COVID-19, Disparities, and Opportunities for Equity in Otolaryngology—Unequal America

The coronavirus disease 2019 (COVID-19) pandemic has laid bare health disparities in the US. Black and Latinx people have been disproportionately affected by COVID-19. In New York City, reported death rates through April 8, 2020, for Latinx and Black people were 22 per 100,000 and 20 per 100,000, respectively—more than twice the mortality rate of 10 per 100,000 for White individuals. The disproportionate burden of hospitalization and deaths in the predominantly minority borough of the Bronx was subsequently confirmed. Michigan, Louisiana, and Illinois also report high mortality rates among Black and other minority residents relative to White residents. Crowded housing preventing social distancing, unavoidable occupational exposure, necessary use of public transportation, and delays in access to medical care are thought to be some of the underlying causal mechanisms. Racial and ethnic minority patients also experience a greater burden of comorbidities, which are associated with increased risk of death from COVID-19. These comorbidities also are direct effects of system-based, societal problems that perpetuate worse overall health for minority patients. The aftermath of the COVID-19 pandemic will continue to reveal the inequality in America’s health care system and societal structure; therefore, we, as otolaryngologists, must act.

Disparities in Otolaryngology and Challenges to Come

The effects of racial inequality, poverty, and unequal health care access in the US are well known to otolaryngologists and other surgeons. We see higher rates of smoking, head and neck cancer, and delayed disease presentation in patients from vulnerable groups. By 2020, despite advances in cancer treatment, such as complex free tissue reconstruction and immunotherapy, we have not eliminated disparities that leave disadvantaged patients with more disease and worse outcomes. Disease, rather than being a great equalizer, has always been unequally distributed.

The first surge required largely halting nonemergency surgical care to protect patients and improve health care capacity for patients with COVID-19. Dental and primary care services that refer to otolaryngologists also were limited. The fallout from a lack of otolaryngology care will be immense for all patient populations. We expect that this will be associated with delays in head and neck cancer diagnoses, along with increases in emergency presentations of conditions such as chronic otitis media and complicated sinusitis. However, we expect the effects of delayed care will be most severe for patients of low socioeconomic status, from racial and ethnic minority groups, with patients limited English proficiency, and the uninsured. These patients and their communities—who already faced difficulty accessing primary or specialty care and were more likely to present with advanced-stage disease before the pandemic—have been hit the hardest by COVID-19 and its economic effects, and may use health care centers without sufficient resources to adapt. Patients with poor internet or device access or limited English proficiency cannot easily transition to virtual health care.

Loss of insurance status and financial distress will further exacerbate health care disparities. According to the US Census Bureau, 27.5 million people in the US were uninsured in 2018. The US Department of Labor reports an influx of 33 million COVID-19-related unemployment benefit claims from March to early May 2020. Therefore, a large proportion of people in the US is expected to suffer loss of health care insurance, gaps in coverage, or transition to alternative insurance coverage. Nearly half of Black adults and more than a third of Hispanic adults live in states that did not expand Medicaid through the Affordable Care Act and may have no safety-net insurance to turn to. Lack of insurance is highly correlated with delays in presentation for cancer and higher mortality rates. Hospitals are currently in financial distress and may feel pressured to expedite care of better-insured patients to remain solvent, further jeopardizing minority patients.

There is additional concern that minority patients from communities ravaged by COVID-19 will face stigma. Asian American and Asian people worldwide have faced virus-related discrimination, and many fear this reprehensible behavior will spread to target other groups that have disproportionately been affected by COVID-19, rather than being extinguished. There is concern that there will be a fear to treat patients from communities of color with a high prevalence of COVID-19. These patients, who may present with otolaryngologic complaints such as sore throat, fever and chills, new hyposmia/anosmia, or dyspnea, need access to testing and timely access to otolaryngology care.

Opportunity for Equity and Call for Advocacy

Health equity must be fully integrated into hospital and clinic operations for routine and disaster management. Many hospitals have implemented incident command structures charged with planning and operationalizing response and recovery efforts. A health equity officer, or the equivalent, should be included in the incident command structure for all major decisions; having a parallel role in each department of otolaryngology is also needed. An equity lens may include advocating for access to interpreters for telephone or virtual health care, facilitation of safe patient transportation, and innovative approaches to mitigate care delays. Most important, all hospital infrastructure, including incident command structures, must act.

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Opinion Viewpoint

Additional financial relief for practices and hospitals that serve a high proportion of disadvantaged patients. A large proportion of racial and ethnic minority patients use a relatively small number of hospitals in the US, frequently termed minority-serving hospitals. These hospitals are more likely to be overwhelmed, poorly resourced, and on the brink of financial insolvency. Medicaid expansion and increased financial support to minority-serving and safety-net hospitals would mitigate risk to minority patients.

Furthermore, otolaryngologists should proactively reach out to patients living in heavily affected communities. Measures as simple as repeated outreach to patients with canceled or rescheduled visits or patients who do not show to an appointment would be helpful, rather than waiting for patients to contact the office. There is widespread concern of underrepresentation of patients with acute and severe illness to US hospitals due to concern of becoming infected with COVID-19. It is unknown whether this phenomenon is more severe in minority patients. However, there is known overall mistrust of the health care system in minority communities relative to non-minority patients. Therefore, otolaryngologists should be intentional in building rapport—even if virtually or by telephone due to COVID-19 restrictions.

Otolaryngologists have the opportunity and responsibility to reduce racial and socioeconomic disparities. The scope of disparities in America is larger than our specialty, yet surgeons have a critical role as advocates in the direct care of patients. The COVID-19 pandemic has highlighted that systemic inequality is a problem that requires everyone’s efforts to solve. Through advocacy to hospital leadership and collaboration across hospitals, we can address regional population health needs within our field. Surgical outcomes—mortality rates, quality of life, safety, complications—hinge on the ability to provide timely and equitable care to patients. Our collective response to COVID-19 as a specialty must strive to demonstrate our dedication to tackle systems-based inequity in US health care.

ARTICLE INFORMATION

Conflict of Interest Disclosures: Dr Bergmark reported support from the Brigham and Women’s Department of Surgery for the submitted work and a grant from the American Board of Medical Specialties outside the submitted work. No other disclosures were reported.

Funding/Support: This work was supported by the Department of Surgery at Brigham and Women’s Hospital.

Role of the Funder/Sponsor: The Department of Surgery at Brigham and Women’s Hospital had no role in the preparation, review, or approval of the manuscript and decision to submit the manuscript for publication.

REFERENCES