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**The Voice of the Cancer Advocacy Coalition of Canada**  
**CANCER CARE IN CANADA REPORT CARD 2001**  
 Winter 2001, Number 3

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**The Voice of the Cancer Advocacy Coalition of Canada (CACC)**  
**CANCER CARE IN CANADA**  
Winter 2001 No.3

1. **Report Card 2001**  
Here is our second annual report card. We find that Canadian statistics on cancer are as full of holes as Swiss cheese, but there is food for thought between the holes.
2. **Re-organizing Cancer Care Ontario - For Whose Benefit?**  
Senior Writer Laura Eggertson examines the pros and cons of Ontario's decision to reconsider the way cancer care is delivered.
3. **Centralization or Decentralization?**  
Dr. Simon Sutcliffe of the BC Cancer Agency looks at options for Ontario.
4. **Case/Fatality Ratios**  
Toe-to-toe outcomes across the US States and Canadian Provinces.

**Only Advocacy can cure Canada's Cancer Problem**

From the editors, Pat Kelly and Glenn Jones.

Welcome to the first electronic version of Cancer Care in Canada. This newsletter includes our Report Card 2001 and is posted on our website **[www.canceradvocacycoalition.com](http://www.canceradvocacycoalition.com)**. In future, all newsletters will be released this way, and we hope to soon be able to add an interactive component so patients and members of the Canadian Advocacy Coalition of Canada could ask questions or post comments on-line.

We can't emphasize enough how important it is that the CACC reflect the concerns of patients and our members. Our strategy is to link everyone together in an electronic community of advocates, so that we may share and work together towards the goal of controlling cancer in Canada.

This year, we had trouble putting together a Report Card, our annual effort to chart the progress of cancer and cancer care in Canada. We tried to get hard information about areas that have not been surveyed, such as the prevalence of cancer, how many people have had cancer in each province, a number greater than the annual incidence of the disease.

We found out there are few statistics available about cancer across Canada. The neighbouring state of Michigan offers more information on its cancer websites than all of our provinces and our federal government. There is one encouraging exception: Statscan's five-year survival rates for common cancers, shown by province. The figures came out on December 13 and are included in our Report Card.

**The reasons for meagre statistics across Canada finally come down to money.** No government has been able to keep up with the funding essential to tackle the most serious disease in the country – cancer. Cancer Care in Canada is dominated by the lack of funding. The Ontario government's decision to change the way cancer control and care is delivered in the province (the subject of our leading article in this issue of CCC) is largely driven by money.

There is a putative National Strategy for Cancer Control but as yet there is no money for it. **Money, much more money is needed if we are to create an efficient and human system based on research and information that only money can produce.**

Lacking Canadian data to determine how we are doing, we must look to some international statistics that compare Canada to other countries. How Canada fares is underscored by some recent reports that reflect the state of Canadian health care in general terms. These contrast sharply with the Federal government's longtime boasts that we have the best, the fairest, the most accessible system in the world.

When the World Health Report 2000 ranked member states by health system attainment and performance, Canada came in 30th of 100 countries, with France at the top. According to the OECD Canada is 5th among 28 countries in spending on health as a percentage of GDP. But we rank low in terms of accessibility to such key technologies in cancer diagnosis and staging such as CT scanners and MRIs: Canada comes in **21st for access to scanners; 19th for MRIs.**

Ironically, the OECD noted that Canada ranked 5th in the number of linear accelerators per capita but it didn't add that we don't have the money for therapists to run the machines or enough oncologists to treat the patients. **This is evident from the excessively long waiting lists for radiotherapy in many provinces.**

Our report includes statistics from the North American Association of Central Cancer Registries (NAACCR). These statistics show how Canadian provinces compare with American states. Last year the data caused controversy as they showed that fewer Canadians were proportionately being diagnosed with cancer, but proportionately more were dying from the disease when compared with Americans.

We were criticized for presenting incidence/mortality ratios, so this year we present case/fatality ratios. These statistics are generally considered more reliable, but the ranking results are very similar to those of last year.

Finally, we underline Dr. Simon Sutcliffe's statement that **cancer is not under control**. Doctors and patients are living with Band-Aid solutions to immediate problems yet cancer is the most important disease in Canada; cancer affects more Canadians than any other.

The only way to give Canadians the cancer care they deserve is to keep asking, demanding, exhorting, and advocating.

**Join us and help us awake our government to the needs of all Canadians.**

## **CANCER CARE IN CANADA REPORT CARD 2001**

Cancer Care in Canada sent a set of questions this past summer to provincial bodies responsible for cancer care. The aim was to better describe the state of cancer control and care in Canada by getting answers to the following questions.

What is the prevalence of patients with a cancer diagnosis? Prevalence is the number of people living with a cancer diagnosis and incidence is the number of people with a new diagnosis of cancer. This is a significant question because prevalence reveals better than incidence how many people are likely to need care, including cancer treatments. For example, Manitoba in 1998 estimated that the prevalence of cancer in the province was three times the incidence.

### **We also asked:**

- What are the 5-year and 10-year survival rates for people diagnosed with the four leading cancers?
- How long do patients have to wait for radiation and system therapy?
- How much are the provinces and territories spending on cancer?
- What are the strategies to improve care?
- What challenges are ahead?

### **A Swiss Cheese of Statistics**

The responses to even these basic questions reveal a very uneven ability to report cancer statistics. There are no standardized reports of cancer numbers in Canada. Quebec and New Brunswick do not have central cancer care agencies and they cannot provide specific numbers about cancer. Cancer patients in the three territories are sent to either British Columbia or Alberta for treatment so there are very few statistics for the territories. Some provinces do not measure prevalence at all. Reporting differs between Canada and the United States. The state of reporting leaves a lot of holes and few provinces could answer all of our questions.

The next section provides more detailed answers to each of the questions.

**The most shocking data were the long waits for radiation therapy.** While urgent cases are treated promptly, average provincial waits are mostly unreasonable. **Some are in excess of the 4-week national recommendation from the Canadian Association of Radiation Oncologists.** This can lead to worse physical and psychological outcomes for cancer patients.

Further a shortage of both medical and radiation oncologists is beginning to extend waiting times for radiation and chemotherapy.

We also have new benchmark numbers. The North American Association of Central Cancer Registries (NAACR 1991-95) ranked Canadian provinces and American states according to case-fatality ratios. That ratio is the number of deaths with a disease divided by the number of patients with a disease. A higher case-fatality ratio is bad news. Of Canadian provinces, only Saskatchewan ranked with the best half of American states and that was a dismal 29<sup>th</sup> of 62 jurisdictions. Ontario, Canada's largest province, ranked 41<sup>st</sup>. It appears that Americans are more likely to be diagnosed with cancer, but Canadians are more likely to die from cancer. These answers require serious attention and action.

## **THE CANADIAN PICTURE**

### **1. How many people are currently living with a cancer diagnosis in your province?**

Six provinces and one territory record the prevalence of cancer. Methods of calculating the number of people alive after a cancer diagnosis differ between provinces. For example, most provinces exclude general skin cancers but include melanoma cancers in their statistics. The difficulty in supplying prevalence figures is that some provinces have no capability to match provincial cancer registry data with records of cancer deaths. Representatives from Alberta, New Brunswick and Quebec said they do not calculate prevalence.

#### **All living persons who have had a cancer diagnosis by Province:**

<b>British Columbia</b>	<b>120,000</b>
<b>Manitoba</b>	<b>33,000 (in 1998)</b>
<b>Newfoundland</b>	<b>3,353 (in 1999)</b>
<b>Nova Scotia</b>	<b>24,000 (if diagnosed after 1979)</b>
<b>NWT</b>	<b>116</b>
<b>Ontario</b>	<b>250,000</b>
<b>Saskatchewan</b>	<b>70,900 (includes non-melanoma skin cancers)</b>

These are the figures just released by STATSCAN:

## 2. What is the 5-year survival rates for people in your province diagnosed with breast, prostate, lung and colorectal cancer?

We found that few provinces could individually provide five-year survival rates; instead, we are publishing the five -year survival rates that have just been released by Statscan. Normally, these figures are only available to Statscan subscribers but Statscan has given us permission to reprint them in the report card.

Note: relative survival compares the observed survival for a group of cancer patients to the survival that would have been expected for members of the general population who have the same characteristics – such as sex, age and province of residence – as the cancer patients.

In general, survival time was calculated as the difference in days between the date of diagnosis and the date of last observation (date of death or December 31, 1997, whichever was earliest) to a maximum of Five years.

Five-year relative survival rates for prostate, breast, colorectal and lung cancer cases diagnosed in 1992, by sex and age group, Canada (excluding Quebec).

Table 1  
Five-year relative survival rates for prostate, breast, colorectal and lung cancer cases diagnosed in 1992, by sex and age group, Canada†

Cancer site/ Age group	Men				Cancer site/ Age group	Women			
	Relative survival rate	95% confidence interval	Number of cases	Number of deaths‡		Relative survival rate	95% confidence interval	Number of cases	Number of deaths‡
	%					%			
<b>Prostate</b>					<b>Breast</b>				
15-54	81	75, 85	242	53	15-39	73	70, 77	663	178
55-64	89	87, 91	1,947	363	40-49	83	81, 85	1,947	345
65-74	89	88, 91	4,752	1,273	50-59	83	81, 84	2,107	410
75-84	86	83, 88	3,585	1,663	60-69	83	81, 84	2,749	620
85-99	67	58, 75	763	577	70-79	86	83, 88	2,405	674
15-99	88	87, 89	11,289	3,929	80-99	78	72, 82	1,137	623
					15-99	82	81, 83	11,008	2,850
<b>Colorectal</b>					<b>Colorectal</b>				
15-49	58	53, 63	424	182	15-49	64	58, 68	362	134
50-59	59	56, 63	828	361	50-59	64	59, 68	551	210
60-69	56	54, 59	1,647	827	60-69	62	59, 65	1,127	477
70-79	56	53, 60	1,673	976	70-79	59	56, 62	1,389	703
80-99	50	44, 56	786	594	80-99	52	47, 56	1,076	752
15-99	56	55, 58	5,358	2,940	15-99	59	57, 61	4,505	2,276
<b>Lung</b>					<b>Lung</b>				
15-49	17	14, 21	409	340	15-49	24	20, 29	402	305
50-59	16	14, 18	1,041	881	50-59	20	17, 23	684	549
60-69	15	13, 16	2,464	2,147	60-69	17	15, 20	1,291	1,081
70-79	13	12, 15	2,196	1,980	70-79	15	13, 17	1,142	995
80-99	8	5, 11	743	713	80-99	10	7, 14	410	384
15-99	14	13, 15	6,853	6,061	15-99	17	16, 19	3,929	3,314

Data source: Canadian Cancer Registry  
† Excluding Québec  
‡ Within first five years of follow-up

(Statistics Canada figures, December 2001)

Three provinces only could provide us with a 10-year-survival rate:

<u>Year of diagnosis</u>	<u>10-year Survival Rate</u>		
	<u>BC</u>	<u>ON*</u>	<u>AB (82-84)</u>
<b>Breast</b>	76%	63%	70%
<b>Prostate</b>	76%	58%	65%
<b>Colorectal</b>			
<b>all</b>	56%	48%	
<b>Men</b>			46%
<b>Women</b>			45%
<b>Lung</b>			
<b>all</b>	11%	11%	
<b>Men</b>			9%
<b>Women</b>			9%

\*Ontario's figures are based on life table analysis of relative survival, with follow-up to 31 December 1998. The figures exclude cases of second and later primaries, cases registered on the basis of a death certificate only, and cases under age 15 or over age 89.

### **3. How long do residents of your province wait for cancer treatment?**

#### **Waiting times for radiation therapy.**

The most distressing feature of cancer care in Canada is the waiting time for radiation therapy. This is mostly due to the shortage of radiation therapists, a problem that is being slowly remedied after the crisis of 2000 when there was a national shortage in excess of 200 therapists. Even though accounting for waiting times is simple, only six provinces could provide information on this problem: Alberta, British Columbia, Manitoba, Newfoundland, Ontario and Prince Edward Island.

Dr. Denis Roy, CEO of the Quebec Provincial Fight Against Cancer program says the delays from diagnosis and referral to treatment "are of paramount importance because it is at the very beginning of treatment that we can make a difference." Even so, he admitted that Quebec has no accurate information on waiting times. Unlike most other provinces, Quebec does not have a centralized cancer agency, which may help explain why the waiting times data is not readily available.

In Ontario, for each of the 12 months ending in August 2001, the percentage of patients treated within a recommended time of four weeks ranged between 28% and 35%. Also, 40% waited more than eight weeks from referral to the start of radiation treatment.

Manitoba has brought down its waiting time from consultant to the start of therapy from 10 weeks, a year ago, to 3 weeks now. However, it cannot deliver newer radiation therapies like brachytherapy for prostate cancer because it doesn't yet have enough therapists.

Until recently, most provinces were sending patients to the US for timely radiation therapy. Prince Edward Island has no radiation therapists and sends its patients off-island, with waiting times in excess of two months.

## Wait Times in days

	<u>From referral To specialist</u>	<u>From consultant to start of treatment</u>	<u>Totals</u>
Alberta	14-28	7-14	21-42
British Columbia	13 (median)	8	21
Manitoba			19
Newfoundland			28
Ontario			47
Prince Edward Island*	7	28-60	35-67

\*PEI has no radiation therapy services. All patients needing radiation therapy must be sent to other provinces; waiting times are growing.

## Waiting time for systemic therapy

There are only short delays reported in giving patients intravenous and oral drugs. Most patients can receive oral drugs right after they see an oncologist. An intravenous schedule takes a little longer to set up. According to Dr. Susan O'Reilly, head of the division of medical oncology at the University of British Columbia and the BC Cancer Agency, "Most medical oncologists and patients would be content if they can start treatment within a week. Up to two weeks is acceptable in most cases." Urgent cases are treated more quickly.

However, there are significant waiting times to see medical oncologists. These specialists are in short supply in most of Canada. In Montreal, says Dr. Brian Leyland-Jones, professor of oncology at McGill University, "there can be a three week wait to see an oncologist." In Newfoundland the shortage of medical oncologists is acute, and it takes two months to see an oncologist.

## Wait Time in Days

	<u>From referral To oncologist</u>	<u>From consultant to start of treatment</u>	<u>Totals</u>
Alberta	14-28	7	21-35
British Columbia	10	5	15
Manitoba	up to 15		8-17
Newfoundland			60
Ontario			34
Prince Edward Island*	10-14	1-2	11-16

\*PEI has only two part-time medical oncologists.

#### 4) How much does your province spend each year on cancer control and care?

Seven provinces provide budgets for agencies dedicated to cancer care, Alberta, British Columbia, Manitoba, Newfoundland, Nova Scotia, Ontario, and Saskatchewan.

The Alberta figures reflect only a fraction of spending on cancer overall, says Dr. Tony Fields, vice-president of medical affairs and community oncology at the Alberta Cancer Board, and they don't include, for example, costs of diagnosis, surgical treatment, and supportive and palliative care. But Neil Berman in the Strategic Partnerships Office of Health Canada says that capturing all the money spent on cancer is impossible. **“The only division devoted solely to cancer at Health Canada – the Cancer Division – represents only a fraction of federal cancer activities. There has never been, as far as I know, an attempt to count the dollar resources allocated to cancer.”**

There was one attempt to account for spending on a site-specific cancer. In 1993, the House of Commons' Subcommittee on the Status of Women held hearings to find out how much federal money was being spent on breast cancer research: the amount was less than \$800,000 a year. This led to a rapid infusion of \$25 million over five years in federal funding for breast cancer. Following the same strategy, the HIV/AIDS advocates have successfully won \$43 million a year from the federal government.

#### Government Budgets on Cancer Care in Canada

<u>Province</u>	<u>total population*</u>	<u>budget for fiscal year 2001-2002</u>
AB	2, 997, 236	\$102 million (Alberta Cancer Board) \$ 33 million in drugs
BC	4, 063, 760	\$180 million (BC Cancer Agency)
MN	1, 147, 880	\$34 million (Manitoba Cancer Care)
NFLD	546.000	** \$13,882.847 million (Newfoundland Cancer Research & Treatment).
NS	940, 996	\$4.2 million (Cancer Care Nova Scotia) \$25 million (Queen Elizabeth II Health Sciences Centre Cancer Care)
ON	11, 669, 344	\$250 million (Cancer Care Ontario)
SK	1 million	\$35.898.708 (Saskatchewan Cancer Agency)

\*From Statistics Canada data for 2000

\*\*\$2,714,606 over budget

## 5) Existing Strategies for Improvement.

“The greatest challenge” says Dr. Brent Schacter, the president and CEO of Manitoba Cancer Care, “is the heavier burden of the growing incidence of cancer (around 3% a year). It creates problems in a number of areas. It changes the way we do our work. We’re trying to develop more effective strategies and programs, screening and human resources...”

**Across Canada there just aren’t enough people working in cancer care to meet the needs of patients. There isn’t enough money.** Some reorganization and attention to problems may improve efficiencies. While the federal government has articulated a National Cancer Strategy, it remains underdeveloped and unfunded. Provinces do what they can with some successes. For example:

**British Columbia.** The BC Cancer Agency has pinpointed certain areas for special attention. Through monitoring existing programs, it has been able to better define a continuing shortage of cancer professionals. Workload staffing standards for key groups of cancer care providers have been set up and link the number of new patients to the required staffing levels. Based on projections of future needs, there is a national and international recruiting drive for professionals. Guarantees of academic time, competitive compensation, recognition and flexible employment options are being used to help retain professionals.

**Alberta.** The Alberta Cancer Board experienced its most severe shortage ever of radiation therapists in 2000. After cobbling together a strategy that included hiring U.S. therapists on contract, asking existing therapists to work overtime, aggressively recruiting internationally, and boosting the number of trainees in local therapist training programs, the ACB has radically reduced waiting times for treatments. Now, the ACB is concentrating on the shortage of oncologists, establishing a resident training program in radiation oncology at the University of Calgary.

**Manitoba.** To attract and retain radiation therapists in the province, Cancer Care Manitoba boosted salaries by 29%. It pays from \$50-63,000 per therapist. In 1995, Manitoba established a comprehensive training program in medical physics to attract high quality physics students. To date, four students have completed the graduate program. Two remained in Manitoba.

**Newfoundland.** The province is recruiting oncologists and introducing screening programs for breast cancer. Radiation therapists were trained in Ontario so patients from Newfoundland no longer needed to be sent to Cleveland. Outreach services to local communities were extended. Unfortunately, the Newfoundland Cancer Research & Treatment has a deficit of \$2,714,606, which has to be addressed.

**New Brunswick.** The province has no separate cancer agency. It is moving to centralize management and control of cancer care. As part of a 5-year national breast screening program initiative, the province is scoring a high 50% participation.

**Nova Scotia.** Cancer Care Nova Scotia's mission is to bring cancer services closer to the community and make them more accessible to everyone. Theresa Marie Underhill, the CCO of Cancer Care Nova Scotia, says, "A district program is being developed with new programs and services and organization at a local level." She emphasizes a need for better quality service and has instituted an education program for professionals to better support the new local outreach clinics. While radiation continues to be offered only at Halifax and Sydney, chemotherapy will be prescribed locally as medical oncologists travel among geographic sites.

**Ontario.** By the fall of 2002, Cancer Care Ontario hopes to have developed provincial wide cancer-reduction targets as well as strategies for preventing cancer by addressing major causes. The agency is lobbying the government for help in recruiting needed staff, seeking to increase residency training positions for radiation and medical oncologists, licensing out-of-country trained oncologists, and facilitating immigration procedures.

**Prince Edward Island.** The single cancer care centre and satellite clinics have no linear accelerator, only an ancient cobalt machine which no technician wants to use any more. Patients must go to neighboring provinces for radiation. Waiting times are lengthening because New Brunswick decided to limit out-of-province patients. There is a government commitment to expand the cancer centre, install a linear accelerator, and hire a radiation therapist. There are two part time medical oncologists and this matches demand.

**Quebec.** In Quebec, cancer care is incorporated into the general health care system. This has the potential to help cancer care, have greater influences on decision-making. Quebec set targets in cancer prevention, and claims that smoking has been reduced by 5% over four years. Screening programs were set up with the goal to reduce mortality rates for breast cancer in women between ages 50 and 69 by the year 2008.

**Saskatchewan.** The Saskatchewan Cancer Agency (SCA) has a complete strategic plan in place to upgrade services. This includes breast and cervical screening programs. This year an integrated management system is being developed. Radiation therapists are being recruited with the offer of a \$14,475 bonus on top of a competitive salary (more than \$50,000 per annum). Other inducements include more vacation time.

## **6) Challenges**

"Dollars!" So says Theresa Marie Underhill of Nova Scotia Cancer Care when asked about challenges ahead. "The challenge is to meet the cost of building an appropriate infrastructure to support a greater incidence and prevalence of cancer. This includes everything from capital equipment to professionals. "

**Human Resources.** The need for more cancer professionals grows as the incidence of cancer grows. **Canada is now in competition with the world for cancer professionals. Radiation therapists can command salaries up to \$63,000 across Canada, but that is dwarfed by US staffing agencies that offer from US\$35-40 per hour.** In Ontario, new cancer centres may be opened without sufficient staff to make them work.

**Screening and Prevention.** Dr. Simon Sutcliffe, president and CEO of the BC Cancer Agency says, **“Cancer isn’t under control, and the power of treatment to profoundly modify cancer mortality is relatively weak.”**

Cancer isn’t under control because more people are living longer and cancer is an illness of old age. But it is speculated that as many as 50% of all cancers could be prevented through changes in lifestyle.

**How realistic is that when the number of combustion engines, probably the greatest source of carcinogens released into the air, increase every year?** Theoretically, the prevention of many cancers would lessen the need for ever greater resources.

**How to get people at-risk of cancer into screening programs?**

**Communication is the key to alerting people about the benefits of being screened** particularly when, as is the case with colorectal cancer screening, the test is seen as disagreeably even dangerously intrusive when it is given ineptly. While there are nationwide screening programs for breast and cervical cancer, Canada lags behind the US where the promotion of screening has greater priority. This may explain why the US case-fatality ratios are better (see the NAACR figures in this issue).

Dr. Tony Fields, vice-president of medical affairs and community oncology at the Alberta Cancer Board puts the US success in screening down to their aggressive marketing of screening in the private sector. In contrast, Canada is aiming at universal penetration of the population and doesn’t have the funding to do it. “I suspect you’d find the US screening rates are excellent among the well-to-do but dismal among the poor,” he speculates.

In the US for example, the blood test for prostate cancer is widely used yet several provinces in Canada do not cover the cost of this test with public funding. There are as well other problems: **in Ontario, privacy laws prevent Cancer Care Ontario from identifying women over the age of 50 as targets for direct mail or telephone campaigns about mammography.**

**Radiation Therapy.** There is no end in sight for the growing need in radiation therapy. Dr. Sutcliffe says that for any foreseeable future, radiation therapy will be the first option. **“Currently radiation therapy equipment has a lifespan of about 10 years and because it is so capital-intensive, it would be very attractive to everyone to think that you would not have to replace the equipment because new therapies will render the equipment obsolete.”**

But he says this is shortsighted: chemotherapy treatments are not as effective as radiation therapy, and such advances as genomics and targeted therapies are still a way off.

**Access to drug therapies.** Two years is the average length of time it takes for a new drug to be approved by Health Canada. For example, a new colorectal cancer drug is being developed and the US is expected to approve it by the spring of 2002, but Canadians are unlikely to get it until 2004.

Most provinces state they have no objection to the system, perhaps because it gives them time to consider how new drugs may be covered and controlled. To this end, there is a proposal to set up a federal/provincial committee to examine the cost benefits of new drugs after they have been approved by the Therapeutic Products Directorate.

CCO has something similar. "Ontario has particular guides that speak to what's the best treatment based on the evidence," says Dr. Bill Evans, CCO's executive vice-president. He criticizes the U.S. aggressiveness that causes doctors to adopt the latest thing even if the evidence isn't compelling.

This is a controversial policy and likely to become more so as drugs become even more expensive. A recently approved cancer drug will have a cost of around \$35,000 per year per person, says Dr. O'Reilly of the BC Cancer Agency. **"We may soon be in a position where provinces can't afford to pay for them and we will have to make some very tough decisions about what drug or treatments to drop off the list."**

The idea of rationing drugs or basing their prescription on outcomes frightens patients and their advocates. Quality of life and the maintenance of hope are what drugs offer. **Anecdotes abound about terminal patients in their sixties who are being denied life-enhancing drugs because they are not expected to live long.**

Carol Loughrey, co-founder of the New Brunswick Breast Cancer Network, says, **"We pay taxes all our lives to ensure that cancer care will be there when we need it. Otherwise how do you justify our higher tax rates?"**

Ms. Loughrey went to bat for a patient who was denied Herceptin, a drug for metastatic breast cancer, at a Fredericton hospital. "Herceptin is a very expensive drug," says Ms. Loughrey, "It improves your quality of life substantially, but on average only increases your life expectancy by six months." After the patient received Herceptin she took a longed-for trip to New Orleans. "It made quite a difference to her dying, to have that drug," says Ms. Loughrey. "And if she hadn't fought for it, I'm not sure she would have got it. **If you're dying of breast cancer, you don't want to have to fight."**

**Becoming informed through the Internet.** Currently, a small but growing percentage of cancer patients are going on line to check out their treatment with medical websites worldwide. The web can be a patient's best friend as long as the patient is aware that there is a lot of misinformation on the web. Authentic websites offer fast, convenient access to clinical trial information and international cancer centers, as well as on-line support from other survivors. They can also provide a basis for challenging a treatment recommendation, or for asking one's health care providers the right questions.

### **Re-organizing Cancer Care in Ontario - For Whose Benefit?**

By Laura Eggertson  
Senior writer for Cancer Care in Canada

**When Joe Witalis was diagnosed with an aggressive form of bone marrow cancer in 1993, there was little about his life that felt secure. Within a week of his diagnosis, Witalis's marriage had broken up. His daughter moved in with his wife, and his son left for university. The 46-year-old supervisor at a treatment centre for adolescents felt alone and afraid.**

But throughout Witalis's original battle with cancer, and a subsequent recurrence, there was one thing he could count on. He says it was the stability of Ontario's cancer care system, Cancer Care Ontario. "I didn't have to worry from one day to the next whether something was going to be available or accessible or not," says Witalis, now a member of the southeast Ontario regional council for CCO. "I had a feeling (that) there was this very permanent presence of cancer services."

That sense of permanency was taken away in May of this year when the Ontario government decided to challenge the way cancer care is delivered in the province. Health Minister Tony Clement announced that CCO's budget would be frozen and its operations taken over by the nine regional cancer centres under CCO's umbrella. Cancer services would now be focussed where the patients receive their care.

#### **Angry reaction to announcement**

The first reaction was that it was all about money. "Many of the cancer treatment centres are way over-budget," said Diane Finkle, senior advisor to the Canadian Cancer Society's Ontario division. From a politician's point of view," she said, "**This is a streamlining exercise to help contain costs.**"

Others thought that perhaps CCO had been too successful in turning the spotlight on such problems as long waiting lists for treatment and the lack of radiation therapists.

CCO had a budget of \$250 million dedicated to cancer at a time when health budgets in general were under pressure. Then, too, CCO also had incurred controversy; there were managerial problems. Witalis himself became one of the sharpest critics of its operations.

Still, the idea of having a single agency dedicated to cancer, like British Columbia, Manitoba, Nova Scotia, and Saskatchewan, was an important boost to the community of cancer patients and their advocates. Ontario, as the largest province, could be a trendsetter in focussing attention on the diseases that make up the cancer challenge. **The transfer of cancer care away from skilled dedicated cancer centers to community hospitals in Ontario might be a major defeat, one of national importance.**

## **Why Cancer Care Ontario?**

**When CCO was established four years ago, it stood out like a beacon among the patchwork of services in the province.** For the first time it was recognized that cancer was THE health problem of Ontario. The impact of cancer is felt everywhere in Ontario, because more than 50,000 Ontarians are diagnosed each year, 25,000 die from it each year, and hundreds of thousands in Ontario are alive after having had a diagnosis of cancer. As the population ages, the current annual increase in **cancer of 3% will rise further. In contrast, other diseases like heart disease are declining.**

The new cancer agency was to replace a patchwork of existing services, to provide order where there was chaos. The mandate was ambitious. CCO was to link and integrate cancer services throughout the province, set priorities, standards and guidelines for treatment in the regional cancer centres. In human terms, it was to help patients through what often seems like a maze of a system, during one of the most stressful periods of their lives.

**CCO would also reach out, in a crucial step, to those who lived far from the most advanced treatment hospitals and to those who were most likely to fall through the net. Dr. Bill Evans, CCO's executive vice-president, emphasizes that one of the inherent problems of cancer is the disparity of care depending on where patients live. To this end, he had begun to develop practice guidelines and treatment standards so a farmer on Lake Superior would get precisely the same treatment as a patient in downtown Toronto.**

## **CCO's Problems**

One of the most fearful aspects of cancer in the province has been waiting times for radiation treatment. This problem goes back at least two decades, and has been most acute in the past two years. It has aroused a storm of controversy. **"The real issue that they've been dealing with is very political,"** says Dr. Andy Padmos, who left CCO in 1998 to become the commissioner of Cancer Care Nova Scotia. He contrasts the management accorded a cancer patient from Toronto who was sent, expenses paid, to Cleveland for radiation treatment, with a similar patient in North Bay, who was reimbursed ten cents a kilometre for travel to the nearest cancer centre.

There are many causes of waiting times. For example, the number of radiation therapists swung widely during the last decade. In the early 1990's, Ontario was graduating too many radiation therapists. Now, there's a shortage. CCO is trying to tackle this through a recruitment program.

The waits for radiation are just one of the many issues facing CCO. Nobody thinks the tasks are easy. However, CCO, which is also a clearinghouse for information and statistics, has recorded some gains. As of last May, for example, patients no longer had to be sent to the U.S. for radiation therapy. On the other hand, as the Cancer Advocacy of Canada Coalition's **Report 2001** shows, **40% of Ontarians in the last year waited more than eight weeks from referral to the start of radiation therapy.** One-step forward, then one step back.

Perhaps there were too many loose ends between 1997 and 2001. Michael Decter, a former deputy Health Minister in Ontario, and now a health care consultant, faults CCO for lack of strong leadership necessary to forge guidelines, which would make the system viable. Despite Dr. Evans' pioneering work, Mr. Decter says, "What worries me is the enormous variation in practice once you get outside (Toronto), into the breadth of Ontario. What you see is an absence of protocols. There are protocols for radiation, but not in the same way for integrated cancer care." At the same time, eliminating the agency or scaling it back considerably would create further gaps. " **There are legitimate fears that if you lose the focus (that CCO has) and you lose the monitoring aspect, then things could get worse.**"

### **The Politics of Cancer Care Ontario**

Overlaying everything are the politics. The Conservatives put into effect a plan developed under the NDP. The new CCO never fit into their reorganization and rationalization of the health system. In a recent interview, Mr. Clement said, "It's been on the board for a number of years to look at the best way to integrate cancer services in the province. We felt it was appropriate at this time to kick-start the process."

The announcement that CCO would be reassessed sparked anger from Graham Scott, who is temporarily in charge of the CCO. Mr. Scott had helped develop the plans for CCO. He warned of "real costs, significant disruptions and genuine setbacks" that would be caused by giving locally oriented hospitals control over the delivery of cancer treatment. The Cancer Advocacy Coalition of Canada called the minister's decision "a giant step backward".

The NDP's Bob Rae was Premier when CCO plans were developed. He has had personal experience with cancer when he lost his brother to leukemia. In an interview with the Cancer Advocacy Coalition of Canada, Mr. Rae said he feared that the CCO's work with patients and their families would be lost "if we simply go back to pure and simple regional and local control again." Without an overarching and transparent plan, Mr. Rae says, it will be difficult to judge how the province is doing at providing the care needed, and to deal with the fact that some hospitals and regions are busier than others. "We're already finding that many hospitals are bailing out of leukemia care because it's expensive, so other hospitals are becoming overloaded," he says.

If CCO's regional operations are integrated more fully into host hospitals, would the province's dedicated cancer funds be swallowed up in general hospital budgets? If so, and moneys are then diverted around, in and out of cancer programs, what would that mean to the standards set out by CCO? Dr. Evans says, "There is a risk of the variance of practice and quality of care widening, rather than narrowing, as it is currently."

## The Hudson Committee

The Ontario minister announced the formation of the Cancer Services Integration Committee to study the current system and suggest modifications or alternatives. The committee is headed by neurosurgeon Alan Hudson. This strengthened fears among some CCO advocates, because Hudson had previously integrated three of Toronto's biggest hospitals into the University Health Network.

Dr. Hudson's report is expected in December 2001.

Mr. Rae views the province's overall challenge to CCO, and Hudson's appointment, as an attempt by hospitals to reassert their control and solidify their power base in the health care system. Nova Scotia's Dr. Padmos says hospital CEOs have always been interested in having cancer care programs integrated into their facilities. **"The difficulty with rolling the funding for cancer care into hospitals is the CEOs might double the investment in cancer because they thought it was a good idea compared to other health issues. Or they might not,"** says Dr. Padmos.

Mr. Clement acknowledged that while he had a bias toward integrating services and providing links between hospitals and cancer centres, the committee's conclusion had not been predetermined. Dr. Hudson has said, "If it was predetermined then there's no need for having any committee." He has also denied suggestions that the committee has cost cutting as its primary aim. "We're not trying to see specifically how much money we can save."

### Who's Accountable?

Will the funding be protected and accounted for in any new proposed system? "Cancer" says Mr. Decter, "has some distinct differences vis-a-vis other diseases, and I do think you have to envelope resources for cancer care and protect them."

When Dr. Hudson presided over the integration of Princess Margaret Hospital, Toronto Hospital and Toronto Western Hospital into the University Health Network, he says he ensured that cancer care, as a percentage of the network's entire budget, would never drop. Now he says his committee will likely suggest the same form of legal guarantees for cancer care in Ontario, as well as some form of volume funding.

**"We would probably look to some sort of volume-finance relationship in cancer," he says, whereby hospitals and the government would agree each year on the number of cancer care cases they would take on. "If waiting lists get too long, the financing for care would be increased, just as it is now for cardiac surgery."**

Dr. Hudson also dismisses fears that his committee will recommend a system that brings about less accountability for outcomes and timely treatment. "One of the biggest things we think is missing (with the current system) is accountability." Underlining the fact that CCO had no control over what went on in hospitals, he says, "You can't hold Cancer Care Ontario accountable for surgical (oncology) waiting lists when they don't run the budgets for the operating rooms and the hospitals. For certain, the plan will significantly increase accountability."

## What are the options now?

Mr. Clement says he has directed Dr. Hudson to look at other provinces and other countries for governance models. There are two examples that show how provinces treat cancer differently: Quebec and British Columbia.

Quebec, with a population of 7 million, has absorbed cancer care into its regional hospitals because it believes that way the needs of cancer patients have a greater influence on provincial decision-making. However, mortality rates in Quebec for major cancer sites indicate that Quebec does not fare as well as other provinces or neighboring states.

On the other hand, British Columbia, with a population of 4 million, has the BC Cancer Agency, and mortality rates there are significantly better than other provinces. It was established in 1935 and has a top-to-bottom cancer care system that is driven by centralized strategy and policy, but delivered locally. Admirers of the BC system point to its comprehensive services and patient-friendliness. Nova Scotia's Padmos doesn't think that approach is gospel, but he thinks, "it may well be a harbinger of what we're aiming for." Guidelines are laid down for every stage of BC's cancer care. No patient, for example, should wait more than two weeks for radiation at any of the four centers in the province.

CCO has its own recommendations for Dr. Hudson. Dr. Evans is urging the committee to adopt the agency's recommendation to create regional "diagnostic cancer recognition centers" that would assess and diagnose the four most common cancers: breast, colon, lung and prostate. "They would ensure patients receive the right treatment in the right sequence, the right way and would concentrate expertise," says Dr. Evans. "It would certainly be easier to track the timelines because there would be a common portal of entry."

Dr. Glenn Jones is a radiation oncologist in Ontario. He is a board member of The Cancer Advocacy Coalition of Canada. **"We should really be open-minded at looking at various options. The model that we've got now does some things well, and other things not so well."** Presently, there is good quality treatment for an increasing number of patients, he says. "That's great, and it is a testimony to CCO and other stakeholders. But we have to do better," he says. "For example, we need longer-range planning and appropriate resource funding to correct the chronic shortages of equipment, radiation therapists and radiation oncologists. We also need to look at prevention and complementary methods in addition to the more conventional treatment side of the equation."

There are now coming onstream an increasing number of advances in detection, testing, therapies and drugs, all of them expensive. **In any health system, but particularly a government-financed one like Canada's, the problem of providing universal access to costly innovations is becoming a major ethical issue.**

Only a strong centralized agency can decide what groups of patients to manage if resources are scarce, says Dr. Jones. "So, potentially, part of the ethical dimension would be lost if we decentralized."

It is questions like these that have not yet been openly debated. **“Answers to such questions help define who we are, and what our relationships are to one another,” Dr. Jones says.**

While the province’s move to re-organize may not have been well thought-out, Mr. Decter says, he thinks it may be a necessary correction. **“In re-thinking it, maybe we’ll get to something that’s better, either the status quo or what was proposed.”** I don’t think that there’s an organizational answer. I think the answer is a performance answer. The bottom line for any cancer care system is to ensure better outcomes and shorter waits for treatment.”

## **A View from BC**

**Dr. Simon Sutcliffe is the president and CEO of the BC Cancer Agency, which sets the policy for cancer control in British Columbia. Because this agency is sometimes held up as a model for its comprehensive handling of cancer control, Cancer Care in Canada asked Dr. Sutcliffe for his comments on the Ontario situation. Before moving to British Columbia, Dr. Sutcliffe was President and CEO of the Ontario Cancer Institute/Princess Margaret Hospital in Toronto.**

## **CANCER CONTROL IN ONTARIO**

**“Cancer control aims to prevent cancer, cure cancer, and to increase survival and quality of life for those who develop cancer by converting the knowledge gained through research, surveillance or outcome evaluation into strategies and actions.” (Definition from National Cancer Institute of Canada.)**

To an “outsider” the issue in Ontario appears to be the relative merit of providing cancer services through a "centralised" (provincial) or "regionalised" implementation model. In reality, it will not be exclusively one model or the other. Getting the right mix or solution will be a consequence of asking the right question. That can only happen when the following premises are accepted:

- **That Cancer is not under control in any jurisdiction. Indeed, it becomes a cumulatively greater problem with each passing year.**
- **That maintaining or better managing the status quo will not result in improved outcomes.**
- **That new knowledge and its effective clinical application are the highest priorities in order to achieve improved outcomes.**
- **That the greatest opportunities for improved outcomes lie in the areas of population and preventive oncology (for the "well population") rather than in treatment and/or support services (for the "ill" population). This is because of the long natural history of the biological process that leads to adult cancers.**

- **That the provision of standard care according to recognised measures of effectiveness can occur most appropriately within the community of the patient and family.**
- **That partnerships are required between a multiplicity of care providers across the public health, acute and chronic care, and community sectors. These partnerships provide services appropriate to the well, the acutely ill, the cured, the chronically ill, and the dying.**

**Only after these premises have been taken strongly to heart, with both intelligence and passion, can certain principles or characteristics of a correct solution become apparent.**

In particular, a population-based strategic response for cancer control is required for a problem that is not under control. It must be directed towards both the healthy and the ill. Canada has articulated a national Strategy for Cancer Control. Logically, this would be implemented through a provincial structure--a centralized "leadership" that can effect strategy at a population level.

**What could a centralized "leadership" provide for Ontario? It should:**

- Create an effective interface for consumers, providers, and provincial payers of cancer control;
- Establish a system capacity for cancer control services through a provincial planning capability that uses information about present and projected incidence, mortality and service processes;
- Establish an appropriate balance of activities across the cancer control program that addresses the needs of the healthy at risk, the ill, and the dying;
- Define standards for care process and performance;
- Maintain equitable and timely access to treatment and care services across a provincial system through planned expansion in capacity, or through a re-balancing of referral and resources across the integral components of the provincial system;
- Maintain information and communication systems across all environments of the patient's clinical trajectory;
- Establish professional development and support services regarding workload standards, remuneration, and educational and professional activities.

Increasingly, care of patients with cancer will move to a community setting. Decentralization of care and services will place these within the same settings and relationships that all other aspects of regional and community health services occur. This is entirely appropriate, with a caveat that such services should be consistent, at standards determined within a provincial cancer control program.

The treatment and care of a patient with cancer is encompassed by a paradigm of "patient-focused" medicine within prevailing standards of professional practice that are independent of geography or funding source.

Meanwhile, reducing the incidence and mortality from all cancers is a result of measures that influence the health of the population as a whole. Therefore, to improve the outcomes of cancer control requires both a patient-focused and population-based approach.

Ontario's issues are optimal governance, management, affordability and sustainability of the cancer system. These are no different from any other jurisdiction. The solution in Ontario will derive from any clarity of what is to be achieved. This will lead to either a strategic, provincial population-based cancer control system, or management of cancer treatment services within a regional health care administrative model.

### **The US-Canadian Comparison - *MORE STATISTICS***

These statistics were selected from the (NAACCR) publication, Cancer in North America 1991-95\* which were released for the first time in our Report Card 2000. They showed that more Canadians were dying from cancer than Americans.

Originally, the figures were given in incidence/mortality ratios. Incidence rates measure the probability that healthy people will develop the disease during a specified time, i.e., the number of new cases of a disease diagnosed in a population over a certain time period. The mortality rate is the number of deaths from a disease over the population at risk of acquiring the disease.

Now we have interpreted the figures in case/fatality ratios, which provide a more accurate picture. **The case-fatality ratio is the number of deaths from a disease divided by the number of cases of that disease; in this case, the case/fatality ratio is a calculation of mortality/incidence per 100,000 population.**

We acknowledge that these figures are not truly definitive: not only is reporting different region to region but the figures have not been broken down according to age. Still, until the US and Canada report cancer statistics in the same way, we think these figures are a significant indicator in themselves; they may point to the fact that the US does more screening than Canada and thus there is more reporting of the disease at an early and treatable stage. If so, that underlines an area in Canada that needs more attention.

**Case/fatality ratios for select American states and Canadian provinces. The following presents Canadian provinces' ranking out of 62 for all cancer sites for women.**

<b>PROVINCE</b>	<b>RANK (out of 62)</b>	<b>case/fatality ratio</b>
Saskatchewan	29	0.389
British Columbia	33	0.392
PEI	36	0.396
Manitoba	37	0.399
Alberta	38	0.400
Ontario	41	0.404
New Brunswick	48	0.421
Quebec	52	0.432
Nova Scotia	53	0.434
Newfoundland	55	0.451
Yukon	61	0.524
NWT	62	0.524

**Breast Cancer - Women**

	<b>Mortality rate</b>	<b>Incidence rate</b>	<b>Case/fatality ratio</b>	<b>Rank out of 62</b>
Hawaii	13.7	89.1	0.15376	1
<b>NWT</b>	<b>10</b>	<b>54.8</b>	<b>0.18248</b>	<b>2</b>
Alaska	17.5	93.5	0.18717	3
Oregon	18.9	99.8	0.18938	5
Washington	19.1	98.5	0.19391	8
Connecticut	20.6	101.1	0.20376	9
Utah	16.3	79.3	0.20555	11
California	19.6	92.6	0.21166	18
New Hampshire	21.6	97	0.22268	28
Michigan	20.6	92.4	0.22294	29
<b>BC</b>	<b>18.3</b>	<b>81.4</b>	<b>0.22482</b>	<b>31</b>
New Jersey	22.5	97.6	0.23053	35
<b>SASKATCHEWAN</b>	<b>18.4</b>	<b>79.4</b>	<b>0.23174</b>	<b>37</b>
<b>YUKON</b>	<b>17.4</b>	<b>74</b>	<b>0.23514</b>	<b>38</b>
Kentucky	19.9	84.1	0.23662	39
<b>PEI</b>	<b>19.4</b>	<b>79</b>	<b>0.24557</b>	<b>47</b>
<b>MANITOBA</b>	<b>21.7</b>	<b>86.6</b>	<b>0.25058</b>	<b>48</b>
New York	22.2	86.7	0.25606	50
Louisiana	21.5	82.4	0.26092	52
<b>NB</b>	<b>20.9</b>	<b>79.9</b>	<b>0.26158</b>	<b>53</b>
<b>ALBERTA</b>	<b>21.2</b>	<b>80.8</b>	<b>0.26238</b>	<b>54</b>
<b>NOVA SCOTIA</b>	<b>22.4</b>	<b>83.9</b>	<b>0.26698</b>	<b>58</b>
<b>ONTARIO</b>	<b>21.8</b>	<b>78.4</b>	<b>0.27806</b>	<b>60</b>
<b>QUEBEC</b>	<b>21.9</b>	<b>76.5</b>	<b>0.28627</b>	<b>61</b>
<b>NWFLD</b>	<b>20.7</b>	<b>69.7</b>	<b>0.29699</b>	<b>62</b>

\* The case-fatality ratio is the number of deaths from a disease divided by the number of cases of that disease; in this case, the case/fatality ratio is a calculation of mortality/incidence per 100,000 population.

## Colorectal Cancer - Women

	<u>Mortality rate</u>	<u>Incidence rate</u>	<u>Case/fatality ratio</u>	<u>Rank out of 62</u>
Hawaii	8.2	27.4		1
Connecticut	10	30.8	0.325	4
<b>PEI</b>	<b>14</b>	<b>39.4</b>	<b>0.355</b>	<b>8</b>
Washington	9.5	26.7	0.356	10
California	9.3	25.8	0.36	12
Michigan	10.4	28.5	0.365	16
New Jersey	12	32.6	0.368	19
Utah	7.9	21	0.376	24
Alaska	10.8	28.3	0.382	30
Louisiana	11.3	29.6	0.382	32
<b>SASK</b>	<b>10.2</b>	<b>26.5</b>	<b>0.385</b>	<b>36</b>
Oregon	9.5	24.6	0.386	37
New York	11.5	29.6	0.389	38
Kentucky	11.7	29.9	0.391	39
<b>MANITOBA</b>	<b>11.9</b>	<b>29.3</b>	<b>0.406</b>	<b>43</b>
New Hampshire	12.6	30.8	0.409	44
<b>BC</b>	<b>10.6</b>	<b>25.8</b>	<b>0.411</b>	<b>45</b>
<b>ALBERTA</b>	<b>10.1</b>	<b>24.2</b>	<b>0.417</b>	<b>50</b>
<b>ONTARIO</b>	<b>12.4</b>	<b>28.9</b>	<b>0.429</b>	<b>51</b>
<b>NB</b>	<b>13.6</b>	<b>30</b>	<b>0.453</b>	<b>55</b>
<b>QUEBEC</b>	<b>14.2</b>	<b>30.5</b>	<b>0.466</b>	<b>56</b>
<b>NOVA SCOTIA</b>	<b>15.8</b>	<b>32.9</b>	<b>0.48</b>	<b>58</b>
<b>NWFLD</b>	<b>17.2</b>	<b>35.5</b>	<b>0.485</b>	<b>60</b>
<b>NWT</b>	<b>23.9</b>	<b>44.8</b>	<b>0.533</b>	<b>61</b>
<b>YUKON</b>	<b>12.1</b>	<b>9.6</b>	<b>1.26</b>	<b>62</b>

\*

## Prostate Cancer- Men

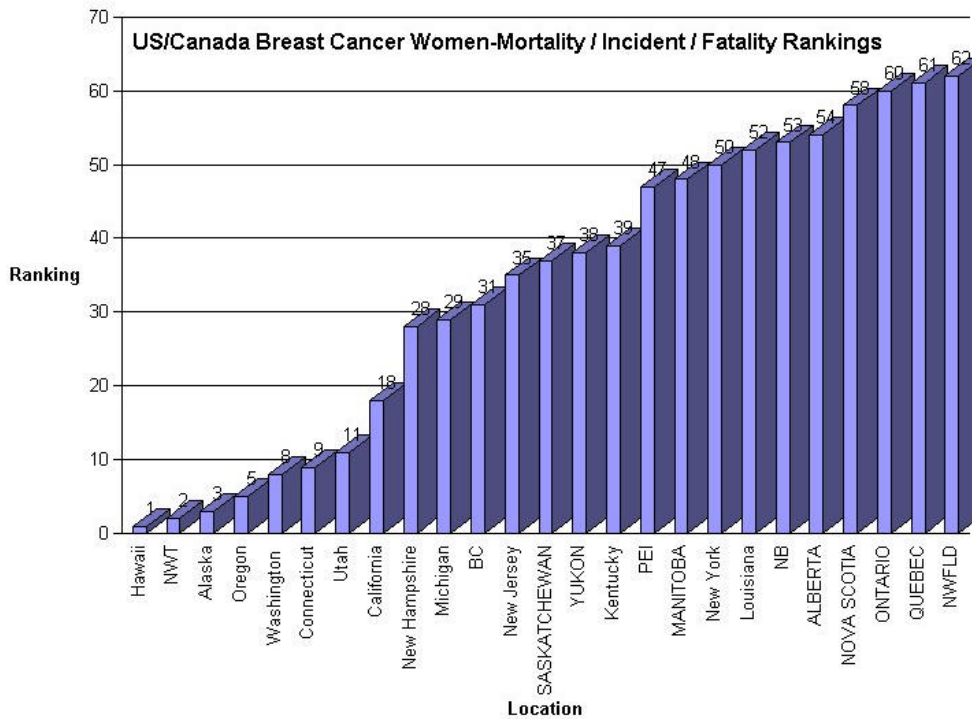
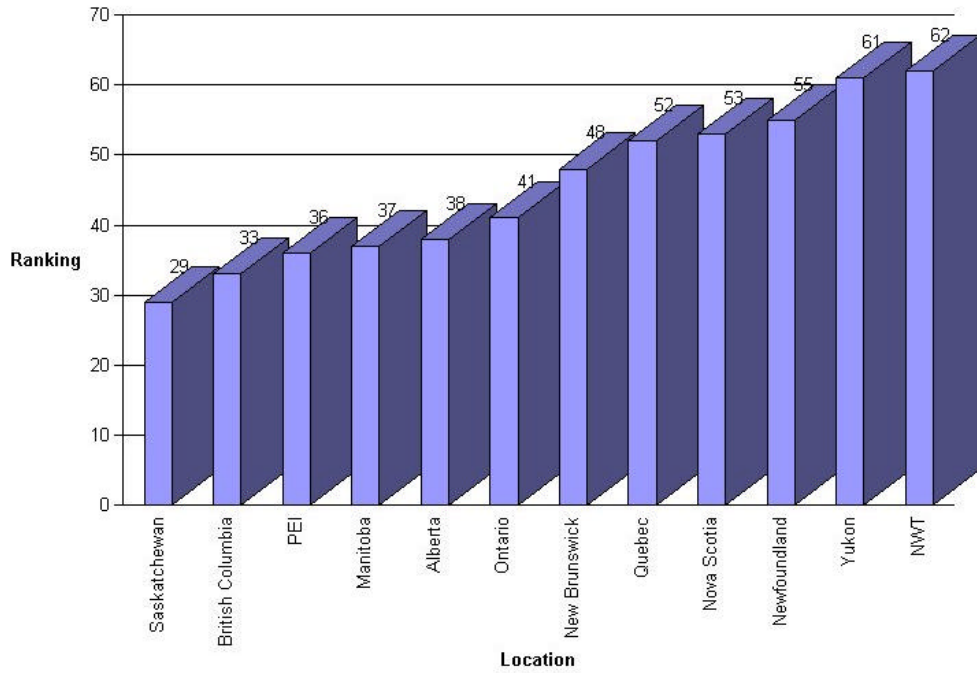
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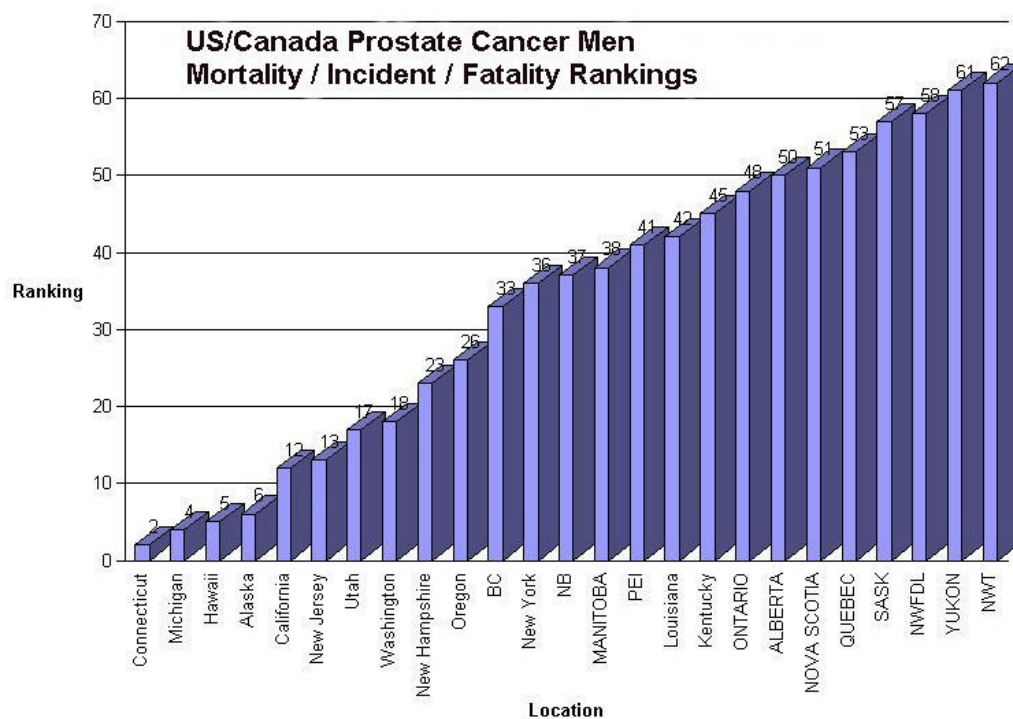
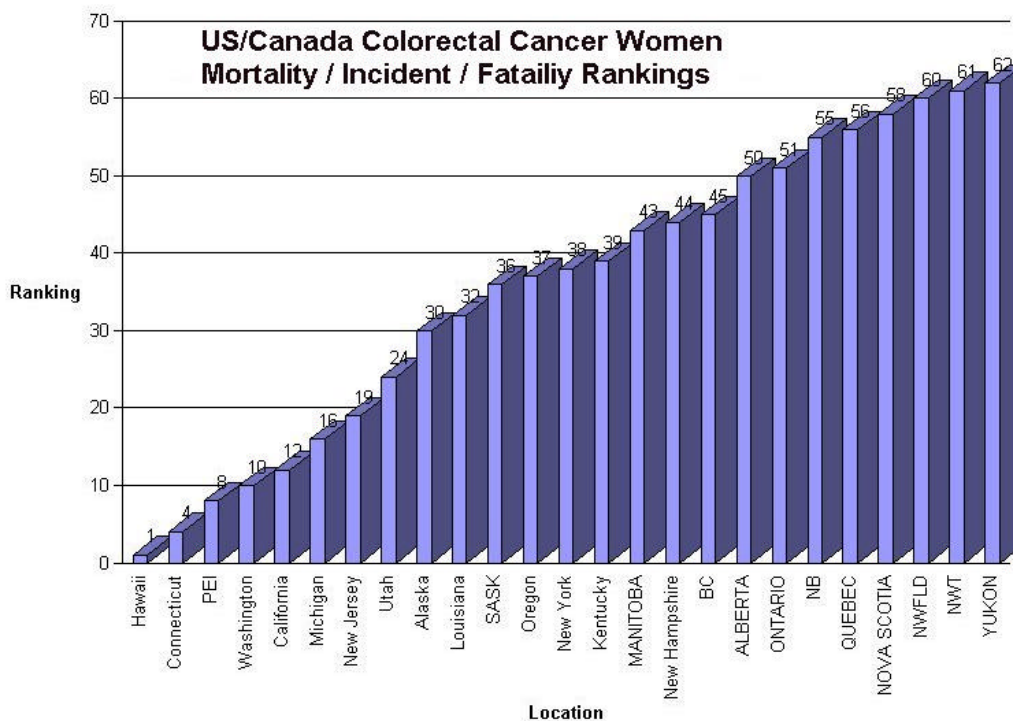
	<u>Mortality rate</u>	<u>Incidence rate</u>	<u>Case/fatality ratio</u>	<u>Rank in 62</u>
Connecticut	14.1	110.8	0.12726	2
Michigan	16.4	124.8	0.13141	4
Hawaii	10.1	76.7	0.13168	5
Alaska	11.6	86.2	0.13457	6
California	14.4	104	0.13846	12
New Jersey	16.5	119.1	0.13854	13
Utah	16.5	115.8	0.14249	17
Washington	14.6	102.1	0.143	18
New Hampshire	15.3	101.8	0.15029	23
Oregon	15.9	103.2	0.15407	26
<b>BC</b>	<b>15.2</b>	<b>92.2</b>	<b>0.16486</b>	<b>33</b>
New York	15.7	93.7	0.16756	36
<b>NB</b>	<b>16.4</b>	<b>97.7</b>	<b>0.16786</b>	<b>37</b>
<b>MANITOBA</b>	<b>16.6</b>	<b>97</b>	<b>0.17113</b>	<b>38</b>
<b>PEI</b>	<b>19.2</b>	<b>108.5</b>	<b>0.17696</b>	<b>41</b>
Louisiana	19.4	109.6	0.17701	42
Kentucky	16.3	84.9	0.19199	45
<b>ONTARIO</b>	<b>16</b>	<b>79.5</b>	<b>0.20101</b>	<b>48</b>
<b>ALBERTA</b>	<b>17.5</b>	<b>84.6</b>	<b>0.20686</b>	<b>50</b>
<b>NOVA SCOTIA</b>	<b>18</b>	<b>85.1</b>	<b>0.21152</b>	<b>51</b>
<b>QUEBEC</b>	<b>15.8</b>	<b>73.6</b>	<b>0.21467</b>	<b>53</b>
<b>SASK</b>	<b>19.6</b>	<b>83</b>	<b>0.23614</b>	<b>57</b>
<b>NWFDL</b>	<b>15.2</b>	<b>58.3</b>	<b>0.26072</b>	<b>58</b>
<b>YUKON</b>	<b>27.9</b>	<b>61.4</b>	<b>0.4544</b>	<b>61</b>
<b>NWT</b>	<b>13.6</b>	<b>24.2</b>	<b>0.56198</b>	<b>62</b>

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**Cancer US/Canada Case Fatality Ranking Ratios for Women in Canada 1-62 Rankings by State or Province**





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**CANCER CARE IN CANADA**  
**Winter 2001 Number 3**

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