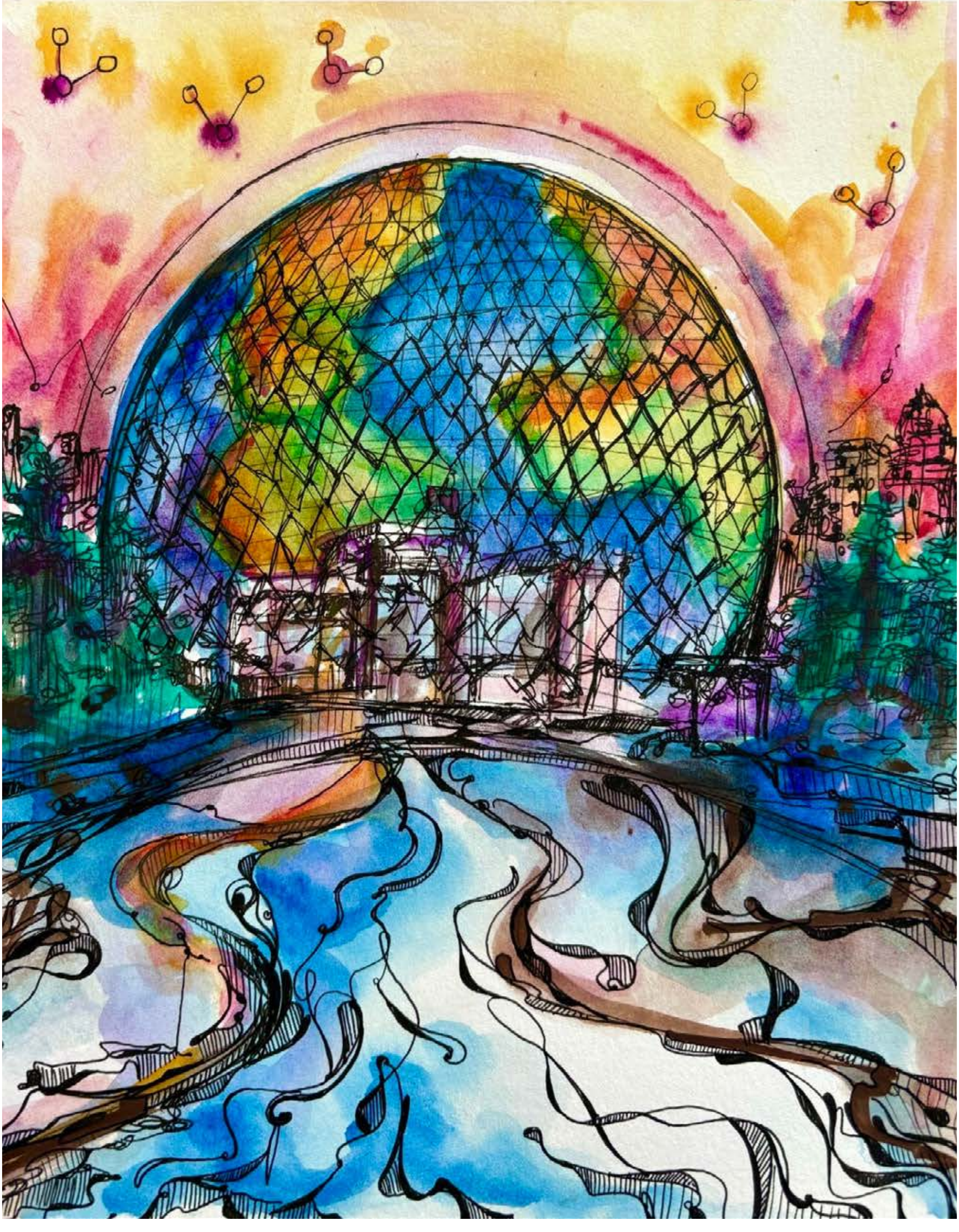
McGILL JOURNAL OF GLOBAL HEALTH

Volume XIV | Issue 1 | 2025



Perspective

Inequities in Endocrine Oncology Care in Canada: When Universal Isn't Equitable

Mohammad Jay[1] and Hussein Samhat[2]*

[1]Department of Medicine, University of Toronto, Toronto, ON, Canada

[2]Department of Epidemiology, Biostatistics and Occupational Health, McGill University, Montreal, QC, Canada

Received: April 1, 2025 | **Published Online:** August 28, 2025

***Correspondence**: Mohammad Jay, **Email:** mohammad.jay@mail.utoronto.ca

Canada's healthcare system is often praised for its universality. But a closer look reveals a different reality: public insurance alone does not ensure equitable care [1]. This becomes especially clear in endocrine oncology, which includes tumors of the thyroid, neuroendocrine system, adrenal, parathyroid, and pituitary glands. While outcomes reflect disease biology, they are also shaped by social and geographic circumstances, leaving low-income, rural, Indigenous, and immigrant communities at a persistent disadvantage across Canada [2, 3].

Diagnosis Isn't Equal When Access Isn't Equal

Thyroid cancer diagnoses in Canada have risen sharply over the past few decades. Diagnosis often reflects socioeconomic status [4]. Wealthier individuals benefit from incidental detection through imaging, while lower-income patients may only access care once symptoms are advanced [3-4]. Similar patterns emerge across other endocrine cancers. One Ontario study found that rural residents with neuroendocrine tumors (NETs) had worse survival, likely due to delayed diagnosis, limited specialist access, and disrupted follow-up [2]. Data for adrenal, parathyroid, and pituitary cancers are limited, but many clinicians suspect that patients in underserved communities face longer diagnostic delays or are simply missed.

Treatment Shouldn't Depend on Your Postal Code

Even after a diagnosis, access to treatment is not guaranteed. Many advanced endocrine oncology therapies such as radioactive iodine, peptide receptor radionuclide therapy, or complex endocrine surgeries are concentrated in major urban centres. For patients in remote areas, reaching these services often requires long travel, time off work, childcare arrangements, and significant out-of-pocket costs. These burdens disproportionately affect rural residents, lower-income patients, and individuals with limited social supports, adding strain to already vulnerable populations.

Many essential services, such as hormone replacement, follow-up imaging, and mental health support, are either excluded or unevenly covered across provinces. These gaps place financial pressure on patients, particularly those with low incomes or limited support, contributing to what researchers call *financial toxicity* [5]. A national study found that patients requiring growth hormone replacement therapy after treatment faced dramatically different costs depending on where they lived. In provinces like British Columbia and Prince Edward Island, no public coverage existed, forcing some patients to pay 25–38% of their annual income out of pocket [6]. These interprovincial differences create what some have called a *postal code lottery*.

Barriers Faced by Marginalized Populations

For Indigenous peoples, immigrants, and refugees, the barriers to care often go beyond cost or location. Language, transportation, mistrust of the system, and unfamiliarity with how to navigate it can all lead to delays or prevent care. Many face services that don't reflect their cultural needs or lived experiences [7,8]. A national study found major differences in cancer rates and outcomes among First Nations adults depending on region and reserve status [9]. But data like this is rare. Most cancer registries still don't report cancer statistics by income, ethnicity, or geography, leaving gaps in our understanding and limiting the ability to design equitable policies.

Surviving Cancer Isn't the End: Gaps in Survivorship Support

For many patients, endocrine cancer care does not end with treatment. Long-term needs—such as hormone replacement, surveillance imaging, and mental health support are common, yet survivorship programs tailored to endocrine malignancies are rare and typically concentrated in urban centres. In rural or underserved areas, many rely on primary care providers who may lack the resources or training for complex endocrine follow-up [10]. For lower-income patients, out-of-pocket costs for medications, travel, and missed work can accumulate long after treatment, compounding stress and lowering quality of life. Patient advocacy groups, such as the International Neuroendocrine Cancer Alliance (INCA), help bridge these gaps by offering navigation, education, and peer support. Formally integrating such groups into survivorship planning could help ensure more equitable, patient-centered care, particularly for those facing systemic barriers [11].

Data Gaps for Rare Endocrine Tumors

Adrenal, parathyroid, and pituitary tumors remain understudied in Canada, particularly when it comes to outcomes stratified by income, geography, or ethnicity. These rare cancers require timely diagnosis and coordinated care, but the absence of disaggregated data hinders equitable planning.

Moving Toward Equity

Improving equity in endocrine oncology will require attention to structural gaps, better data, and more responsive service delivery. The following policy, research, and practice recommendations outline opportunities to support more inclusive care across Canada.

Policy reform should focus on ensuring consistent public coverage of essential endocrine therapies across provinces to reduce variation in access and cost. It should also include expanding and simplifying travel and accommodation supports for patients who must access specialized services far from home. In addition, provincial cancer agencies should be required to collect and publicly report data on incidence, outcomes, and service access by income, ethnicity, and region, in order to guide more equitable planning and delivery of care.

Research priorities should include establishing national registries for rare endocrine tumors that incorporate sociodemographic data, as well as updating population-level information on thyroid and neuroendocrine tumor trends, with attention to migration and differential access to technology and imaging. In addition, it is important to explore how culturally safe navigation and patient education can improve outcomes, particularly for individuals facing language or systemic barriers.

Practice innovations should focus on embedding peer navigators or multilingual staff in cancer centres to assist patients from underserved communities in navigating their care. Expanding virtual care is also important to support follow-up, multidisciplinary consultations, and survivorship planning, particularly for those in rural or remote settings. In addition, comprehensive survivorship programs should be developed that integrate endocrine follow-up, mental health, rehabilitation, and financial counseling, with particular attention to patients with limited resources.

A Call to Action

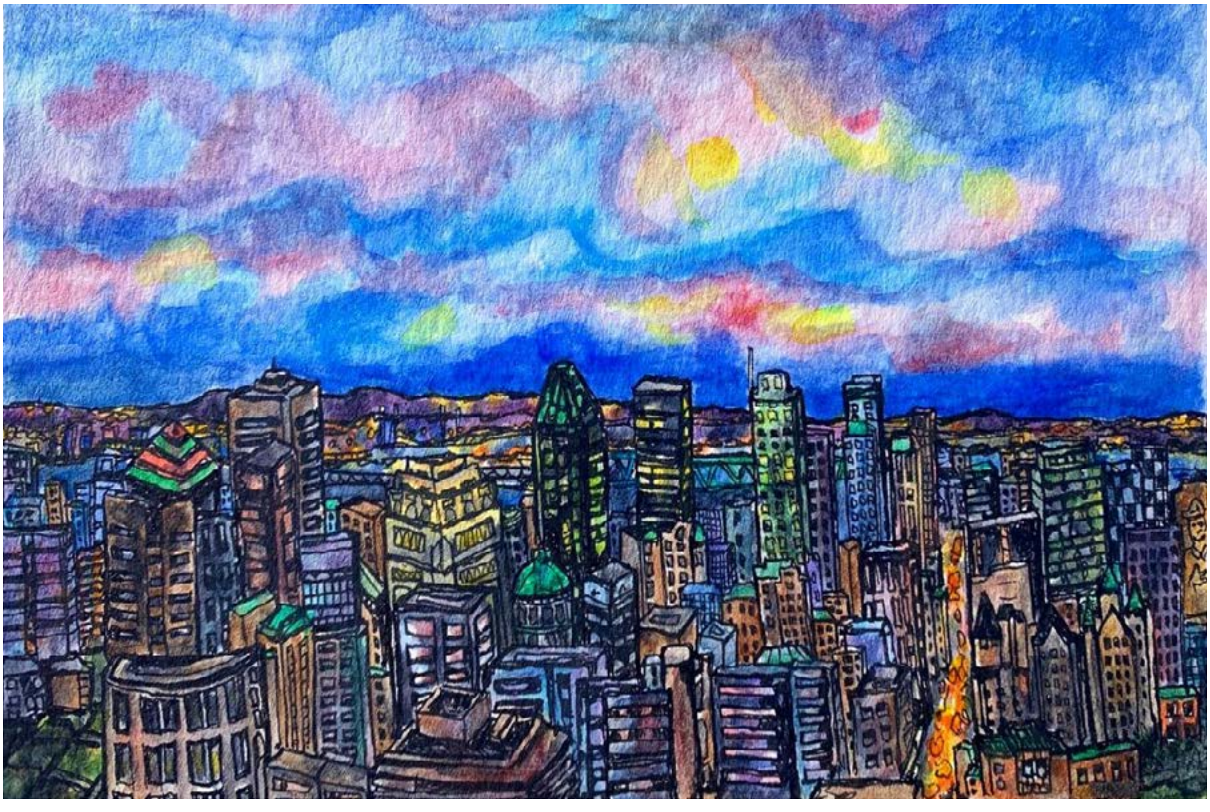
Canada's healthcare system rests on a foundational promise: that access to care should be based on need, not income or geography. But in endocrine oncology, that promise remains unfulfilled for too many. True universality means building systems that include everyone, regardless of geography or language. Equity in cancer care isn't a luxury, it's a responsibility. While the challenges are complex, the solutions are within reach. Through coordinated policy reform, community-informed research, and culturally responsive support systems, we can begin to close the gaps that shape not just survival, but the quality of life after cancer. Endocrine cancers don't discriminate. Our care systems shouldn't either. A more equitable model of endocrine oncology care is possible, but only if we confront the structural barriers that persist. Progress begins with acknowledging where we fall short and committing to change grounded in equity, accountability, and compassion.

References

1. Martin D, Miller AP, Quesnel-Vallée A, Caron NR, Vissandjée B, Marchildon GP. Canada's universal health-care system: achieving its potential. Lancet. 2018;391(10131):1718–35.
2. Hallet J, Law CH, Karanicolas PJ, Saskin R, Liu N, Singh S. Rural–urban disparities in incidence and outcomes of neuroendocrine tumors: a population-based analysis of 6271 cases. Cancer. 2015;121(13):2214–21.
3. Davis S, Ullmann TM, Roman S. Disparities in treatment for differentiated thyroid cancer. Thyroid. 2023;33(3):287–93.
4. Guay B, Johnson-Obaseki S, McDonald JT, Connell C, Corsten M. Incidence of differentiated thyroid cancer by socioeconomic status and urban residence: Canada 1991–2006. Thyroid. 2014;24(3):552–5.
5. Carrera PM, Kantarjian HM, Blinder VS. The financial burden and distress of patients with cancer: understanding and stepping up action on the financial toxicity of cancer treatment. CA Cancer J Clin. 2018;68(2):153–65.
6. Hasan H, Howard F, Morgan SG, Metzger DL, Gill S, Johnson M, et al. Provincial disparities of growth hormone coverage for young adult survivors of paediatric brain tumours across Canada. Healthc Policy. 2014;9(3):80–90.
7. Graham S, Muir NM, Formsma JW, Smylie J. First Nations, Inuit and Métis peoples living in urban areas of Canada and their access to healthcare: a systematic review. Int J Environ Res Public Health. 2023;20(11):6093.
8. McKeary M, Newbold B. Barriers to care: the challenges for Canadian refugees and their health care providers. J Refugee Stud. 2010;23(4):523–45.
9. Mazereeuw MV, Withrow DR, Nishri ED, Tjepkema M, Marrett LD. Cancer incidence among First Nations adults in Canada: follow-up of the 1991 Census Mortality Cohort (1992–2009). Can J Public Health. 2018;109(5):700–9.
10. Howard AF, Smillie K, Turnbull K, Zirul C, Munroe D, Ward A, et al. Access to medical and supportive care for rural and remote cancer survivors in northern British Columbia. J Rural Health. 2014;30(3):311–21.
11. Kolarova T, Bouvier C. The role of patient support groups in neuroendocrine neoplasms. Curr Oncol Rep. 2021;23(1):5.

McGill Journal of Global Health

Volume XIV | Issue 1 | 2025



Mount Royal, Quebec, Canada © Evelyn Rogan