poor women can pay for these services out of pocket . As a result there is no association between poverty and screening rates for cervical cancer. Meanwhile rates of mammography are closely connected to socioeconomic status, indicating that if poor women are not entitled to free or low cost mammograms, they are unlikely to get them on their own (Ross, 257).

Cost is not the only barrier for poor, uninsured women. Most communities offer screening services for free to uninsured women, but disparities in use persist. Therefore we must consider not just the affordability of the services, but also public awareness of their availability and importance. Women who have a regular doctor and who are told to receive yearly mammograms are more likely to do so. Women with access problems, defined as women who have not seen a primary care provider in over a year, are more than twice as likely not to be screened for breast cancer. An estimated 80% of women with limited access did not receive a mammogram in 2000 (Meissner, 62).

In 2004, researchers found access to a primary care physician more important than insurance status in terms of encouraging screening. While 68% of women without insurance went without a mammogram that year, a larger percentage of women lacking a personal doctor did not receive a mammogram that year (ACS, Breast Cancer Facts and Figures, 16). Therefore, access to a personal physician who can encourage women to undergo screening for breast cancer may be the best way to ensure that the ACS's recommendations are followed.

Women without insurance are less likely to have a personal physician. Survey data indicate that many doctors are reluctant to take new patients who do not have health insurance.

Those that do accept uninsured patients typically demand full payment at the time of service (O'Toole, 695). As a result, an estimated "40% of uninsured persons are unable to see a physician when they need to because of cost, compared to 7% of those with insurance" (Saha, 714). Health insurance grants a woman access not just to the mammogram itself, but also to a personal physician who can recommend and encourage preventative care.

Physicians can meet this need only if they are aware of the ACS recommendations and take the time to inform their patients. However, in many cases practicing physicians neglect to inform women that they should undergo screening. Therefore, even a woman with regular medical care may not receive a mammogram if her physician neglects to recommend one. In many instances "communication between patients and providers about the importance of mammography screening needs to be improved in clinical settings" (Meissner, 67).

As a result, underprivileged women are doubly disadvantaged. Not only do these women have less access to primary care, but for those that do have a personal doctor, the communication barrier between patient and physician may be extremely difficult to breach. NHIS data from 2000 show a correlation between a patient's level of education and "whether [she] reported that [her] doctor recommended a mammogram" (Meissner, 68). Therefore, one must consider how "communication between physicians and patients who are older, less educated, or not born in the U.S." affects health outcomes (Meissner, 68). Multiple factors including lack of insurance, language barriers, "poor comprehension of the system...cultural beliefs, and poor social supports" impact screening use (Coburn, 131). Little is known about precisely what type of outreach efforts would encourage women of lower socioeconomic status to seek regular screenings.

Disparity in screening rates exists despite recent attempts to make mammography more widely available. In 1990, the United States Congress passed the Breast and Cervical Cancer Mortality Prevention Act, which created the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) through the Center for Disease Control and Protection (CDC) (U.S. Dept of Health, online). The NBCCEDP provides mammograms at low or no cost to uninsured or underinsured women between the ages of 40 and 64 who fall within 250% of the poverty line (U.S. Dept. of Health, Natl. Cancer Institute, online). However, the budget is limited. When first created, the NBCCEDP operated in 5 states on a budget of \$30 million. However, the growth of the program has not been met with an appropriate increase in funding. Although the NBCCEDP now has \$182 million, the program extends across “all 50 states, the District of Columbia, five U.S. territories, and 12 tribes or tribal organizations...”(U.S. Dept. of Health, online). Approximately “only 13.2% of eligible women received a mammogram in 2002/2003 due in part to inadequate funding of the program” (Ward, 13). The current level of funding will coverage “only 20% of eligible women” at a maximum (Smigal, 180).

The limitations of the program are regrettable, because it provides screening for many uninsured women. Between 1991 to 2006, more than 3 million women were screened for cervical and breast cancer. As a result, almost 31,000 women have been diagnosed with breast cancer, women whose diseases would likely have gone undetected without the program. By diagnosing uninsured women “at early stages where treatment is most effective....it [NBCCEDP] reduces both the immediate costs of treatment and the need for repeat treatments of late-stage disease” as well as giving the patient a better chance of survival (U.S. Dept. of Health, online).

Stage at Diagnosis

Women without insurance are less likely to see a personal physician and receive mammograms, which delays diagnosis. A study of nearly 10,000 women in Florida diagnosed with breast cancer in 1994 considered the impact of health insurance status and race on the stage of breast cancer at diagnosis. The study found that “patients insured by Medicaid and patients who were uninsured were at greater risk for late stage disease” (Roetzheim et al, 1411). A study of breast cancer patients conducted from 1998 to 2003 by the NCDB corroborated these findings. Uninsured women and women on Medicaid were “1.5 times more likely to be diagnosed with stage II versus Stage I and 2.5 times more likely to be diagnosed with Stage III/IV versus Stage I” (Ward, 23). These trends exist even when looking within a single racial group, showing that this inequity is not the result of racial differences (Ward, 25).

Advances in cancer treatments prevent a diagnosis of breast cancer from being a death sentence. The earlier the disease is diagnosed, the better the chance of survival for the patient. Survival rates are very high for localized tumors, but once the cancer metastasizes a patient’s prognosis becomes worse (Figure 2). The gross disparity in survival rates based on stage at diagnosis proves the importance of screening. Uninsured women or those without regular sources of care are dying of breast cancer because their illness is not found until it is too late.

A. Five-Year Survival Rates* by Stage at Diagnosis and Race (%)

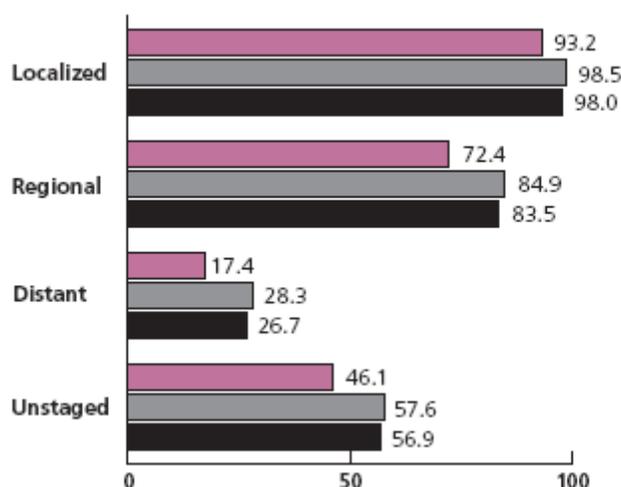


Figure 2. Five-Year Survival Rates Based Upon Stage at Diagnosis. (ACS Breast Cancer Facts and Figures, 9)

*Survival rates are based on patients diagnosed between 1996-2003 and followed through 2004.

Data source: Surveillance, Epidemiology, and End Results (SEER) Program, SEER 17 Registries, 1973-2004, Division of Cancer Control and Population Sciences, National Cancer Institute, 2007.

American Cancer Society, Surveillance Research, 2007

Not only do differences appear with respect to stage at diagnosis, but the size of the varies by insurance status. In a study of breast cancer patients in Rhode Island, women with “Medicare, Medicaid, and no insurance all presented with larger tumors than women with private insurance” (Coburn, 131). The average tumor size for a woman without insurance was 10 millimeters greater than the average size detected in women with private insurance (Coburn, 130).

These effects cannot be concretely attributed to insurance status, because often researchers do not perform longitudinal studies. Instead, they merely look at a patient’s insurance status is at the time of diagnosis. However, given the dramatic and consistent correlation between stage and size of the disease and insurance status, it is logical to conclude that a woman’s insurance coverage is an important factor which determines how likely she is to detect breast cancer at a treatable stage.

It makes intuitive sense that women without insurance are less likely to be screened for breast cancer and therefore more likely to go undiagnosed until a late stage of the disease, the fact that Medicaid patients are also being diagnosed at late stages is surprising. Although women covered by Medicaid have “access to cancer screening and diagnostic services,” coverage for this population tends to be sporadic (Roetzheim et al, 1413). Nearly “two thirds of new Medicaid recipients lost coverage within 12 months” forcing them from the “continuous insurance coverage that is conducive to comprehensive preventative care” (Roetzheim et all, 1413).

Treatment

There have been a wide range of studies and conflicting conclusions about the quality of care given to breast cancer patients based on their insurance status. Many research projects have studied the outcomes of state screening programs. One analysis of NBCCEDP in Detroit, New Mexico, and California found no significant differences in the care received by women diagnosed with early stage breast cancer through NBCCEDP and those receiving medical care from a private provider (Richardson, 133). Despite a lack of insurance and low income, these women were still received treatment comparable to that of their insured counterparts.

Yet a similar study in Rhode Island based on data from 1996 to 2005 found a great deal of difference in treatment based upon insurance status. When considering only women diagnosed with an early stage tumor, women with Medicaid coverage were less likely than privately insured women to have a mastectomy (Coburn, 132). Rates of breast conservation surgery were also lower for women with Medicaid or no insurance (Coburn, 132). This disparity exists despite the fact that since 2001, Rhode Island uninsured women with breast cancer are covered through Medicaid.

Researchers responsible for studies of state sponsored programs warn that “results may not be generalizable to other low income women diagnosed with breast cancer in other healthcare settings or even to other programs participating in the NBCCEDP” (Richardson, 139). Although NBCCEDP and Medicaid cover breast cancer patients in every state, the quality of that care varies. The number of medical facilities and physicians available, and the backgrounds of those physicians differ from community to community. These differences affect what treatment recommendations women receive (Richardson, 139).

Treatment for uninsured women may simply be luck of the draw based on where she lives. Women diagnosed in “Detroit and New Mexico were less likely to undergo breast conservation surgery than women diagnosed in California” (Richardson, 138). This variation has been “attributed to community characteristics and to available medical facilities” (Richardson, 138). Therefore, it may not simply be a lack of insurance causing the disparities in treatment. Undergoing a mastectomy, receiving radiation, or chemotherapy can profoundly affect not just the patient, but also her family members. Women with few sources of financial and social support may be ill-equipped to handle the aftermath of these procedures. Little data has been collected on the experiences of women after being treated in a hospital for breast cancer. Yet the ability to recover requires having the time and money to do so.

Disease is not purely a physical challenge, every diagnosis has psychological connotations and effects. Education, socioeconomic status, and cultural norms affect the way in which a woman responds to her diagnosis. Many minority women report feeling a lack of “control over their medical care” (Ashing-Giwa et al, 5). They do not seek second opinions or challenge the decisions of their physician as often as white women. Additionally they may face

language barriers, lack of access due to “lack of insurance, lack of transportation, and...long, inflexible work hours that inhibit their ability to seek early care” (Ashing-Giwa et al, 5).

Evidence for discrimination based upon financial status or race is largely anecdotal, but indicates a problem that must be addressed. We ought to consider not only the type of care that women receive, but also the way in which they receive it. A woman who believes that her class and insurance status put her at risk for poor treatment experiences a psychological trauma in addition to a physical one.

Past and Future Policy

The current system of healthcare in the United States favors intervention rather than prevention. In 2000, Congress passed the Breast and Cervical Cancer Treatment Act which extends the work of the NBCCEDP. The act allows states to use Medicaid funds to pay for treatment of uninsured or underinsured low-income women who have been diagnosed with breast cancer (U.S. Dept. of Health, online). This ensures that women will receive adequate care after diagnosis. However, most data indicate that outcomes for breast cancer patients relate strongly to the stage of the disease at the time of diagnosis. Preventative care can not be neglected; the largest problem facing the uninsured is a lack of access to primary medical care.

Insurance status affects access to primary care. Women without insurance or with inconsistent coverage are less likely to have a personal physician. These women have no regular source of care to guide them through the decisions that directly impact their health and well-being. No one reminds them to be screened for breast cancer, and as a result their illnesses go undiagnosed and untreated. Although low-cost and free screening services are available to uninsured women via the NBCCEDP, the data indicate that they are under funded and

underused. By the time an impoverished, uninsured woman is diagnosed with breast cancer, her chances at long term survival are poor. This outcome is unacceptable because it can be avoided.

In theory, screening for a particular disease could be conducted without establishing a system of universal health care. For example, the NBCCEDP could be expanded to include all women without insurance. However, research demonstrates that many illnesses, not just breast cancer, depend upon early detection for effective treatment. Rather than partition resources based upon disease, we ought to focus on making medical care more holistic in approach. By ensuring that each person has a personal doctor and access to preventative care, we can avoid ineffective interventionist treatments.

Knowledgeable physicians must dedicate time to communicate with patients, explore treatment options, and ensure that each person has the resources to care for themselves. Doctors should be trained to provide patients with information that is understandable and empowering. Rather than being a passive recipient of health care services, patients ought to have reason to believe that the procedures they are undergoing have a purpose. A more personal approach to healthcare, one which is sensitive to cultural and socioeconomic differences will allow patients to be more active participants in their treatment. This requires a closer relationship between doctor and patient.

Therefore, insurance is a necessary but insufficient part of meeting health care needs. We must provide universal health insurance in order to grant all residents access to primary care. That care must include health education, preventative medicine, and use of treatment appropriate for a particular patient's needs and lifestyle. Insurance coverage is a means to achieving the ultimate goal of healthcare – to provide people with the tools they need to live healthy lives.

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