Neighborhood-Level Redlining and Lending Bias Are Associated with Breast Cancer Mortality in a Large and Diverse Metropolitan Area—Letter

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Collin and colleagues recently published their findings characterizing how redlining and lending bias (e.g., mortgages) impacted breast cancer mortality among patients in Georgia (1). This retrospective analysis builds upon their prior work that identified how institutional racism and bias against those with lower socioeconomic status manifested as a form of neighborhood financial deprivation, which was in turn significantly associated with higher breast cancer mortality (2). Specifically, women who lived in redlined areas had a 60% increase in breast cancer mortality (compared with nonredlined areas). Interestingly, non-Hispanic Black women had a lower increase in mortality compared with non-Hispanic White women (HR, 1.13 vs. 1.39, respectively), suggesting that socioeconomic status had a larger association with mortality than race.

Their studies represent a unique aspect of how racial and social inequalities lead to significant health disparity for the most common female malignancy. When reading their well-designed articles, a number of questions come to mind that warrant further investigation.

As expected, a higher proportion of patients in redlined areas presented with advanced disease (stage III/IV). To obtain the best outcomes, it is well-established that the contemporary management of breast cancer incorporates a multidisciplinary approach, encompassing surgery, chemotherapy, radiation, endocrine therapy, and novel targeted modalities. Many studies have identified disparities among each of these components of breast cancer care, all leading to health inequity (3).

In the setting of the multidisciplinary management of breast cancer, are the authors able to decipher whether a particular component of the breast cancer care in their cohort was associated with worse mortality? In other words, was access to breast cancer care and screening globally limited, or was mortality linked to a particular service that was lacking? These questions are important to address as they may provide the rationale on how to address and minimize treatment disparities to improve mortality and health equity. By further dissecting the causes of these health disparities, an action plan may be developed that focuses on the services that are most needed. In addition, further questions arise as to whether these populations were managed optimally with regard to omission of certain treatments (such as sentinel lymph node biopsy in patients with luminal A type tumors over the age of 70) and with respect to treatments associated with quality of life (such as reconstruction; refs. 4, 5). This study provides an essential foundation for implementing change in the healthcare system to promote equity among patients with breast cancer.

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