The coronavirus disease 2019 (COVID-19) pandemic has upended health care delivery systems around the globe and generated a massive amount of research, most of which has focused on public health measures to contain the pandemic and the provision of acute care to patients with serious infections. However, lurking in the background are the less visible and more insidious changes resulting from the sudden reduction in elective, non–COVID-19–related care. A glaring example has been a 25% reduction in outpatient services, with a concomitant skyrocketing number of telemedicine encounters. Evidence of the potential harms from the curtailments in face-to-face care has included a precipitous drop in the delivery of preventive care, including reductions of 90% or more in screenings for breast, colon, and cervical cancers. As is often the case in the US health care system, these failings have disproportionately affected individuals who belong to racial and ethnic minority groups and individuals with socioeconomic disadvantage.

In this issue of JAMA Network Open, Whaley and colleagues provide additional details about the association of the pandemic with the delivery of primary and elective specialty care using a national database of claims from individuals with employer-based insurance. Their findings replicate reports from other sources, revealing striking decreases in colonoscopy and mammography rates as well as a 50% decrease in testing for hemoglobin A1c levels. They also observed a 22% decrease in vaccinations among young children, raising concern that the pandemic is exacerbating an already worrisome trend in the United States. In addition, their data document an extraordinary increase in telemedicine encounters, as high as 4000%, which, nonetheless, did not compensate numerically for the 25% decrease in ambulatory visits. Telemedicine encounters were less frequent among individuals living in areas with lower income and more residents who belong to minority racial and ethnic groups. Somewhat surprisingly, individuals in these areas were less likely than individuals in more affluent communities to have deferred the preventive services examined in this study.

This study provides an important snapshot of the dramatic changes in ambulatory and what is considered elective care, but it reflects only a narrow view of the substantial changes in health care in the United States in response to the pandemic. We desperately need more research, such as that from Whaley and colleagues, to understand the implications and consequences of the shift from in-person to virtual ambulatory care. For example, what consequences has the rapid surge in telemedicine services had on the quality of clinical preventive services (eg, cancer screening, counseling services, use of preventive medications) and routine follow-up care for common chronic diseases that require in-person assessments and laboratory tests, such as cardiovascular disease, hypertension, and diabetes? Has the stage at which cancers are diagnosed advanced? What has happened to the management of hypertension and diabetes, given that clinicians often titrate medications based on measurements that usually occur in office or in a laboratory? Has the incidence of preventable sequelae from cardiovascular, kidney, and other chronic diseases increased?

The study by Whalen et al also raises serious questions about how the COVID-19 pandemic has affected preexisting inequities in the US health care system. Although they did not observe significant disparities in deferred preventive care associated with racial/ethnic or socioeconomic differences, Whaley and colleagues included only individuals with employer-based insurance and excluded large segments of the population who lacked adequate access to care before the pandemic. Nonetheless, as their study demonstrates, the rapid shift in the care we provide and how we provide it has created new disparities, confirming reports from other investigators. This likely reflects the well-characterized digital divide that exists among racial/ethnic minority, low-income, and rural
populations. Moreover, the health care organizations on which they rely have experienced greater losses of revenue and taxes that support the care they provide, leaving them with even fewer resources to support virtual care. Even more concerning, many hospitals and health care systems in rural communities, where access was already limited, have been unable to survive the pandemic, reducing access even further. These issues have only served to compound existing disparities by worsening access to care and failing to protect essential workers at the bottom of the socioeconomic hierarchy in communities where the preexisting burden of chronic disease was disproportionate.

Equally important, it is essential to understand the sustainability of the current health care financing model for telemedicine and the implications for access to primary care even after pandemic. We need to better understand how the current financing model of health care in the United States has led to the loss of primary care access. Did countries with national programs for providing health care to all residents fare better? We also need to develop and evaluate approaches to integrating necessary in-person services and robust remote monitoring with virtual care. Without access to vaccinations and other preventive services or follow-up for the long-term sequelae of COVID-19 and chronic conditions, the health of our population will deteriorate. Response to the pandemic has prompted adoption of technology that has the potential to expand access to care, but it appears that this promise has not yet been realized in terms of ensuring that high-quality virtual care is provided equitably.

Finally, we must learn how the response to the pandemic can inform policies to make care more accessible. Such evidence will be essential to structuring a new normal that not only preserves but also advances preventive and primary care and evolves in new ways to provide care, such as telemedicine, in a way that is efficient and promotes equity.

ARTICLE INFORMATION

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REFERENCES


