Editorial

Sex in the Time of COVID-19

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Time passes swiftly and is irrecoverable. In Love in the Time of Cholera, Gabriel García Márquez uses cholera as an analogy for the physical and emotional burdens caused by longing and lovesickness. Just as Florentino Ariza suffers physical and emotional pains from his longing for Fermina Daza, as one might suffer from a disease like cholera, in this issue, Katz and Ye tell a story of longing for equal access to rheumatology services.1 In this story, female individuals suffer the wait, and as time passes for people with rheumatic diseases, the disease will progress, and their prognoses worsen.2 The importance of understanding sex and gender differences in health and healthcare is established, as is the commitment to ensuring that research is conducted inclusively and equitably by funders in Canada and worldwide. Accordingly, the number of articles documenting the existence or absence of inequities between people according to their sex and gender should be increasing. In this issue of The Journal of Rheumatology, Katz and Ye share important results from Alberta, Canada, about the inequalities between biological sexes in access to rheumatology services.1 Concerningly, they found that female individuals and younger people experienced increased wait times for their first appointment with a rheumatologist during the coronavirus disease 2019 (COVID-19) pandemic.1 Timely access to care is critical to achieving optimal outcomes for people with arthritis and other rheumatic diseases, and ensuring equitable access to services is essential to meet the accessibility criterion of the Canada Health Act.3

The study by Katz and Ye1 adds to a body of literature, with mixed conclusions on the differences in wait times for a first rheumatologist visit and in treatment for people with arthritis and rheumatic diseases. Two European studies found that female patients experience longer wait times for their first rheumatologist visit than their male counterparts that were caused by delays in receiving a referral to a rheumatologist.4,5 Consistent with these findings, a more recent European study found that female patients and younger people have a longer delay in receiving a diagnosis for axial spondyloarthritis than male patients and older people.6 In Canada, no clear pattern has yet emerged. One study of referrals from primary to specialty care in Ontario found that rheumatology was a specialty in which female patients had higher wait times to see a rheumatologist.7 In contrast, a study from Quebec found that female sex and younger age were associated with a shorter time to the first consultation with a rheumatologist.8 Finally, a further study from Ontario found no difference in the delay from referral to a rheumatologist, although female physicians were found to refer people more quickly to rheumatologists.9 Adding this latest study by Katz and Ye to this mix suggests that a pattern consistent with the findings from Europe might be emerging. In our recent analysis from British Columbia, a similar story emerged—female individuals experienced a more extended time between referral from a primary care physician to a rheumatologist. Once seen by a rheumatologist, we found no difference between subsequent times to treatment for male and female patients (unpublished data, 2023). In a further cruel (but well known) twist to this story, female individuals are far more at risk for most rheumatic diseases than male individuals and so are more likely to need timely access to rheumatology services and treatment.10

The analysis presented in the research1 is essential, timely, and thought-provoking but raises several questions that could be explored further. One might wonder whether the observed difference in healthcare access and outcomes between male and female individuals is the continuation of an underlying trend, whether this trend changed during the COVID-19 pandemic, or whether a recent change led to the results observed. These questions underscore the value of robust study designs, for example, interrupted time series,11 which allow for the estimation of changes at a specific timepoint—such as the COVID-19 pandemic, in this case—while considering other external factors like seasonal effects or long-term trends that could influence the

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outcome. The limitations of the available data in this study may preclude this type of analysis. However, presenting trends in the available data would help readers contextualize and interpret the results. It is also important for the reader when reflecting on these results and the robustness of methods, to consider the implications for the health systems reflected in this paper. Whether the differences reported between male and female individuals result from underlying trends or the impact of the COVID-19 pandemic, it is important to build on these results to understand why it is happening; these results should represent the first step. Understanding the context and causes is the next. Qualitative research is likely needed to shed light on these factors and to understand whether previous explanations for disparities between biological sexes in referral times include some, all, or none of previously suggested explanations like symptom presentation, referral patterns, and physician bias.9,12

Throughout his novel, García Márquez examines the effects of societal expectations and social standing on women’s ability to find their voice and agency, and how differences in these contextual factors between characters complicated their relationships. Similarly, and perhaps more importantly, we should consider whether the results of Katz and Ye1 signal a plethora of further unexplored inequalities in access to services. Using available administrative data to examine differences in disease outcomes based on sex is valuable. Still, it is silent on the question of gender and a multitude of other social, cultural, and individual factors, all of which may influence the ability to access services or the desirability of these services to our diverse population. So, although we might be confused by a lack of consistency and some contradictions in findings of differential access to rheumatology services between sexes, at least there is the growing literature facilitated by the widespread collection of data on sex in clinical and research settings. There have been considerable advances in conceptualizing the sources of inequalities and outcomes in health services, for example, using the PROGRESS-Plus (place of residence, race/ethnicity/culture/language, occupation, gender/sex, religion, education, socioeconomic status, and social capital) framework to stratify health outcomes and opportunities.13 However, few of these sources of inequalities are often measured beyond age and sex, and there is inconsistency in the measurement of these data.14 If we are committed to providing equitable services for all, this information must be collected routinely and used to report inequalities in health opportunities associated with a multitude of characteristics of individuals and their intersections. Findings about inequalities between sexes are valuable in their own right but carry greater importance as a symbol for a potential plethora of inequalities of access to rheumatology services and treatments.

Because funders in Canada, for example, the Canadian Institutes of Health Research, the National Institutes of Health, and others, increasingly require investigators to produce research that reflects their commitment to promoting sex- and gender-sensitive research, this study1 will be important as a point of reference. It will benefit from contextualization in additional research to see if Alberta represents an outlier or the norm. Including sex and gender in research is essential to understand the full potential and limitations of the way healthcare interventions and services are designed and provided. However, these data represent the tip of the iceberg—a reminder of the degree of progress needed to realize equitable healthcare services and treatment for all.15 Studies that have included sex in rheumatology have already highlighted important differences in disease presentation, treatment response, and long-term outcomes. Extending this research to include gender is equally important, but understanding how individual, societal, and cultural factors affect disease outcomes requires a much more comprehensive approach. The COVID-19 pandemic has highlighted how pervasive inequalities are and has simultaneously created opportunities and posed threats to the field of rheumatology. The pandemic additionally highlighted the potential and importance of telemedicine and remote patient monitoring while creating disruptions to research and clinical care. The rheumatology community must embrace this disruption and continue to adapt and innovate. As Love in the Time of Cholera explores the complexities of human experience, love and relationships, and the fleeting nature of time, we need to consider similar complexities in individuals and the societal context in which we offer health care if we are truly longing for equal access to rheumatology services.

REFERENCES


