

EDITORIAL

For years it has been known there is a west-east gradient in cancer mortality in Canada. In the last 10 issues of this Report Card we have documented the reasons for this gradient. Let us review the facts and factors that led to them, and consider what fixes might be needed.

The differences are almost perfectly correlated with the degree of provincial government funding for cancer control programs in each province. Cancer mortality is lowest in British Columbia and increases steadily as you go east. Coincidentally, the more money spent by each province, the lower the cancer mortality (Report Cards 2003, 2004).

Waiting times for treatment vary between and within provinces (Report Cards 2004, 2005), with delays reaching medically dangerous levels in some instances (Rayson, Report Card 2005). Repeated efforts to get pan-Canadian agreement on standard definitions of a waiting time have failed.

Public funding for cancer drugs is almost three-fold greater in the west and conversely, private expenditure is almost seven-fold greater in the Atlantic Provinces (Report Cards 2005- 2008). As revealed in this issue, the off-loading of drug costs from public insurance to private insurance is increasing, particularly for take home cancer drugs. If this trend continues at its current rate the private sector will be paying more than the public sector across the entire country.

Medical guidelines for drug treatment vary greatly between provinces despite the fact they are based on the same scientific information. Some provinces do not even publish guidelines, while others perennially state theirs are in development (Report Card 2004). As a result, the standard of care varies. In this issue we examine the fact that medically necessary insured services in one province can be deemed not medically necessary in another. Canadian courts have protected the right of provinces to make such decisions.

Deployment of modern technology varies: access to PET scanning, an important diagnostic technique, differs among provinces by a factor of five- to 30-fold (Report Card 2006). We suspect this variation also extends to other modern diagnostic technology, e.g., digital mammography.

Of particular importance in optimizing cancer care delivery is the availability of accurate and timely information through use of electronic health records connecting distant communities to their regional cancer centres. This too is highly variable. In only three of the eight provinces surveyed this year were acceptable standards met for linking the sampled communities, and in four provinces the sampled communities had no electronic linkage at all.

As for prevention, the record is not much better. Consider how the new vaccine against cervical cancer has been deployed: the province with historically the lowest incidence of cervical cancer has introduced the highest vaccination rate, while the province with the highest cervical cancer incidence has one of the lowest rates of vaccination (Report Card 2008). Deployment of screening mammography, proven more than 20 years ago to reduce breast cancer mortality, still varies greatly: the percentage of the target population screened can vary two-fold from one province to another. No province reaches the target 75 per cent level (Report Card 2006).

These discrepancies between provincial efforts at cancer control probably explain why cancer mortality is not dropping in Canada compared to other jurisdictions.

Why are western provinces capable of better cancer control? Or to rephrase: why do western provinces devote more effort (money) to cancer control? We think the answer is in large part because they have better organization, and have established a different set of priorities. We also wonder if they have had leaders with different skill sets than those in the eastern provinces.

Regarding the importance of organization one has only to look at cancer mortality in provinces that have historically lacked a provincial cancer agency: PEI, New Brunswick, and Quebec. Their cancer mortality has been consistently well above the Canadian average (Report Cards 2003, 2004). In contrast, provinces with the best results have been served by organized cancer agencies with a combination of central funding, cancer centres juxtaposed to academic centres, and well developed networks of community clinics. Unfortunately the recent trend has been to reduce or dismantle these organized cancer agencies in the interests of reorganizing to achieve higher (nebulous) health system goals. This has already occurred in four provinces, including two in the west. One can predict that cancer control in those provinces may either stop improving, or worse, will begin to deteriorate.

The adverse effects of competing priorities can be seen resulting from competing interests in provincial politics, different cancer delivery systems vying for resources within the same province, vagaries accompanying governance of large populations, or the desire to meet societal needs more fundamental than cancer control.

As for leadership, the issues are more complex. This could be investigated as a possible factor determining the effectiveness of cancer control in the various provinces. Particular attention would then have to be paid to the process of selection of cancer agency heads and cancer centre directors.

The matter is urgent. Cancer will be the number one cause of death within three years. What fixes are required to ensure that Canadians have an equal chance of surviving this disease?

Firstly, organization of cancer control should not be subjugated to a preponderance of bureaucratic or ill-conceived considerations. Governmental deconstruction of cancer agencies or their relegation to lesser status should not be allowed to continue.

Secondly, forceful and concerted advocacy is required to elevate cancer control to higher government priority. Existing cancer organizations must ramp up their advocacy efforts. Charitable organizations must not continue to let government surveillance of their budgets, limiting them to 10 per cent for advocacy, in effect completely prevent their advocacy efforts. The media has a critical role to play but they can only be as effective as the information they receive, and only then when deterioration has reached near-crisis proportions.

As we discuss on the back page of this issue of the Report Card, doctors should take up their societal responsibility. So far, medical oncologists have not collectively voiced their concern on behalf of their patients in an attempt to improve access to the new blockbuster drugs. Instead, they remain publicly silent, while privately admitting they are delivering suboptimal treatment.

What was the good news?

Provincial health ministers are attempting to constructively address the process of drug approval and funding. This is ongoing under the watchful eyes of advocacy groups.

Most importantly has been the creation of the Canadian Partnership Against Cancer (CPAC). CACC proposed and advocated strongly for the creation of a national cancer control body functioning at arm's length from other government health agencies. CPAC was a result of these initiatives. We look to CPAC to facilitate achievement of high standards for cancer control.

The bioresearch establishment continues to produce major technical advances. That's good. However, we are coming to the conclusion that the production rate of these new technologies and treatments has outstripped the capacity of the public system to absorb them; provincial health insurance systems can never completely cover the cost of new cancer drugs. Public and private insurance systems must therefore address the risk to the individual patient in a coordinated fashion rather than allowing continuation of the present disconnected mode. Quebec has required for some years that all individuals must have supplementary private drug insurance.

We have been advocating for a national forum to determine the means by which provincial disparities in access to treatment could be remedied, and have garnered the support of federal and provincial ministers and politicians for this idea. As a result, the Provincial and Territorial Health Ministers proposed that "Beginning in 2009, ministers will host a series of forums with governments, experts and stakeholders to advance collaborative work towards a sustainable health system that delivers excellent care at affordable cost." We will press this initiative.

In the end, it will be the Canadian public that must demand inter-provincial disparities be minimized and high standards of care be provided to all Canadians. In this issue of the Report Card we propose that cancer patients have complete access to their own health record in electronic form. They can then determine if they are getting the right treatment from the right health professional at the right time. If they find they are not, some will be motivated to take matters into their own hands and advocate for change.

James D. Gowing, Chair, CACC

William Hryniuk, past Chair