terwards; still others not at all), as well as the precise start and end points used to track the delay (i.e. Does the wait start at the moment of referral, of first appointment or of specialist consultation?).

Very few provinces can state the average waits between diagnosis and surgery, though many acknowledge regional variations within their provinces due to factors such as reduced operating room availability and shortages of operation room nurses.

Nova Scotia cancer officials report being satisfied with their ability to see patients within a reasonable time frame at the moment. "We generally work on the rule that patients should be seen in consultation by an oncologist less than three weeks from the time the referral request is received," says Dr. Andrew Padmos, Commissioner of Cancer Care Nova Scotia and Chair of the Human Resources Planning Working Group for the Canadian Strategy for Cancer Control. Detailed waiting time information remains unavailable because, while the Cancer Registry does record dates of first radiation treatment, it does not presently record the date of surgery or first chemotherapy. "That would require a retrospective audit of patient charts and has not been done across the board," says Dr. Padmos. "Calculation of waiting times is notoriously difficult."

The Canadian Association of Radiation Oncologists guidelines state that, for maximum benefit, radiation should begin no more than four weeks after a patients is referred (two weeks from referral to consultation with a radiation oncologist; two weeks from consultation to first treatment). These guidelines appear to be accepted in principle by most provinces, but few are consistently able to meet these time frames. British Columbia's 1998 Report Card finds that at any given time in 1998, between 32% and 62% of cancer patients were receiving radiation therapy within two weeks of consultation. Cancer Care Ontario officials report that in June 2000, 40% of Ontario cancer patients requiring radiation therapy received treatment within four weeks of referral. This is an improvement over 1999, when only 30% of patients received radiation within four weeks. In Alberta, the wait for radiation is an average 3.5 weeks from referral for most tumour groups, but extends from four to 11 weeks for some groups. Ontario and British Columbia attribute part of the excess wait to shortages of radiation professionals in the face of increases in both the number of cancer patients and the use of radiation therapy.

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

Despite vocal concerns that the costs of treating cancer are going through the roof, matched by equally vocal concerns that spending is insufficient, the provinces do not know exactly how much is spent on all facets of care. Those with central cancer agencies tend to have more centralized budgets and a clearer picture of spending. However, even there, the costs of cancer surgery are not included and neither are the screening, research and other initiatives of organizations like community health departments and the Canadian Cancer Society.

INFORMATION A PREREQUISITE FOR ACTION AT ALL LEVELS **Michael Decter, Chair of the Canadian Institute for Health Information (CIHI), is committed to pushing Canadian health information to a whole new level**

"An informed public is the best guarantee of sensible health policies and quality health care services. Yet to be informed, the public requires much more health information than we have historically provided in this country. This deficiency is now being addressed as governments work with CIHI to improve information gathering and dissemination, and as Statistics Canada develops new data sets and linkages between health databases. This work will, among many other things, provide a much clearer view of cancer survival than is available at this time.

Accountability for and comparisons of health system performance will only be possible once every province is collecting the same data and using the same definitions. To provide a complete picture, we also need to broaden our reach in gathering information from the traditional hospital setting to other settings such as home and community care. This challenge is now being addressed, as is the need for solid data on drug interventions that can complement data available on hospital and physician interventions.

Over the next few years, Canadians can expect steady improvements in the quality and quantity of health information, allowing sound and comprehensive report cards to be produced on all aspects of our health care system."

***Michael Decter** previously served as Deputy Minister of Health for Ontario and is the author of two books on health care: Healing Medicare (1994) and Four Strong Winds: The Growing Challenges to Health Care (2000).*

PART 3

Short Staffed

Why do we lack cancer care professionals? How do we get them back?

We are seeing "regular, repetitive, and serious deficiencies in the cancer workforce," warned Dr. Andrew Padmos, head of the QEII Health Sciences Centre Cancer Program in Nova Scotia, in a June 2000 interview with the Globe and Mail. And when cancer care professionals are in short supply, patients wait too long for treatment, screening programs stagnate, existing staff burn out and the quality of care inevitably suffers.

In a survey conducted by Cancer Care Ontario of medical oncology staff, all of the professionals from administrative staff to nurses and doctors surveyed felt that cancer patient care in Ontario is suffering and that there is a lack of time or resources to treat patients. Study respondents reported frustration and embarrassment at the deterioration in care, seen in long waiting times, the inability to obtain test results, and the inability to offer effective new treatments.

Why are there shortages?

The main limitation to care right now is not money, but the availability of trained personnel in radiation therapy, radiation physics, and radiation and medical oncology, says Dr. Bernard Cummings, Chief of Staff in Oncology at Princess Margaret Hospital in Toronto. "Equipment is secondary at the moment. As long as we have the staff, we can run our machines longer hours."

Anticipating staff needs ahead of time is essential, according to Dr. Cummings. "A considerable amount of time will pass from when you recognize the shortage, to when you get the resources, to when the trained people are available," he says. "In the meantime, existing staff is under tremendous pressure, their working conditions deteriorate, and they may choose to go elsewhere.

Shortages are becoming apparent in virtually all areas of cancer care, from radiology to oncology (Ontario retains only 33% of it's oncology graduates) to medical physics. Rick Boyd, VP of Human Resources at the Alberta Cancer Board, states that even where shortages are not posing an immediate problem, they can be expected in the near future. Demand for cancer care services in Alberta is increasing by 7 to 8% annually, and most provinces have new cancer centres, or increased capacity at existing centres in their plans. Some of the worst shortages today are in

▶ WHY ARE THEY LEAVING?

Dr. Bill Hryniuk, a noted clinical oncologist, was Director of the Hamilton Regional Cancer Centre and VP of the Ontario Cancer and Research Foundation (now Cancer Care Ontario). Now he's looking for cancer cures... in Detroit. His story reveals much about why cancer specialists are finding Canada a less attractive place to work, and money doesn't even enter the picture. **READ IT ON THE CACC WEBSITE: www.canceradvocacycoalition.com**