






COVID-19 pandemic and health care disparities in head and neck cancer: Scanning the horizon

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Abstract

The COVID-19 pandemic has profoundly disrupted head and neck cancer (HNC) care delivery in ways that will likely persist long term. As we scan the horizon, this crisis has the potential to amplify preexisting racial/ethnic disparities for patients with HNC. Potential drivers of disparate HNC survival resulting from the pandemic include (a) differential access to telemedicine, timely diagnosis, and treatment; (b) implicit bias in initiatives to triage, prioritize, and schedule HNC-directed therapy; and (c) the marked changes in employment, health insurance, and dependent care. We present four strategies to mitigate these disparities: (a) collect detailed data on access to care by race/ethnicity, income, education, and community; (b) raise awareness of HNC disparities; (c) engage stakeholders in developing culturally appropriate solutions; and (d) ensure that surgical prioritization protocols minimize risk of racial/ethnic bias. Collectively, these measures address social determinants of health and the moral imperative to provide equitable, high-quality HNC care.

KEYWORDS

COVID-19, head and neck cancer, health care delivery, racial and ethnic disparities, social determinants of health

1 | INTRODUCTION

The COVID-19 pandemic due to SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) has disrupted and transformed the delivery of health care in ways that few would have imagined or thought possible. Clinicians, health care administrators, insurance companies, policy makers, researchers, and patients are all grappling with how to deliver and access medical care in the COVID-19 era while planning for an unpredictable future contingent on several unknowns (eg, viral seasonality, vaccine development). The various stakeholders are charting a course for health care delivery during a time of unprecedented resource scarcity, relatively uncertain but potentially significant personal risk (for clinicians and patients), and massive economic upheaval. In response to the COVID-19 pandemic, best practices in health care delivery for head and neck cancer (HNC) have been upended amid urgent efforts to protect patients, providers, and communities while stewarding scarce resources.

As the pandemic has unfolded across the world, it has become increasingly clear that COVID-19 is a disease with varying incidence and mortality in racial/ethnic subgroups.^{1,2} Although the causes for COVID-19-related racial and ethnic differences are still being examined, they seem to stem from (a) long-standing systemic inequities and differences in social determinants of health, access to care, and quality of care and (b) biologic determinants such as comorbidity burden, genetics, and immune phenotype.³⁻⁵ COVID-19 reminds us that determinants of health are multifactorial. Thought leaders in global public health have recently called for development of polysocial risk scores, adapted from the polygenic risk modeling to quantify social determinants of health.⁶ In that sense, the COVID-19 pandemic has been described as a magnifying glass that has brought attention yet again to stark racial/ethnic disparities in health outcomes in the United States.³

We have long recognized that HNC is a disease with marked racial/ethnic disparities in outcomes.⁷⁻¹¹ Although the reasons underlying observed racial/ethnic differences in mortality for patients with HNC are multifactorial, disparities in both access to care and timely cancer care are major drivers for poor outcomes.^{8,11-15} Although the calls to view health care delivery as science that informs national improvement priorities are not new,¹⁶ the disruptive forces of the COVID-19 pandemic regarding crisis standards of care (CSC) are unprecedented. It is imperative that we consider how COVID-19-related changes to health care delivery exacerbate existing disparities in access to care and may worsen oncologic outcomes for patients with HNC. Many health

care system changes attributable to COVID-19 will likely persist long after the pandemic has waned.¹⁷ We must explore strategies to mitigate disparities in care for patients with HNC that have arisen from this “stress test” on our health care delivery system.

2 | IMPACT OF COVID-19 ON THE EQUITY OF CANCER CARE DELIVERY FOR PATIENTS WITH HNC

First, COVID-19-associated changes in health care delivery may widen the existing disparities in timely diagnosis and treatment of HNC as a result of reduced access to health care providers. For patients with HNC, access to and receipt of timely treatment across the cancer care continuum is critical to optimal oncologic outcomes.^{18,19} It is therefore not surprising that racial and ethnic differences in timely treatment are strongly associated with racial and ethnic differences in oncologic outcomes.^{8,11-15} Care during the COVID-19 pandemic has brought about an abrupt and precipitous reduction in the number of patients accessing HNC-related care.²⁰ There has also been an associated transformation in the method of care delivery for patients with HNC, with a shift toward telemedicine in lieu of in-person consultation and follow-up.^{20,21} However, access to telehealth is a privilege not shared by all.²² Studies across a variety of disease states have demonstrated that telehealth-based interventions are neither culturally appropriate nor tailored which may result in low uptake among African American and Hispanic/Latino communities, exacerbating disparities in access.²³ The specific financial, structural, and institutional characteristics of health care systems that affect racial and ethnic differences in care also require attention. The hospitals where African Americans, Hispanic/Latino, and other racial/ethnic minorities tend to seek care are often less likely to have the resources and may have less capacity for a comprehensive telehealth program, further creating a divide.²⁴ Many telehealth platforms require the use of electronic devices with certain software requirements, which may not be readily available to low-income and racial/ethnic minority patients.²⁵ Furthermore, access to telehealth may also be limited by inadequate health literacy and low English proficiency, which may be more prevalent in these populations.²⁶

Second, ongoing initiatives to triage, prioritize, and schedule HNC-directed therapy to accommodate scarce resources during the COVID-19 pandemic may exacerbate preexisting racial/ethnic disparities in timely treatment initiation. The considerations mirror national discourse on CSC that modify health care operations and

preferentially triage lifesaving resources based on likelihood of survival. The latent threat to minorities in CSC is that when comorbidities are used in prioritization schemes a proxy for health, minority patients who, in general, have higher base rates of comorbidities (and increased risk of mortality) may be deprioritized for access, placing them in double jeopardy.²⁷ Although risk stratification protocols have been developed to maximize objectivity in determining treatment priority,²⁸ the risk of bias, implicit or explicit, looms large.²⁹

Third, the marked changes in employment status, health insurance coverage, and dependent care responsibilities may further aggravate racial/ethnic disparities in access to care and treatment for patients with HNC, particularly because workers of color are more likely to have lost employment during the pandemic.³⁰ According to the US Census, over 36 million Americans have already filed unemployment claims as of May 14, 2020. Prior to the COVID-19 pandemic, insurance coverage was strongly linked to stage at diagnosis, timely treatment initiation, and oncologic outcomes.^{31,32} The abrupt loss of insurance coverage for vulnerable patients, compounded by the financial shock of having to absorb the out-of-pocket costs of care, will certainly worsen racial disparities in access to multidisciplinary HNC care. In addition, the increased need for childcare due to school closings during the COVID-19 pandemic may introduce another barrier to seeking care that disproportionately burdens racial and ethnic minorities.

3 | STRATEGIES TO ADDRESS WORSENING HNC CARE DISPARITIES DURING THE COVID-19 PANDEMIC

Although the COVID-19 crisis has shone a light on already-marked disparities, it has also provided an impetus for structural changes that can mitigate inequities in access and outcomes both in times of pandemic and beyond. We offer the following suggestions.

3.1 | Collect detailed data on access to care by race/ethnicity, income, education, and community

It is imperative that we collect data about HNC care delivery and access to care in a manner that allows us to more comprehensively examine racial and ethnic disparities as well as the underlying social determinants of health. Otolaryngology-head and neck surgery groups analyzing the impact of COVID-19 on access to care did not report or

analyze data by race/ethnicity, income, education, or community.²⁰ A similar problem with data collection in part delayed the recognition that COVID-19 was disproportionately harming African Americans and Hispanic/Latinos.⁵ In-depth exploration of the social determinants of health that are the underlying drivers of disparate outcomes are needed,⁶ and such data need to be publicly available to allow clinicians, policy makers, public health professionals, and policy makers to make informed decisions to better care for these marginalized groups within the broader HNC population. These steps will indeed require investment of time and resources; but the absence of data does not imply the absence of a problem.

3.2 | Raise awareness that racial and ethnic disparities exist

We should be proactive in recognizing the potential for exacerbating disparities in access and outcomes during this massive upheaval of clinical care. Raising awareness at individual, team, and hospital administrative levels will be key to ensuring that a broad range of stakeholders can be brought together and can combine their collective areas of expertise to proactively seek out, identify, and address areas of concern. As clinicians and team leaders, we share responsibility for drawing attention to this problem and addressing it.

3.3 | Engage communities and stakeholders to understand their challenges and develop culturally appropriate solutions

We also need to reach out to the African American, Hispanic/Latino, and other at-risk communities to better understand the specific challenges they are facing during this crisis. Although publications from reputable institutions describing their experiences altering HNC care delivery during times of crisis may also inform current solutions,³³ it would be presumptuous and ineffective for clinicians or administrators to pre-suppose that they already know how to address the problem. Building a strong coalition of involved stakeholders will help ensure that whatever health care delivery interventions arise will be delivered in a manner that is culturally appropriate, community competent, and relevant to the needs of the more vulnerable populations. Furthermore, such a coalition will enable us to also look beyond health care services into improving community support systems and policy-level solutions, which can have significant influences on individual health outcomes.^{34,35}

3.4 | Ensure that surgical care prioritization protocols proactively address the potential for racial/ethnic bias

We should develop and utilize measures that acknowledge the role that racial/ethnic implicit or explicit bias can play in prioritizing surgical cases. Although the content and underlying ethical principles of these prioritization decision-aids could vary, the role of race and ethnicity will have to be carefully considered. Although omitting race/ethnicity data in prioritization may give the sense of a “color-blind” approach, clinical stage and severity of comorbidity would likely be part of a prioritization scheme,²⁸ particularly if one of the guiding ethical principles is maximizing benefit (eg, life-years).³⁶ However, African American and Hispanic patients are significantly more likely to present with advanced-stage disease and have more severe comorbidities. Therefore, a “color-blind” prioritization system based on maximizing benefit that includes comorbidity and stage may systematically de-prioritize care for African American and Hispanic/Latino patients with HNC. Although it might be inappropriate to eliminate use of stage or comorbidity, one could consider incorporating race/ethnicity into prioritization schemes with an evidence-based, data-driven weight, determined by relative patient populations and local or regional prevalence of HNC so as to avoid building implicit racial bias into prioritization schemes.²⁷ Alternatively, developing a prioritization framework based on different ethical principles (eg, giving priority to the worst off)³⁶ might actually prioritize racial/ethnic minorities. Although the details of the optimal solution are not known, there is a critical need to establish objective measures and metric-based interventions to diminish current disparities in the receipt of HNC care. Such a solution would likely be consistent with the recommendation from the World Health Organization that the process of surgical prioritization adhere to principles of inclusiveness, transparency, accountability, and consistency.³⁷

4 | CONCLUSION

Although COVID-19 pandemic may eventually dissipate, health care disparities will likely persist. The COVID-19 pandemic has provided us with a lens, opportunity, and rationale for renewed dedication to investigating the causes of and solutions for racial/ethnic disparities in access and outcomes for patients with HNC. Although many factors contribute to racial/ethnic disparities in morbidity and mortality in patients with HNC, health care delivery should not be one of them.

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CONFLICT OF INTEREST


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