Ann Surg Oncol (2022) 29:6520–6521
https://doi.org/10.1245/s10434-022-11948-9

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

EDITORIAL – BREAST ONCOLOGY

Disparities in Time to Treatment for Breast Cancer: Shifting Focus to the Root Cause

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Breast cancer mortality for African American (AA) women remains 40 % higher than for white women.[1] In addition to earlier onset of disease, later stage at diagnosis, and genetic predisposition to aggressive breast cancer phenotypes, AA women face inequities in access to quality breast cancer treatment.[1] Disparities in time to treatment are well documented, with AA women facing a longer time to treatment than white women for surgery, chemotherapy, radiation, and endocrine therapy.[2–5] Because delays in treatment correlate with worse outcomes and reduced overall survival, it is imperative to address this inequity.[5]

Song et al.[6] conducted a retrospective review of the National Cancer Database (NCDB), identifying 557,816 women older than 65 years with non-metastatic breast cancer (2010–2017). Time from diagnosis to initial treatment was evaluated by race/ethnicity and hospital type in both Commission on Cancer-accredited minority-serving hospitals (MSHs) and non-minority serving hospitals (non-MSHs).

Minority patients were found to have higher odds of treatment delays than non-Hispanic white patients for all types of initial treatment. These disparities persisted after multivariate regression adjusted for MSH status as well as patient, tumor, and hospital-level characteristics. Overall, those treated at MSHs had higher odds of treatment delays than those treated at non-MSHs regardless of race/ethnicity.

In concordance with previous studies, these results demonstrate a longer time to treatment for minorities and worse outcomes at MSHs. The treatment of minorities is concentrated in hospitals that care for higher proportions of underinsured and low-income populations secondary to residential segregation by race and income.[7]

Lack of financial reserve contributes to fewer resources and decreased quality of care at MSHs. In addition, MSHs have been disproportionately influenced by the COVID-19 pandemic, further contributing to the financial burden. To address inequities in resources, policy, and reform, allocation of financial support to improve the infrastructure of MSHs is imperative.

Because most minorities seek care at a small number of facilities, the authors suggest targeting improved quality of care at MSHs to mitigate racial disparities in time to treatment. However, although achieving equitable care at MSHs is necessary, the persistence of treatment delays for minorities at non-MSHs suggests that systemic barriers are pervasive. It is imperative that the root cause of these systemic factors be addressed in parallel with any targeted initiatives.

As described by Dimick et al.[8] racial disparities can be described by two main emerging theories: lower quality of care at MSHs and lack of provider cultural competence. Few studies evaluating MSHs account for the racial/ethnic makeup of their hospital, yet racial concordance between patients and providers improves communication and mitigates disparities, including treatment delays.[9–13] Cultural competence is central to understanding treatment delays because a willingness to adhere to treatment is influenced by trust, communication, and bias. Therefore, mitigation of disparities requires increased representation of minorities

First Received: 8 April 2022
Accepted: 16 May 2022
Published Online: 1 August 2022

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among the physician workforce and integration of diversity, equity, and inclusion training for all levels of providers.

Social determinants of health (SDH) are non-medical factors that account for 30–55% of health outcomes. These are conditions in which people are born, grow, live, work, and age. According to the World Health Organization, these factors can have a more significant influence on health than health care, underscoring the importance of comprehensive approaches to addressing health inequities.[14] Therefore, we must be aware that improving outcomes for minorities encompasses a much broader scope than MSHs and includes policy, employment, education, safety, and economic stability. Focus on these structural and systemic barriers will arguably have a more considerable impact on minorities by tending to the root of health care disparities, not just the branches.

Future studies should account for the contributing role of social determinants in time to treatment for breast cancer patients. Additionally, focus should be placed on identifying characteristics of hospitals and providers as an approach to assessing the role of trust, bias, and systemic racism while addressing health care disparities in their entirety.

DISCLOSURE Vivian J. Bea received grant funding from the American Cancer Society and Pfizer, Inc. Solange Bayard has no conflicts of interest.

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