Reply to M.H. Kanter et al

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The critique by Kanter et al\(^1\) suggests that something more than system-level integration is required for best outcomes, perhaps including care teams, outreach, case management, and health care providers working to their full level of training. Although we can imagine this possibility, no actual evidence is provided to support this speculation. Published results on the Veterans Healthcare Administration facilities, a form of integrated health delivery system quite different from the one we studied,\(^2\) found results similar to our own.\(^3,4\) The Veterans Administration system also operates under a single-payer system that works to minimize variations in care, such as promoting adherence to clinical guidelines, the active ingredient that our study suggests can make a difference in colon cancer disparities.\(^2\) Our comparison cohort was one in which hospitals and provider groups may be networked but have highly variable administrative structures and respond to diverse incentives from multiple payers and purchasers—not exactly optimal conditions for reducing variations in care. Nonetheless, we still found that even these fragmented systems were associated with closure of the racial disparity gap when we accounted for the delivery of evidence-based care.

Future studies should delve more deeply into the granular mechanisms that allow integrated systems to achieve the same clinical outcomes for patients regardless of race. But as they currently stand, our results should be regarded as actionable evidence supporting a critical role for health care systems to eliminate cancer disparities. Promoting the widespread adoption of evidence-based guidelines is a clear step that any health system committed to reducing disparities can, and should, act on now.

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REFERENCES

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