

# THEN AND NOW

## SOME PROGRESS, BUT ...

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CACC began its inter-provincial comparisons of key indicators more than a decade ago, with an early focus on screening programs, wait times and the allocation of prevention research dollars. Over time, other topics of interest were added, such as access to diagnostics (PET scans) and drugs and numerous fields in the organization of care, including the creation of rapid diagnosis centres, secondary prevention programs, cancer care in smaller communities and supportive care. Not every topic is covered in every Report Card, so it is time for an update on two of them: wait times and screening.

### WAIT TIMES

In 2003, a year before the Health Accord that motivated provinces to care about wait times, CACC reported on complete disarray in the ability or interest of provinces to capture such data, let alone report any of it.<sup>1</sup> Only five provinces were able to respond to the CACC data request and one year later only four could offer data.

CACC found no common definitions of what constitutes a wait, no commonality in the types of data elements being tracked by the provinces – if any – and widespread obfuscation. Not one province was meeting the two week wait limit for radiation therapy recommended by the Canadian Association of Radiation Oncologists, although BC had created its own standard (four weeks) and claimed to be meeting it, overall. Elsewhere, standards or targets for waits were said to be impossible.

Then the 2004 Health Accord kicked in and waiting times became a priority. The Canadian Institute for Health Information (CIHI) was the designated home for data. The Wait Time Alliance (WTA) was formed the same year and began publishing annual reports in 2005.

Provinces received most of the \$5.5 billion federal fund for wait times reduction that year, with a requirement that the five priority areas would see significantly reduced waits by 2007.<sup>2</sup> The only category for cancer was the wait for radiation therapy. The Accord expired in 2014 and has not been replaced.

Progress in the data collection, cooperation of provinces, and public reporting are demonstrated in the contents of Tables 1 and 2. These two tables give reason for both optimism and gloom regarding the willingness of provinces to monitor and be monitored. Information gaps might be caused by workload and technical problems that could be temporary; or there is a continuing pattern of reluctance across the provinces.

To determine which position is more realistic, a check on the annual reports from CIHI and WTA between then and now is revealing.

Just before the 2007 deadline, WTA was writing that provinces were not reporting radiation wait times based on the terms set by their health ministers in 2005 and were meandering about when a wait starts. “We see few attempts to rectify this situation and we remain very troubled by this. Canadians expect and deserve better.”<sup>3</sup>

When data for the year end of 2007 were released,<sup>4,5</sup> for the first time every province was included. The provinces continued to use different time frames for when a wait starts and different methods of reporting (median, percentage seen within a target period, or a range of time periods applicable) and different blocks of months/years represented by their data. Every province reported they had achieved and even over-achieved on the four week target.

By 2007, CIHI was routinely reporting on wait times for an oncology appointment, cancer surgery and chemotherapy with data from only three, two and four provinces

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**Table 1 Wait times for 2002**

Source: Report Card 2003-04, Cancer Advocacy Coalition of Canada

Data were collected by a survey sent to all provinces. The full report for this selected year and for other years can be found on the CACC website. Wait time feature articles were published in all the Report Cards between 2003 and 2006

Province	Wait Times in Days					
	SYSTEMIC THERAPY			RADIATION		
	Breast	Prostate	Lung	Breast	Prostate	Lung
NL	30	17	21	53 to 60	51 TO 58	34 to 41
PEI	14	6	5	73	N/A	21
NS	N/A			33		
NB	N/A			N/A		
QC	N/A			N/A		
ON	73			63	76	23
MB	"No wait except for more common cancers"			28 to 35		
SK	N/A			N/A		
AB	N/A			N/A		
BC	N/A			31	31	19

**Table 2 Wait times for 2014**

Source: Time to Close the Gap, Report Card on Wait Times in Canada 2014, Wait Times Alliance

Grading shows the per cent of population treated within the benchmark.

A+ = 90-100%,  
A = 80-89%,  
B = 70-79%,  
C = 60-69%,  
D = 50-59%,  
F = less than 50%.

\* all body sites combined.

? Province does not report these wait times.

☞ Province reports these wait times but not in a manner that WTA can grade.

Province	Wait Time Grades Based on Government and WTA Benchmarks 2014					
	Radiation therapy	From referral to consult *	From decision to treat to start of treatment *	Breast	Prostate	Lung
	(Benchmark)	4 weeks	14 days	14 days	14 days	14 days
NL	A+	?	D	?	?	?
PEI	A	A	D	?	?	?
NS	A+	B	B	B	B	B
NB	A+	?	?	?	?	?
QC	A+	?	☞	?	?	?
ON	A+	A	A+	A+	A	A+
MB	A+	?	B	S	F	B
SK	A+	☞	A	?	?	?
AB	A+	D	B	?	?	?
BC	A+	?	B	?	?	?

respectively and the usual variety of reporting methods that make comparison impossible. By 2010, WTA was tracking the waits from referral to consultation and from consultation to treatment, and Table 2 shows the five categories now reported annually.

In 2014 CIHI announced the provinces have adopted a common approach to measuring wait times for cancer surgeries for breast, prostate, colon-rectal, lung and bladder.<sup>6</sup> This initiative does not yet include any benchmarks, but a few provinces have guidelines that set out the stage of cancer and other factors to be considered urgent. A common timeframe for the wait has been adopted, which is the time between the date of booking and the date of surgery.

For this very first report on the new approach to cancer surgery waits,<sup>6</sup> the shortest waits were for breast cancer: half the patients were treated within 17 days and 90 per cent treated within 42 days. The longest waits were for prostate cancer at 37 days and 85 days for the 50th and 90th percentiles. For bladder, lung and colon-rectal cancer surgeries the rates were similar: 18 to 24 days for the 50th percentile and 44 to 59 days for the 90th.

### Achievements

- Every province meets the four week target wait for radiation therapy with an A or A+, meaning 80 to 100 per cent of all cancer patients are seen within the target time frame.
- Provinces report at least some wait times on their own websites; CIHI and WTA both publish comprehensive reports annually on a wide range of categories.
- Improved data collection and reporting are notable across the country, compared to 2004. Instead of averages, medians, ranges and estimates, the provinces now provide medians, 50th and 90th percentile waits.
- The original five areas of reporting required by the 2004 Health Accord included only radiation therapy as a cancer measure. CIHI and WTA now report on a wider range of cancer services and waits.
- The new effort to measure waits for cancer surgeries is encouraging. Hopefully the provinces can work from their existing guidelines and move toward establishing one common set of benchmarks reasonably soon.
- Ontario ranked at the bottom of the pack in 2002 and now leads all provinces in reducing wait times, although progress on systemic therapy waits has stalled over the past four years, according to WTA.<sup>7</sup>

### Disappointments

- Variations across the country and even within provinces remain disconcerting.
- The WTA continues to point out that current reporting on wait times — from referral to first consult and then from the decision to treat to the start of treatment — exclude the entire block of time spent in waiting for test results, or scheduling diagnostic imaging.<sup>6</sup>
- Most provinces do not report on the wider range of

wait time measures sought by WTA. In 2014 only NS and ON reported on all the newer categories of cancer waits identified by WTA; NB and QC reported on none of them, the other provinces were somewhat scattered but four provinces reported on the all-body-sites-combined wait time from referral to consult and eight of 10 provided answers on the all-body-sites-combined wait time from decision to treat to start of treatment.

## SCREENING

In 2005 and 2006,<sup>8,9</sup> CACC reported uneven uptake of breast cancer screening programs, peaking between 50-60 per cent of the target population in three provinces and dropping below 30 per cent in three provinces, with the other four provinces in between. At the time, programs complained about inadequate integration with the cancer system, lack of staff, information systems, core funding and even a limited capacity to handle any new cancers that might be caught.

Not all mammograms are for screening purposes, not all screening is done for women within the target age range of 50-69 and many are privately sought outside the organized program. Ten years ago, the CACC survey was exclusively for activity within the organized screening program of the cancer agency or department. Patients who directly accessed a mammogram outside that program were not captured, because no province could verify how much of that activity was for screening.

When these articles were first published, there were no screening programs for colorectal, lung or prostate cancer, although the mortality rates for each were much higher than breast cancer. Screening for colorectal cancer is now in place or in development across the country; for lung cancer the first steps to plan screening are barely begun and for prostate cancer arguments about PSA testing continue, with no sign of resolution.

Breast cancer programs were mostly well established and encompassed all the features necessary for organized screening — although in some cases these features were in development. AB for example, did not introduce its province-wide screening program until 2008. The essential elements include proactive recruitment of the target population, active follow-up and referral, call-backs every two years and reliable data collection. A host of other detail is involved, too elaborate to list here.

CACC had also asked about quality assurance, meaning:

1. is there a formal recall system in place for an abnormal result?
2. is there a written guideline to move a patient to the investigative phase after an abnormal result? and
3. if a cancer develops in the interval between screens, is it flagged to determine what happened with the first test?

For each of these questions, respectively, nine, eight and seven provinces answered yes.

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**Table 3 Breast cancer screening 2001-04**

Source: Report Card on Cancer in Canada 2006, Cancer Advocacy Coalition of Canada

Note: Activity represents a mammogram by an organized screening program within the previous two years, except NL. Target populations are generally women aged 50-69 although BC and ON accepted women up to age 74 and 75 respectively. BC, AB and NS accepted women from age 40 and MB will cover all women on referral. The AB province-wide program did not begin until 2008 and reporting was very limited.

Province/Territory	Year Program Initiated	Compliance in 2001-02	% of Target Population Screened in 2004
NL	1996	23.2%	30% in 1 yr
PEI	1998	43.5%	N/A
NS	1991	34.0%	45%
NB	1995	51.9%	55%
QC	1998	43.7%	48%
ON	1990	22.4%	26%
MB	1995	48.5%	51.4%
SK	1990	53.0%	approx 57%
AB	1990	12.0%	N/A
BC	1988	50.7%	48%
YT	1990	N/A	N/A
NWT	2003	N/A	N/A

**Table 4 Percentage of eligible women (aged 50-69) reporting a screening mammogram in the last two years - 2008 and 2012 reporting years**

Source: The 2014 Cancer System Performance Report, Canadian Partnership Against Cancer.

Note: Activity represents all self-reported mammograms for screening within the previous two years, both inside and outside organized screening programs.

Province	2008	2012
NL	70.3	72.6
PEI	57.6	59.5
NS	71.0	68.1
NB	74.7	72.1
QC	74.0	74.9
ON	73.0	73.5
MB	70.5	74.1
SK	73.0	63.3
AB	73.6	73.6
BC	67.7	70.2
YT	64.7	57.4
NWT	67.2	66.8

In short, the breast screening programs knew what to do and how to do it but felt constrained.

Tables 3 and 4 show screening for the target population, which is a larger population in Table 3 where the provincial variation in eligible age groups is noted. Table 4 shows only the 50-69 age group.

In 2011 the Public Health Agency of Canada (PHAC) released data on the participation in organized breast screening programs for 2005 and 2006.<sup>10</sup> As a follow-up to the CACC report for 2002 and 2004, it tracks closely and shows the early trend of increased participation as seven provinces instead of four hover around 50 per cent uptake among women aged 50-69. AB was again artificially low because their province-wide program did not yet exist, ON reported 32.4 per cent, NL 35.4 per cent and NWT 26.3 per cent. The national average was 40.0 per cent but when data were compiled for a 30 month period, the national average rose to 43.9 per cent, with proportionately higher rates for each province.

PHAC also included information on the utilization of mammography outside the organized breast screening programs for 2005-2006. Only seven provinces were captured in this material, leaving out NB, NS and PEI. At that time, all mammograms outside the organized program were counted as screening, which produces a misleading result when looking only for screening, but indicates activity that would have included some screening. There was predictably high outside use in AB at 53.7 per cent of all mammograms in the province, followed by ON at 31.1 per cent and NL at 28.5 per cent.

PHAC'S 2013 report,<sup>11</sup> (for 2007-2008) shows a national participation rate for organized programs of 45.9 per cent. Seven provinces reach 50 per cent or more, with PEI leading at 64.1 per cent. ON and NL grow to 40 per cent participation of the target population. These are slow improvements, still far short of everyone's agreed target of 70 per cent.

Statistics Canada captures self-reported mammography and can separate screening from other reasons but does not do so in the public materials on their website; therefore these cannot be regarded as screening reports. CPAC does obtain that breakdown and provides a combined total screening percentage in their system performance reports.

The retention rate for participation in screening is reported by PHAC (2007-2008)<sup>11</sup> as consistently "close to" 70 per cent over a period of years, with individual programs ranging from 55.7 to 81.8 per cent (provinces not identified). Patterns of retention show that after the second screen, women are more likely to continue.

Eligibility for a publicly funded screening mammogram has expanded over the years. Ten years ago BC and ON would welcome women up to age 74 and 75, while BC, AB and NS would permit a screen for women aged 40-49 with a physician's referral. By 2008, every jurisdiction but NL and SK would accept women aged 40-49 on referral and all but PEI would screen women over the age of 75.<sup>10</sup>

By 2012 PEI had the highest rate of screening for women

over age 75, at 40 per cent and the lowest rate was in NB at 22.4 per cent.<sup>12</sup>

### Achievements

- Provinces routinely provide screening outside the minimum recommended age range of 50-69.
- Between 2008 and 2012, breast cancer screening rates remained relatively stable in most provinces and territories.<sup>13</sup> There have been declines that rebounded and increases that diminished but largely, in spite of the aging population and greater demands on the screening programs, the rates are being maintained.

### Disappointments

- Reporting on participation rates has been uneven across all the organizations that have attempted it. Current national information on the volume of breast screening delivered within organized programs and outside those programs is no longer readily available. Some provinces do track this point; for example, an ON report<sup>14</sup> for 2009 shows only 42 per cent of the target population was screened by the organized program. At the same time, the combined inside+outside screening was reported as 72-73 per cent for the same age group.<sup>12</sup> If there are issues to resolve in women's preferences for the provider of the mammogram, surely the first step is to define the problem as precisely as possible.

## SCREENING + WAITS

The wait time target for a diagnosis after an abnormal screen is five weeks if no tissue biopsy is needed, or seven weeks if it is needed.

In the CPAC report for 2011, shown in Table 5, nine provinces plus the NWT come in well under the five week target for the median wait time when no tissue biopsy is needed.<sup>15</sup> Data were not available for ON and YT. PEI and the NWT show the longest median wait at four weeks and four provinces, BC, SK, MB and NB, have the shortest median waits, between two and three weeks.

When presented as the 90th percentile of patient waits, not one province meets the five week target, although NB is best at 5.3 weeks, NS and SK are similar at approximately six weeks, BC, AB, MN and PEI hover around eight weeks. NL and NT both hit 10 weeks while QC shows 10.9 weeks.

Overall, in descending order of success, NB, SK, ON, NS, MB and BC all meet the target wait time for 80-89 per cent of women aged 50-69. Even at the lower end of this scale, QC and PEI reach 64.4. and 68.1 per cent of patients seen within the five week target and AB reaches 70.9 per cent.

On the surface, the results might appear similar for the waits encountered when a tissue biopsy is necessary.<sup>15</sup> Seven provinces and the NWT meet the seven week target for median wait times, with the best results in NB, AB and SK showing 5.3, 4.9 and 4.5 weeks. The NWT shows 3.0 weeks,

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which is lower than their performance without a tissue biopsy, indicating other factors are at play. MB starts to need eight weeks although without that biopsy they only needed 2.4 weeks. Only QC fails by the same magnitude, but the time gap between their no-biopsy-needed performance and biopsy-needed is smaller than the gap in MB.

The percentage of women diagnosed within seven weeks ranges from the highest in AB and SK at 74.2 and 75 per cent, down to the lowest, at 40.5 per cent in MB and 41.2 per cent in QC. All of the East coast, plus BC and ON are similar in the high-50 and low-60 per cent range. These rates show a slow but steady improvement over previous years.

From the same CPAC report, the 90th percentile wait time for a diagnosis requiring tissue biopsy indicates just how erratic this part of the activity can be. Starting from a modest 9.6 weeks in PEI, the numbers leap. AB, SK, and NB all show the 90th percentile between 12 and 13 weeks. NS needs 13.7 weeks, BC needs 14.9 weeks, MB needs 16.4 and QC needs 17.6 weeks.

What does this mean for patients? Across the provinces, between 25 and 59.5 per cent of new breast cancer cases detected from screening and followed by tissue biopsy are not being diagnosed within seven weeks and some could wait as long as three or four months for a diagnosis. Further research should examine why the need for tissue biopsy

generates such extended delays.

From the no-biopsy-needed data it is clear that the follow-up referral process to move the patient to a consult is efficient in most parts of the country. Somewhere, the notion that tissue biopsy could be added to the process and completed within two weeks seemed rational. However, when that task is separated from the aggregate wait (in Table 5), only PEI, SK and AB can achieve that two week goal, even as a median. (NWT does too, but their numbers are outliers.)

There can be many reasons for extended waits, including distance from the follow-up appointment, language barriers, complicating health issues, and whether the biopsy is invasive (surgical) or not. For example, PHAC reports that in 2008, 15 per cent of cases required surgical biopsy, down from 24.5 per cent only four years earlier.<sup>11</sup> These were more common in younger patients and in first-time participants in an organized screening program.

Certainly not every delay is caused by a failure of the health system. But certainly, some of it is.

Ultimately, what these data show is that wait times for a diagnosis remain inconsistent and often far too long, causing unnecessary torment and delaying the start of treatment.

**Table 5** Wait times for diagnosis following breast cancer screening, 2011

Source: Canadian Partnership Against Cancer, [www.systemperformance.ca](http://www.systemperformance.ca)<sup>15</sup>

Province	Median Wait Between Abnormal Screening Result and Diagnosis (weeks)		Median Wait Time Attributable To the Need for a Biopsy Before Diagnosis (weeks)
	Without tissue biopsy target is 5 weeks	With tissue biopsy target is 7 weeks	
NL	3.0	7.0	4.0
PEI	4.0	6.0	2.0
NS	3.1	6.6	3.5
NB	2.1	5.3	3.2
QC	3.9	8.1	4.2
ON	-	-	-
MB	2.4	8.0	5.6
SK	2.5	4.5	2.0
AB	3.9	4.9	1.0
BC	2.7	6.0	3.3
YT	-	-	-
NWT	4.0	3.0	-1.0

## OPPORTUNITIES

- 1. Wait times are still reported from the perspective of the health system rather than recognizing that patients experience multiple delays beyond the official waits being compiled. It is time to work on a model that will capture the true patient journey with all its different waits.**
- 2. While it is important to know the overall participation rates for breast cancer screening, it is relevant to capture and report on the amount achieved by organized screening programs and compare that to the volume of opportunistic screening outside those programs.**
- 3. Waits for a diagnosis require further research. Most provinces easily meet the first (five week) target for a diagnosis after abnormal screening. However, a high percentage of all those needing tissue biopsy fall seriously outside the target (seven week) wait.**

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**September 16, 2004**

### **A 10-year plan to strengthen health care**

First Ministers agree that access to timely care across Canada is our biggest concern and a national priority. First Ministers have come together and agreed on an action plan based on the following principles:

- universality, accessibility, portability, comprehensiveness, and public administration;
- access to medically necessary health services based on need, not ability to pay;
- reforms focused on the needs of patients to ensure that all Canadians have access to the health care services they need, when they need them;
- collaboration between all governments, working together in common purpose to meet the evolving health care needs of Canadians;
- advancement through the sharing of best practices;
- continued accountability and provision of information to make progress transparent to citizens; and
- jurisdictional flexibility.

**First Ministers Meeting on the Future of Health Care 2004**

<http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php>