Cancer Care During COVID-19—A Shock to the System
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The COVID-19 pandemic has caused severe interruptions in care for patients across the disease spectrum. Reductions in health care utilization during the initial stages of the pandemic have been identified both domestically and internationally.1,2 In the study by Walker et al,3 the authors examined the changes in cancer care services across the continuum of care in Ontario, Canada, associated with the COVID-19 pandemic. Their results demonstrated an overall deficit in the first year of the pandemic, punctuated by steep reductions during the initial wave of COVID-19 followed by rebounding trends later in the year. These findings cast into stark relief how the COVID-19 pandemic represented a shock to the health care system in general, and to cancer care in particular.

Individual components of cancer care delivery have been previously studied. In the US, Bakouny et al4 examined screening patterns in the Massachusetts General Brigham health care system and found that for common cancer screening examinations, including low-dose computed tomography, Papanicolaou test, colonoscopy, prostate-specific antigen screening, or mammography, the proportion of patients receiving at least 1 examination during the first 3 months of the pandemic amounted to only 24.0% of the total receiving at least 1 examination in the 3 months prior to the pandemic. In a study in Scotland, Baxter et al5 reported that the receipt of scheduled anticancer systemic therapy delivery deceased 28.7% in the first 2 months after the outbreak of the pandemic compared with the 2 months prior to the pandemic, with particularly large reductions for some cancers, including colorectal cancer (43.4%).

These studies highlight the profound hesitancy that patients with cancer likely had when faced with the necessity to interact with the cancer care system during the initial stages of the pandemic. Such hesitancy extended even to the prospect of participating in clinical trials. According to a study by Fleury et al,6 1 in 5 patients with cancer indicated they would be less willing to participate in a clinical trial owing to fears about contracting COVID-19. Such fears are not unfounded, especially given the risk that receipt of systemic therapies could pose to patients of becoming infected with SARS-CoV-2 while receiving care at clinics, a result that would surely exacerbate existing clinical risks that patients with cancer already face.7

A decided strength of the study by Walker et al3 is that it examined the changes in cancer care during the COVID-19 pandemic across the continuum of care, including screening, imaging, surgical treatment, pathological reporting, systemic treatment, radiation treatment, and psychosocial oncological care, rather than only for individual components of care. Across the entire first year of the pandemic, Walker et al3 identified 1 167 412 fewer health care services received compared with the year prior to the pandemic, a 20.7% reduction. Reductions were particularly pronounced for cancer screening tests, with a 42.4% reduction compared with the prior year. Importantly, Walker et al3 found that the first year of the pandemic was actually bifurcated into 2 periods. In the first 6 months, reductions in services were much greater, highlighting the initial shock to the system. In fact, as the authors showed, there was a relative reduction of 31.1% in overall services during the first 6 months compared with the prior period, including a 66.4% reduction in cancer screenings. Thereafter, a strong rebound occurred, with service utilization increasing dramatically. In fact, in early 2021, total services appeared to even exceed prior trends, suggesting a potential pattern of delayed—rather than foregone—use of cancer services.3

Another strength of the study by Walker et al3 is a focus on the Canadian health care system. Because this system relies on universal, publicly funded health care coverage that provides free medically necessary services for all citizens and permanent residents, there was much less likelihood...
that the study findings were biased owing to differential access to care between the prepandemic and pandemic periods. One potential analytical limitation is that the estimates of cancer services reductions rely entirely on the experience of utilization in the year prior to the pandemic. This short baseline period, representing only a single year of volume, may itself be unrepresentative for unknown reasons. Moreover, the use of a longer baseline period (such as 3 years) could have established whether service volumes were trending higher over time. If so, the results may actually represent an underestimate of the true impact of the pandemic.

Despite this, the overall findings by Walker et al are almost certainly valid and are consistent with those found in other settings. Delayed or foregone services for cancer, especially screenings aimed toward identifying newly developing cancers, are likely to result in negative health consequences for individuals that unfold for years to come. In this context, the findings of the study by Walker et al suggest how the changes in care patterns associated with the pandemic may ripple outward over time, potentially for a decade or more. Understanding both the combined and individual components of these outcomes is necessary for researchers and policy makers to address the impact of the current pandemic and to anticipate future pandemics.

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