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# COVID-19: Opportunity to Reduce Low-Value Practices in Oncology


COVID-19 has brought significant challenges to the practice of oncology. In order to prevent the transmission of infection, patient flow to cancer centres and hospitals has been reduced and in-person visits are being substituted with electronic and/or telehealth consultations. The frequency of follow-up visits has also been reduced as has surveillance imaging and other diagnostic tests. The goal is to minimise face-to-face patient visits and control the spread of COVID-19. When it comes to cancer patients, these measures are quite critical because data already shows that patients with cancer are at a higher risk of death with COVID-19 infections.

However, an important question to ask is whether this new model of working with reduced in-person visits and a reduction in unnecessary low-value treatments and testing could provide a lasting benefit to cancer systems beyond the pandemic period? There is a possibility that the measures designed for the pandemic could provide long-term benefits to many already overstretched, costly and inefficient cancer care systems. Also, there will be an economic impact of lockdowns and restrictions in the post-COVID-19 world and saving healthcare resources, and funding will be a priority for most healthcare systems. Could this be an opportunity to eliminate low-value practices in oncology?

The concept of value-based cancer care has been much talked about in recent years. The concept that cancer treatment should be based on clear evidence of improvement in survival or quality of life has been discussed, especially when the proposed treatments are quite costly. Because of COVID-19, the oncology community has been forced to re-evaluate the priority therapies to be offered to patients and are focusing on those that result in improved outcomes and that justify the increased risks to patients as they would have to come to the hospitals to receive treatment.

A common theme with most guidelines that have been issued during the COVID-19 pandemic regarding cancer care has been the use of a priority-based approach. For example, in Ontario, Canada, cancer care priority levels are based on A to C recommendations where A is the priority category while C is the delay until the pandemic is over category. Similarly, NHS has issued guidelines in the UK and is prioritising treatment based on 6 levels of treatment, while treatment strategies with a high chance of success are priority level 1 while priority 6 is for noncurative therapy. The American Society of Clinical Oncology has suggested a case-by-case approach to assess which treatments should be prioritised and which should be delayed.

The point is that it might be time to reassess cancer treatment regimens and to make sure the benefits outweigh the risks for patients. The COVID-19 pandemic may have provided the opportunity to choose wisely and critically evaluate treatment strategies so that cancer systems focus on using patient outcomes and value at the centre of all key decisions.

Source: JAMA Oncology

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