Twenty years after the 2000 Healthy People 2010 campaign set the goal to eliminate health care disparities, the coronavirus disease 2019 pandemic has brought the continuing ethnic and racial disparities in our health care system front and center. Racial disparities persist in every part of the continuum of care, from disease prevention to access and outcomes. Cancer is no exception. Cancer is diagnosed at a later stage in Black patients, they have lower treatment rates and higher mortality rates across every stage, and, in those with metastatic disease, have higher rates of burdensome care at the end of life.

The good news, according to a retrospective cohort study of Medicare beneficiaries by Lam et al that assessed whether racial disparities in 30-day postoperative mortality and complications after cancer surgery changed over a 10-year period (2007-2016), was that postoperative mortality and complication rates declined across the board for both Black and White patients. Given the time period evaluated (30 days) is a relatively narrow window, this outcome likely relates to a combination of improvements in surgical technique, increased adherence to quality standards, and ongoing efforts by hospitals to decrease postoperative readmissions, complications, and mortality.

So, what is the bad news? Even in this population of insured patients, the authors found no decrease in racial disparities in postsurgical outcomes in the 10 years studied. Black patients had higher 30-day mortality rates and postsurgical complications throughout the decade. Furthermore, even after accounting for clustering of patients by hospital, mortality tended to improve at approximately the same rate for Black and White patients. Hence, the lack of progress toward closing the racial disparity was not the result of Black patients shifting between hospitals.

Although the study did not explore which specific factors were associated with the overall improvements, the outcome was clear: whatever interventions were put into place to improve surgical outcomes resulted in no change in the racial gap. This finding underscores the importance of expanding our perspective and the scope of our efforts. As a means of studying racial disparities, it is clear that the biomedical model has run its course. Focusing on purely biomedical factors has resulted in major blind spots that have kept us from recognizing the importance of the social determinants of health, such as racism. To this day, Black individuals in the US continue to experience structural racism. Black communities have less access to high-quality health care. Due to the persistent legacy of housing segregation, Black individuals are exposed to higher levels of pollution and live in food deserts (ie, areas that have limited access to affordable and nutritious food). Moreover, despite an overall decrease in unemployment across the US for the 2000-2018 period, unemployment for Black individuals increased and the median income for Black households continued to be lower than average in some states. These differences are reflected in the Lam et al report in which Black patients had a lower household income and an 18% higher probability of having Medicare and Medicaid dual status. However, the fact that the racial gap remained unchanged after adjusting for socioeconomic status (income and high-school completion) indicated that the disparities seen are not entirely due to a difference in these factors.

It is time to embrace a multisectoral approach to better understand contextual factors traditionally considered as external to the health care system. We need to exchange the narrow biomedical lens that hospitals and health systems have used for so long to evaluate and improve health care for an equity lens that allows for assessment and amelioration of factors that contribute to disparities. Using an equity lens can help us commit to aiding and advocating for vulnerable populations, understand how bias can influence medical care, and identify the social determinants of health.
health that act as contributors to disparities. Moreover, the study's finding that the racial mortality gap did not narrow after accounting for treating hospital underscores the role that hospitals and health systems have to play in perpetuating or ameliorating racial disparities. Now is the time for hospitals and health systems to expand their focus beyond the overall quality of care they deliver (ie, what is our overall 30-day mortality rate for all patients) to evaluate whether their care and outcomes are equitable (are we ensuring similar outcomes across racial, ethnic, and socioeconomic groups?). By tracking equity, hospitals could detect disparities across the continuum of care, identify contributing factors, and consequently implement plans and strategies that can narrow the racial gap.

Racism is impacting every aspect of patients' lives. Until we recognize its powerful influence on health care, we will not be able to narrow disparities in health outcomes. Looking at the surgical care we provide through the equity lens is a good way to start.

ARTICLE INFORMATION
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