We Can Do Better

Re-establishing care equity for cancer care

Fact Sheet

Summary

- Cancer is Ontario's leading cause of death (StatCan 2020). In 2020, 30,054 people died from cancer and only 4,758 deaths were attributed to COVID-19 — cancer killed 6X more people (OCS 2024)
- The early infection fatality rate of COVID-19 was low (0.27%) (Ioannidis 2021) and primarily limited to the elderly (WHO-China Joint Report)
- Implementation of lockdowns satisfied Ontario's legal obligation to slow the spread of COVID-19 (GoC IHR)
- Hospitals across the province were directed to suspend non-emergent care to ensure sufficient acute care capacity (CMOH Directive 2). Repeated suspension of care decimated cancer care, resulting in delays in screening, diagnosis, surgery, and treatment (Ontario Health 2021)
- As a result, cancer was left growing and spreading in the bodies of individuals for longer. In 2020, all-cause mortality among cancer patients increased by 4.5%, and only a minority of the cancer patient deaths (0.7%) were attributed to COVID-19 (OCS 2024).
- Case-based COVID-19 data does not reflect active COVID-19 infection (GoC PCR Test); raising questions regarding the reliability of COVID-19 surveillance data
- Our COVID-19 response overestimated the threat of COVID-19 (Gordon 2021) and underestimated the collateral damage caused by these interventions (McLeod 2024)
- The diversion of life-saving resources away from cancer patients toward empty acute care wards is unjust and exposed cancer patients to undue harm (PHAC Ethics)
- **We Can Do Better** - Future pandemic planning must move out of silos toward shared decision-making that empowers teams of clinical experts to weigh reliable evidence and shape policy that balances the needs of all patients.

Was Ontario's COVID-19 Response Safe?

Delayed Cancer Detection

- The first year of the pandemic relative to 2019: (Walker 2022)
    - 294,852 fewer mammograms were performed (-42.6%)
    - 341,394 fewer pap tests were performed (-38.3%)
    - 21,013 fewer colposcopies were conducted (-20.6%)
- According to the Ontario Medical Association, as of February 2024, 2.3 million of 16.1 million Ontarians (14.3%) do not have a family doctor (OMA Press Release)
- In-person primary care visits are essential for the detection and diagnosis of cancers of female reproductive system. (Walker 2022) As of April 2020, 82% of primary care visits were virtual, with high levels of virtual care (49%) persisting up to October 2021 (Kiran 2023)
- **Billing Incidence Rates:** The suspension of in-person care resulted in a drop in visits for female cancers in 2020, followed by a rebound in visits in 2021 and 2022 as cancer care recovered (McLeod 2024)

Delayed Cancer Diagnosis

- Imaging (MRI/CT scans) and pathology (biopsies) are essential for the diagnosis and staging of female cancers (Parmar 2022)
- The number of CT (−25.9%) and MRI (−26.7%) scans dropped dramatically in April 2020 relative to prepandemic levels (Walker 2022)
- Peak biopsy report reductions were seen in July 2020 (-41.2%) and were cleared by the end of 2021 while peak reductions in cancer resections occurred in May 2020 (Walker 2022) with evidence of surgical backlogs extending to March 2024 (OH Annual Report 2023/2024)
- In 2020 alone, there were 5,894 fewer cancer diagnoses (78,438 vs. 84,332) relative to 2019 (OCS 2024), and 9.5% fewer female cancer diagnoses (OCS 2024)
- **Stage Migration:** In 2020, there was a shift toward fewer curable (stage 1) breast (-2.5%) and cervical (-7.3%) cancers relative to 2019 (OCS 2024)

Delayed Cancer Surgery

- Ontario issued three directives to suspend elective surgical procedures and prioritize P1&P2 surgeries over the COVID-19 pandemic (FAO 2023)
- A year into the pandemic, there was an increase in the number of P2 surgeries for aggressive cancers (+65.6%), no change in P3 surgeries for suspected or invasive cancers, but significant reductions in P4 surgeries (-40%) (Walker 2022)
- However, backlogs resulting from subsequent suspensions would be more difficult to clear. From March 2020 to September 2022, 424,428 fewer surgeries were performed in Ontario relative to 2019 (CIHI 2023)
- However, by March 2024, a fifth (21%) of P2–P4 cancer surgeries and almost half (48%) of P2 surgeries for aggressive cancers were exceeding target wait times (Ontario Health Annual Report 2023/2024)
- Modeling studies estimate that even a 3-month delay in stage I and stage II breast and stage II and III ovarian cancer can negatively impact survival (Sud 2020)(Johnson 2020)

Suboptimal Cancer Treatment

- Treatment protocols were adapted to minimize COVID-19 exposure and compensate for surgical delays (Cancer System Quality Index)
- Six months into the pandemic new consultations for systemic therapy (-15.1%) and radiation therapy (-14.8%) had dropped dramatically (Walker 2022)
- As of March 2021, supportive or adjunctive care visits were well below pre-pandemic levels (-27.4%) with 23,051 fewer patients receiving care (Walker 2022)
- As of February 2021, visits for radiation remained below pre-pandemic levels coinciding with directives to shift toward increased use of hypofractionation (Walker 2022)
- A survey of Canadian cancer patients found that half of patients reported that their care appointments had been cancelled, postponed or rescheduled resulting in increased fear and anxiety (CCSN 2020, CCSN 2022)
- **All-Cause Mortality:** In 2020, there was a 4.5% increase in all-cause mortality among cancer patients, primarily limited to the elderly and only a minority of the cancer patient deaths in 2020 was attributable to COVID-19 (0.7%). There was also a 2.5% decrease in the 2-year relative survival ratio for all cancers (OCS 2024)
- **Survival**: The full impact on mortality and survival due to delayed and suboptimal treatment will likely not be realized for another 5 to 10 years (OCS 2024).

Prevention Undermined

- Well-being in cancer patients is significantly influenced by physical exercise, healthy eating habits, and good mental health (Sharman 2024)
- Lockdowns promoted poor health habits like lack of exercise, poor diet, excessive alcohol intake and high stress (Park 2022)(APA survey, 2021). A total of 61% of people developed an unhealthy habit during the pandemic they wanted to change (PR Newswire 2021)
- Stress and unhealthy behaviors are linked to increased risk of cancer as well as increased risk of progression and death (Zhang 2020)
- COVID-19 vaccines underwent expedited development (Banoun 2023) and phase III trials excluded cancer patients limiting quality efficacy and safety data (Polack 2020) (Baden 2021)
- Recent population-based studies have shown an increased risk of breast cancer 1-year after vaccination and an increased risk of hospitalization for cancer (Kim 2025) (Martellucci 2025)
- **Age-adjusted incidence rates, ASIRs:** Over the COVID-10 period, there was an increase in ASIRs (new cancers) relative to 2019:
    - There was a 6.7% increase in female cancers over the COVID-19 period while the rate for all cancers dropped by 7.1% (OCS 2024)
    - There was a net increase in age-adjusted female incidence rates (ASIRs) for breast +6.5%, cervical +21.6%, uterine +3.1%, ovarian +9.6% cancer over the COVID-19 period (OCS 2024)

Was Ontario's COVID-19 Response Effective?

Did lockdowns protect cancer patients from COVID-19?

- Use of PCR and RAT tests as screening tools had poor clinical accuracy, raising questions about the reliability of COVID-19 surveillance data (Alberta PH Management Guideline, August 2020)
- As estimates of infection, hospitalization, and death among cancer patients were case-based rather than infection-based, the true risk of COVID-19 complications among cancer patients is unclear (WHO-China Joint Commission)(Taylor 2023)
- Estimates of COVID-19 hospitalization for cancer were in line with normal levels of hospitalization for cancer, raising questions regarding actual COVID-19 risk (OCS 2024)
- Excess all-cause mortality in the general population greatly exceeded COVID-19 deaths. Peaks in all-cause mortality were seen in April 2020, coinciding with the first lockdown, and again in early 2022, coinciding with the arrival of Omicron and the rollout of COVID-19 boosters in high-risk populations (Rancourt 2025)(OCS 2024)

Did lockdowns preserve hospital capacity?

- Hospitals in Ontario suspended non-emergent care and diverted resources toward surge capacity (CMOH Directive 2) (FAO 2023)
- In doing so, cancer care was compromised resulting in prolonged delays in detection, diagnosis and treatment (Walker 2022)
- Case-based COVID-19 data was unable to accurately project surge capacity needs. Although data from Ontario is not available, >95% of acute care beds remained unused at the peak of Wave 1, and >50% of beds remained unused at the peaks of Waves 2 and 3 in Alberta (Gordon 2021)

Was suspension of care ethical?

- The ethical principles that govern public health care in Ontario include the principles of justice and minimizing harm (Ontario Health 2021)
- Guidance on the allocation of limited resources during the pandemic prioritized care for patients with need and efficacy of treatment (CCO 2020)
- Cancer is six times more deadly than COVID-19 (OCS 2024), and effective, well-established treatment protocols exist for all stages of cancer (CCO 2025)
- Diversion of life-saving cancer resources away from real cancer patients toward potential COVID-19 patients in acute care wards is unjust, avoidable, and exposes cancer patients to undue harm (PHAC Ethics)

We Can Do Better

- We need to right the harm done to women by investigating the rise of female cancers
- We need to ensure that future pandemic planning must shift from centralized silos to shared decision-making, empowering clinical experts to weigh reliable evidence and shape policy that balances the needs of all patients