The role of racial and ethnic discrimination in breast cancer disparities

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The Lancet *Breast Cancer Commission* report encompasses prevention, personalised treatment, inclusive management of metastatic breast cancer, identifying the hidden costs of breast cancer, tackling breast cancer gaps and inequities through global collaboration, and communication and empowerment.[1] It is also important to recognise and address discrimination as a key determinant of breast cancer disparities. Here we elucidate mechanisms through which racial and ethnic discrimination affects breast cancer outcomes, and provide a few promising examples to address discrimination via the implementation of anti-discrimination health-care policies and interventions and the mobilisation of minority groups.

Race and ethnicity are social constructs without a biological basis that categorise people into groups with a hierarchy that privileges some groups.[2,3] Both racial and ethnic discrimination operate at individual, institutional, and systemic levels,[2] and impact health through overlapping mechanisms that intersect with other systems of oppression.[2,4] The mediating processes, structures, and injustices are insufficiently investigated, perpetuating the misconception that race and ethnicity reflect inevitable biological differences and limiting the design of effective interventions.[4–6]

Racism and other forms of discrimination negatively impact health and health outcomes.[6] For breast cancer, there is evidence, from different countries in all continents, of minoritised racial and ethnic groups presenting with more advanced cancer stage distributions, more aggressive biological subtypes, and worse survival rates than dominant groups.[7–18] Discrimination can influence breast cancer outcomes in different ways, including biological, community structure, and health-care delivery mechanisms.[6] We purposefully attempted to provide examples of each of these mechanisms' impact on cancer outcomes from different regions of the world; however, much of the research on racism in health care comes from high-income settings, particularly the USA.[5]

With regard to biological mechanisms, the experience of ongoing discrimination causes chronic overactivation of the stress pathway that can damage health.[6] Breast cancer risk has been linked with poverty, neighbourhood disadvantage, and racial discrimination.[10] Research suggests that living in a historically redlined geographical area in the USA subjected to historical and contemporary racist mortgage discrimination policies can be associated with more aggressive breast cancer subtypes (oestrogen receptor–negative) in non-Hispanic Black women.[11] Although the specific molecular mechanisms have not been elucidated, emerging evidence suggests that living in disadvantaged neighbourhoods may cause chronic psychosocial stress reactivity and inflammation which in turn can lead to these aggressive breast cancer types.[12]

Discrimination also shapes the way communities are structured, segregating minoritised people and often confining them to places that undermine their access to resources, including health information and health-care services.[6] Lower awareness of breast cancer symptoms and greater barriers to accessing care have been reported among minority ethnic groups in the UK, many of whom lived in the most socioeconomically deprived areas.[13] There is also evidence that living in low-income Black or Hispanic segregated neighbourhoods in the USA is associated with shorter breast-cancer-specific survival, even for non-Hispanic White patients.[14] Indigenous populations worldwide living in rural and remote areas are also affected by disparities in accessing health-care services both in high-income and low-income settings.[15–17]

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Breast cancer disparities are also affected by health-care delivery mechanisms. Discrimination diminishes quality and use of health-care services.[6] Health-care providers' unconscious biases and pernicious stereotypes attributed to minoritised people can result in disrespectful interactions, negligence, discrimination, and even abuse of patients.[5,14–16,18] These biases can be exacerbated when individuals are not only from a minoritised ethnic or racial group, but in addition are women, socioeconomically disadvantaged, and from rural communities.[5] Health professionals' implicit biases towards ethnic, racial, and gender minorities lead to unequal quality of health care and disparities in cancer outcomes.[18] For example, Black women in the USA have less probability of receiving guideline-concordant treatment[14] and are more likely to have treatment delays and to receive late-stage diagnosis for breast cancer than non-Black patients.[19] There is also evidence of Indigenous women facing disrespectful, dismissive, and discriminatory treatment from health-care workers in Australia, Canada, and Latin America, which in turn negatively impacts their trust and use of health-care services.[15,16,20]

Multilevel systemic interventions are needed to address racial and ethnic discrimination in breast cancer care. First, broad-level anti-racist interventions at the policy and organisational levels—supported by long-term leadership commitment, non-discriminatory dedicated funding, and implementation plans—are crucial.[21] This approach can involve changing national policies on how health-care funding is allocated to reduce past patterns of racial and ethnic discrimination. The experience in post-apartheid South Africa illustrates that anti-racist policies enabled enhanced spending on primary health-care services; however, persistent racial disparities in access to cancer care underscore the need for further leadership and commitment.[22]

Second, within health-care institutions, breast-cancer-specific interventions can help reduce disparities in outcomes. *The* Lancet *Breast Cancer Commission* highlights a promising example of a cancer-specific multilevel intervention directed at addressing racism: the Accountability for Cancer Care through Undoing Racism and Equity (ACCURE) Pragmatic Quality Improvement trial.[23] The ACCURE approach included automatic alerts in the electronic record to flag patients with missed appointments and unmet points in expected care; a patient navigator trained in race-specific barriers to support patients navigate barriers to care; a physician champion who gave health-care teams race-related feedback on treatment completion; and training in health equity issues for staff. ACCURE showed the effectiveness of specific interventions to reduce cancer disparities and improve treatment completion rates.[1,23]

Third, upholding the agency of minoritised communities is crucial for developing equitable breast cancer care interventions. For example, the Integrative Multicomponent Programme for Promoting South Asians' Cancer Screening Uptake (IMPACT) focused on improving breast, cervical, and colorectal cancer screening rates among minority ethnic populations in Hong Kong by working with minority groups to obtain insights into actual needs and barriers.[24] IMPACT then designed culturally sensitive multimedia and community-health-worker-led interventions to successfully improve screening rates among minoritised groups. As the Commission mentions, community-based participatory research is needed to "meet patients in the context of their cultural needs and preferences and assist with dismantling care inequities".[1] The priorities, lived experiences, and preferences of racially minoritised communities and patients with breast cancer is essential in shaping breast care and research agendas.

Fourth, there is an urgent need for more research on racial and ethnic discrimination in health care from different geopolitical contexts. Additionally, reporting of research results by racial or ethnic categories should be accompanied by a considered interrogation of the specific mechanisms (eg, access barriers to health services, racial or ethnic discrimination, and socioeconomic inequalities) that underlie the observed health disparities in any given context. Categorising people on whatever basis (race or other categories) without unpacking underlying mechanisms that explain health inequities serves to divide and stigmatise rather than to assist in finding meaningful solutions to disparities. Research on the mechanisms that underlie reported racial disparities in health outcomes needs to be increased and requires the joint commitment of researchers, journal editors, international health organisations, and funding agencies; it is imperative that collectively we uphold a more rigorous standard to avoid perpetuating the status quo. *The* Lancet *Breast Cancer Commission*'s commitment "to strive to raise the bar

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and close the equity gap for breast cancer"[1] necessitates addressing racial and ethnic discrimination.

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