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Ontario Cancer News

The changing face of cancer in Ontario

Humourously, April Fools' Day 2003 marks the one year anniversary of Dr. Alan Hudson's leadership of Cancer Care Ontario. More seriously, it also marks the beginning of cancer month. These are two good reasons for us to host a 'state of the union' on cancer care in Ontario. On April 24, Dr. Alan Hudson will give the first ever annual address on the major challenges facing our cancer system. He will also provide details on how the new Cancer Care Ontario is evolving and meeting the challenges that lay ahead. We encourage all of you to attend.

For more information on the 'state of the union' click here.

Waiting for cancer surgery

In recent weeks, the media spotlight has been shining on cancer surgery wait times. Cancer Care Ontario's Surgical Oncology Program, led by Dr. Hartley Stern, plans to investigate wait times as part of its program of identifying and measuring indicators of quality cancer surgery.

The following review of the literature, conducted by Program Manager Anna Gagliardi, provides much needed insight on this complex and topical issue.

LITERATURE REVIEW: What Does the Literature Tell Us About Waiting Times?

Highlights

- Waiting for treatment may influence cancer stage which, in turn, affects prognosis but further study is required to establish reasonable benchmarks.
- Waiting times are influenced by multilevel factors.
- Few empirical studies examining waiting times have properly considered the degree of influence of multilevel factors - those that have demonstrate little impact of health care supply on demand, suggesting that resources can bring about reductions in waiting times.
- Increased resources should be accompanied by studies investigating factors that contribute to lengthy wait times so that additional complementary strategies can be deployed.
- Possible additional strategies include reviews of human resource capacity, development of priority criteria, significant investment in wait list infrastructure and implementation of electronic registries, and regional coordinators to actively manage surgical services and those on waiting lists.
- Access to care is not affected by the introduction of alternate funding formulas.
- Public reporting of waiting list data should provide explicit details defining standardized measurement, describe how the statistics should be interpreted, and how professionals and the public can make use of the information.

Summary

The results of a literature review (MEDLINE search for [(neoplasms/su or surgery) and waiting lists] and Internet search for [surgery and waiting lists]) describe studies and initiatives in Canada and other countries; theory and methods related to the measurement and evaluation of waiting lists; and the impact of treatment delay on clinical outcome and health-related quality of life.

The majority of these studies involved elective surgery or surgery for conditions other than cancer. Three Canadian studies (Simunovic 2001, Mayo 2001, Shaw 1999) and one British study (Spurgeon 2000) measured waiting times for cancer-directed surgery. Several studies examine the impact of delays in diagnosis and treatment on clinical outcome and health-related quality of life for various types of cancer including prostate, breast, bone, bladder, gynecologic, lung, skin, colorectal and head and neck. A meta-analysis examining the relationship between delay in radiotherapy and outcomes (local control, metastasis, survival) found that the 5-year local recurrence rate (LRR) was significantly higher in patients treated with adjuvant RT for breast cancer more than 8 weeks after surgery than in those treated within 8 weeks of surgery (odds ratio [OR] = 1.62, 95% confidence interval [CI], 1.21 to 2.16) and that the local recurrence rate was significantly higher among patients who received postoperative RT for head and neck cancer more than 6 weeks after surgery than among those treated within 6 weeks of surgery (OR = 2.89; 95% CI, 1.60 to 5.21) (Huang 2003).

Examined together these studies suggest that waiting for treatment may influence cancer stage which, in turn, affects prognosis. However, there are few studies for each type of cancer involving small numbers of patients. In instances where there is more than one study per cancer disease site the reported measures vary and therefore the results cannot be pooled.

Based on existing evidence the Committee on Standards of the Canadian Association of Radiation Oncologists (CARO) recommended that the interval between referral and consultation should not exceed two weeks and that the interval between consultation and initiation of radiotherapy should also not exceed two weeks. The CARO standards were also applied to cancer surgery when the Canadian Society of Surgical Oncology (CSSO) adopted the two week maximum for the intervals of referral to consultation and decision to treat to surgical treatment.

The remaining literature described models and theories applicable to the measurement of waiting times, and the development of interventions

for managing waiting times. These include queuing models, economic models, and advanced access. The development of an appropriate model is complex because the factors that influence waiting times are multilevel, including patient, provider, organizational, disease-specific and system-level factors. This also explains why the implementation of maximum waiting times for diagnostic and treatment intervals reduced waiting times but to a limited degree.

One area of controversy is whether additional resources improve waiting times. It was thought that added funds initially reduced wait times but, by increasing supply, further induced demand, once again driving up wait times. However, few empirical studies examining this theory have been conducted, and none properly considered the degree of influence of multilevel factors on waiting times. One such study using a supply and demand model found that the most important indicator of utilization was need, suggesting that, contrary to popular belief, there is little impact of health care supply on demand (Martin 1999). Therefore increased resources could bring about reductions in waiting times. Resources need to be directed toward providers of care and support professionals, facilities, and infrastructure, plus further research and education for both providers and the public.

In response to concerns that funding schemes for specialists might negatively impact access to care, waiting time to first appointment with medical specialists at an academic centre were monitored both before and after implementation of an alternate funding formula (Shaw 1999). Data comprising 18,623 first referrals by 26 primary-care physicians were gathered for two-year periods before and after the AFP's implementation. Analyses of variance were used to determine whether pre-AFP versus post-AFP differences in mean waiting times existed. The study found that patients did not wait longer to see specialist after they were funded in this manner.

Other studies have demonstrated that altering processes such as admissions, length of stay, and occupancy rate can improve performance while controlling costs (Gorunescu 2002). Additional types of strategies include balancing of supply and demand, reducing backlog, reducing the variety of appointment types, developing contingency plans for unusual circumstances, working to adjust demand profiles, and increasing the availability of bottleneck resources (Murray 2003). ***Therefore, increased resources are necessary to address lengthy waiting times but should be accompanied by additional strategies.*** The required additional strategies can be determined through audits of institutional and provider practice because activity data can pinpoint areas that need improvement.

Audits of waiting lists themselves revealed differences in statistical reporting, differences in how patients were assigned to the waiting list, and a high proportion of patients who should not be on a list or, in retrospective studies, were never admitted, highlighting a need for standardized measurement and use of waiting lists. Systems by which to prioritize patients on waiting lists have been developed (Lack 2000, WCWL). In the United Kingdom, where waiting times are actively monitored, a recent audit found that most regions had serious flaws in how they collected and reported data on waiting lists (BMJ 2003;326:517). Errors in reporting were found in 19 of the 41 trusts investigated; system errors that could increase risk of reporting errors were found in 15 trusts; and three trusts deliberately misreported information on their waiting lists. Only three of 41 trusts were free from obvious errors. The report suggested that problems causing the errors included the complexity in the organization of waiting lists, the large number of staff needed to maintain them, and information technology problems.

Patients exhibit behaviour counter to publicly voiced concerns over lengthy waiting times for diagnosis and treatment - they often decline cross-border access to services, preferring to wait for local service provision; prefer to wait rather than spend additional money on private services or extra health coverage which might reduce waiting times; and, when asked, express acceptance of waiting times considered unacceptable by providers. A survey of professionals and patients revealed support for a more explicit system of rationing access to elective health care by waiting lists based on factors such as level of pain, rate of deterioration of disease, and level of distress and disability, but not age, ability to pay, cost of treatment, evidence of cost-effectiveness, existence of dependents, and self-inflicted ill health (Edwards 2003).

Public reporting of waiting lists is becoming more common but a review of six government web-sites in English-speaking countries with publicly-funded hospitals found that they reported waiting times using a variety of statistics, offered poor overall advice to general practitioners and patients, did not state whether the statistics predicted expected waiting times, and provided inadequate information on the uncertainty associated with making statistical inferences.

Particular studies examining waiting times that warrant mention include the Western Canada Waiting List (WCWL) project, the Ontario Cardiac Care Network, a surgical wait list management strategy for Saskatchewan, and a federal report on waiting lists and waiting times for health care in Canada. While none of these are cancer-specific, like the literature on waiting times theory and measurement, they offer possible strategies for changes in practice and policy development.

The WCWL project is an ongoing collaboration of 19 partner organizations committed to influencing the way waiting lists are structured and managed. The focus of the WCWL project has been to develop and refine practical tools for prioritizing patients on scheduled waiting lists. Scoring tools for priority setting were developed through extensive clinical input and highly iterative exchange by clinical panels in five clinical areas: cataract surgery; general surgery procedures; hip and knee replacement; magnetic resonance imaging (MRI) scanning, and children's mental health. It should be noted that this project was characterized by the length of time taken to reach consensus, and the delay in developing and implementing prioritization tools.

The Cardiac Care Network also developed a prioritization scheme which is used to manage patients on a provincial waiting list for cardiac surgery, ***employs regional representatives*** to liaise with community providers and acute care hospitals providing cardiac surgery to coordinate care, established an electronic data registry to track patients and monitor waiting times, and publicly reports cardiac surgery waiting times on a web site (www.ccn.on.ca/ and www.longwoods.com/hq/spring01/HQ43mb.pdf).

The purpose of the *Surgical Wait List Management: A strategy for Saskatchewan* report was to review current Saskatchewan efforts related to waiting times for elective surgery, review initiatives in other provinces and countries, and recommend a provincial wait list strategy including implementation and communication strategies. A review of other jurisdictions revealed that there is widespread concern about waiting times for elective surgery, with emphasis being placed on ensuring those most in need receive care, development of more structure and rigor to the provision of surgical services within clinically appropriate times, and an emphasis on measurement and analysis. The provincial review process revealed a lack of accurate data, no consistent patient prioritization process, and frustration on the part of providers/surgeons and the public. Published in 2002, it issued the following recommendations:

High Priority Recommendations

- Continue the Human Resource Initiative
- Create a rolling three-year surgical wait list fund with three distinct sections for operating costs, equipment costs and facilities costs
- Each district develop OR time allocation mechanisms to actively manage surgical wait times across specialties
- Develop a province-wide electronic registry
- Develop standardized priority criteria and tools
- Each region designate a person as the surgical services coordinator to facilitate communication between the district, patients and their referring physicians
- Implement an advisory committee to the provincial ministry of health to assist with improving access, equity and efficiency in the provision of surgical services made up of representatives of providers, regions and government

Medium Priority Recommendations

- Carry out a thorough review of day procedure processes, equipment and facilities, and identify needed changes and investments to facilitate the maximum clinically appropriate use of day surgery.
- Define precisely the surgical services role of each hospital to set out expectations for ongoing and periodic services.
- Define the responsibilities of smaller hospitals to larger hospitals and vice-versa, and develop province-wide integrated care paths for high-volume and high-risk procedures.

A federal review of *Waiting Lists and Waiting Times for Health Care in Canada*, published in 1998, was based on a review of national and international literature on waiting lists and waiting times, interviews with key informants from each provincial/territorial Ministry/Department of Health, survey of all large hospitals and all regional health authorities, and interviews with representatives of a wide range of consumer and other non-government organizations. It concluded that:

- In Canada at the present time it is impossible to either understand the true magnitude of wait lists or genuinely and rationally manage the patients on waiting lists; there is no standardized definition of surgical waiting times.
- It is virtually impossible to know how to interpret any particular claims about the length of time patients are currently waiting for any particular procedure. Criteria are absent for determining when patients should be added to a wait list and how they should be prioritized.
- Commonly, 20% to 30% of those on wait lists found in the international literature are
- inappropriately placed for a variety of reasons.
- There is no evidence from Canada or elsewhere that private financing is an effective solution.
- ***Resource augmentation is likely to be an ineffective solution to whatever real problems exist; adding resources without improving management, audit and evaluation is futile (CCO emphasis).***

Not unlike the Saskatchewan report, the federal report issued the following recommendations:

- Develop standardized methods for measuring and reporting waiting times; operational measures of clinical severity; and measures to assign patients places on waiting lists
- Put in place mechanisms to hold individual clinicians accountable for the placement and prioritization of patients on lists; periodic audits.
- Develop mechanisms at the provincial level to integrate lists and prioritization across institutions.
- Develop registries for conditions where volumes are insufficient to justify service capacity in all jurisdictions.
- Need for significant investment in wait list infrastructure (ie. development of shared wait lists and appropriate audit mechanisms)
- Develop consistent criteria to determine whether a wait list "requires attention"
- Train more clinicians to become skilled in critical appraisal, clinical practice guidelines development and implementation.
- Health Canada and other funding agencies should support research and dissemination of waiting list investigations.
- Valid and reliable measures of wait lists and wait times should be routinely and widely reported.

The summit—advancing the integration of cancer services

Integration activities continue to move forward at a swift pace, and a number of important milestones have been achieved. We were delighted to receive another letter of support from Mr. Tony Clement, minister of Health and Long-Term Care, expressing his ongoing support for integration and encouraging us to "keep the momentum going."

On March 6, a contract summit was held with host hospital CEO's, regional vice presidents and Cancer Care Ontario to discuss the contractual arrangements that will be in place between Cancer Care Ontario and host hospitals. Strong alignment on key issues and unanimity of purpose were outcomes of the meeting. Details associated with wording in the next draft of the contract are currently being worked out, and we are still targeting to have final sign off of the host hospital / Cancer Care Ontario agreement by end of June 2003.

We are confident that integration will help improve quality of patient care for people with cancer across the province, and we are pleased with how everything is moving along. As with any major change, numerous questions arise and we encourage people to bring them forward to senior leaders in the cancer centres so that they can be addressed.

Canada's first cancer quality council

Working closely with cancer care partners across the province, the Cancer Quality Council of Ontario will monitor outcomes and promote guidelines to improve cancer services for the people of Ontario.

Established last September as a key recommendation of the Cancer Services Implementation Committee, the council has a vision to achieve the highest possible quality in all cancer services in Ontario. To accomplish this, the Quality Council will monitor and assess cancer incidence, prevalence, treatment outcomes and overall health burden; efficiency indicators such as access, waiting times and length of stay; and patient satisfaction.

Led by council chair Michael Decter, a former deputy minister of Health for Ontario, and executive management lead Dr. Terry Sullivan, Cancer Care Ontario's vice president of Preventive Oncology, the council will focus on quality and performance in the delivery of all cancer services - from health promotion and disease prevention, screening and early detection, primary care, diagnosis, treatment, rehabilitation, home and community care, to supportive care and palliative care.

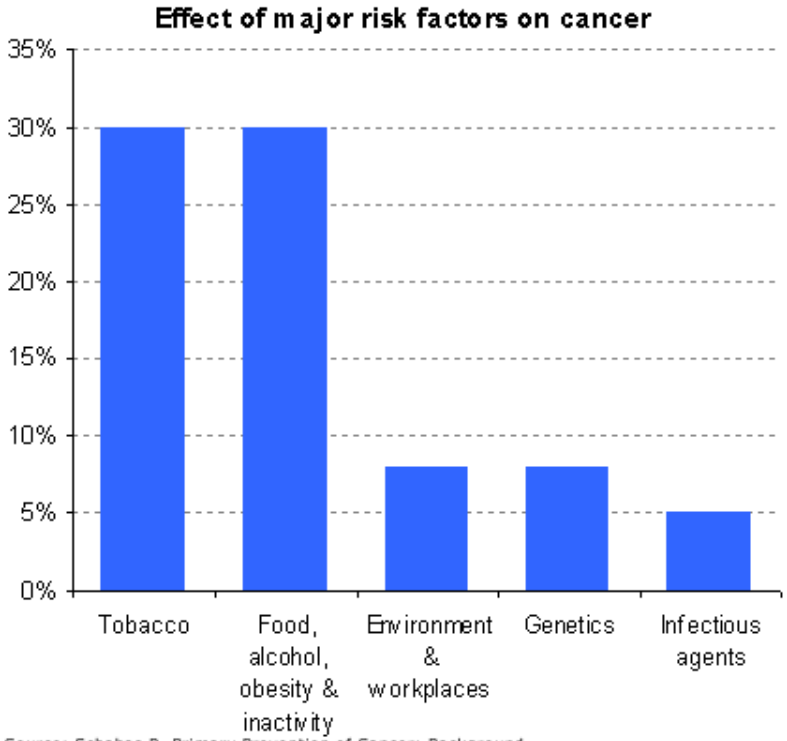
First year priorities include producing a benchmark report, miminum system-wide performance indicators, and a quality improvement report on colorectal cancer. A signature event planned for this June will mobilize over 100 experts and leaders in cancer care to focus on quality improvement and contribute to the development of an action plan for colorectal cancer.

Follow this link for an electronic presentation on the Cancer Quality Council of Ontario. For more information about the work of the Quality Council, send e-mail to helen.angus@cancercare.on.ca.

Ontario Cancer Facts

Tobacco, food and obesity, and physical inactivity are major causes of cancer. Tobacco includes all forms of smoking, second-hand smoke and chewing tobacco. It is responsible for about one-third of cancers because it causes several types of cancer: lung, mouth and throat, larynx, bladder, kidney and pancreas.

Another one-third of cancers might be prevented if people ate more fruits, vegetables and grains, drank less alcohol, had a healthy body weight and were more physically active. These changes could lower the risk of cancer of the bowel, mouth and throat, stomach, breast, uterus, kidney and prostate. They may also reduce the risk of diabetes, heart disease, stroke, and other chronic conditions.



Source: Schabas R. Primary Prevention of Cancer: Background Paper. http://209.217.127.72/cscc/pdf/pprev/CancerPrevention_Background Paper - Final.pdf

The environment and workplaces, infectious agents and genetics are other important causes of cancer. Much more research must be done before we know how important these are. A best guess now is that about 8% of cancers might be caused by things in the environment and workplaces (not including second-hand smoke), 8% by genetic factors and 5% by infectious agents. Viruses and bacteria are important in cervical cancer and stomach cancer, for example. Sunlight, radon and air pollution cause cancer but we need research on many other environmental exposures. Workplace exposures that can cause cancer occur mainly in a few industries. This means that more of the cancers occurring in workers like uranium miners and asbestos workers may be caused by their exposures at work.

Reducing exposures to things that cause cancer is not easy. It depends on individual behaviour, on community norms and what society considers acceptable levels of risk, and on policy and regulations to limit or reduce exposures.

For more information, talk to your health care provider or call Cancer Information Service (1-888-939-3333)

Survey highlights

We asked for your opinion, and you gave it to us. Read on to see what you had to say about the first issue of Ontario Cancer News.

We asked you to rate the first issue of Ontario Cancer News from 1 to 10.

- 66% of respondents rated the newsletter between 8 and 10
- 29% of respondents rated the newsletter between 4 and 7
- 0% of respondents rated the newsletter between 1 and 3
- 5% of respondents did not complete the question

We asked whether you thought the content of Ontario Cancer News would be relevant to you.

- 72.5% of respondents rated the content relevance between 8 and 10
- 22.5% of respondents rated the content relevance between 4 and 7
- 0% of respondents rated the content relevance between 1 and 3
- 5% of respondents did not complete the question

Most useful were your suggestions and comments. Many of the topics you've requested will appear in this and future issues of Ontario Cancer News. We can't list them all here, but some of your suggestions were:

- Cancer services integration and the integrated cancer programs
- Prevention and screening
- Waiting times
- Cancer research
- Cancer Quality Council
- Technological advances
- Tobacco control
- New cancer centres
- Cancer 2020
- Practice guidelines updates
- Best practices information

We heard you loud and clear on the issue of font size. You'll notice the type is bigger in this issue. But please keep in mind that your screen settings determine how documents appear on your computer. If you use a very high screen resolution, the type may still appear small to you. (And if you use a very low screen resolution, you may have to scroll back and forth to read the text on your screen.)

Some of you liked our look; others thought we should include fewer or more photos and illustrations. We've chosen a design for the newsletter that is consistent with the new visual identity of Cancer Care Ontario. The images we use will change depending on the articles in each issue; and we may include additional images in the articles where appropriate.

Several respondents mentioned technological issues. We recognize that some readers are using older computer systems. This should not affect your ability to receive Ontario Cancer News. Those who cannot receive HTML files should automatically receive a text only version with a link to the newsletter on the Cancer Care Ontario Web site. What may affect your ability to receive or view the newsletter, however, is the use of certain security settings, such as firewalls and virus scanners. These may affect how Ontario Cancer News appears your mailbox. If you have trouble receiving or viewing Ontario Cancer News in your e-mail, you can always read the newsletter on the Cancer Care Ontario Web site at http://www.cancercare.on.ca. A new issue will be posted on the first Tuesday of each month, and past issues will be archived there as well.

Those readers who want to view the entire newsletter on one page can simply click on the "print newsletter" link at the bottom left side of the front page. This will take you to a Web page containing all of the articles in that issue.

On a final note, we'd like to thank everyone who participated in the survey. Your survey submissions were sent to our mailbox anonymously. That means we cannot respond to those of you who asked specific questions. If you are awaiting an answer, please resend your question to publicaffairs@cancercare.on.ca.

Coming this month...

New Publications
Look for the first in a new series of publications called Insight on Cancer. Cancer Care Ontario has partnered with the Canadian Cancer Society, Ontario Division to produce the series, which will focus on current cancer trends, news and information. The first issue, Insight on Cancer, News and Information on Prostate Cancer, is expected later this month.

Cancer 2020 is a long-term plan for cancer prevention and early detection in Ontario. This month Cancer Care Ontario and the Canadian Cancer Society, Ontario Division, will release a forward-looking action plan including measurable goals and targets for cancer prevention and early detection.

Both of these publications will appear on the Cancer Care Ontario and Canadian Cancer Society Web sites.

State of the Union
Dr. Alan Hudson's first annual address on Ontario's cancer system takes place at 8:30 a.m. on April 24 at Hart House at the University of Toronto, 7 Hart House Circle, Toronto. (An invitation and map are available at http://www.cancercare.on.ca) In his presentation, "A picture of cancer care in Ontario," Dr. Hudson will focus on the past year, as well as the years ahead. Those who wish to attend are asked to RSVP by April 17 to Karen Ramlall at (416) 971-5100, extension 1622, or publicaffairs@cancercare.on.ca.

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