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Ontario Cancer News

Taking the Vital Signs - An Annual Report on Cancer in Ontario

Join Cancer Care Ontario President and CEO **Terrence Sullivan** in Toronto on April 28, 2005, for his first annual public address, focusing on quality, accountability and innovation in Ontario's cancer system. For more details, go to the Cancer Care Ontario Web site.

Cancer Care Ontario in the News

For the first time, Ontario's hospitals are being told to improve their standards of cancer care or face a funding freeze.

To get money for expanded treatment programs next year, hospitals must sign on to a new surgery improvement plan created by **Cancer Care Ontario**, the provincial agency that oversees and funds cancer services.

Hospitals must commit to tracking 25 quality indicators developed by a team of top cancer surgeons - including strict real-time reporting of waiting times for diagnosis and treatment, tracking tumour size, and how long it takes for pathology reports to be completed. Recording all this will help the agency determine where there are treatment bottlenecks.

Next month, the agency plans to announce that cancer patients will have online access to the indicators, which will give them practical information about the quality of surgery available in their region. The plan for improving care across the province focuses on:

- Dealing with the root causes of long waiting times for diagnosis and treatment.
- Urging that consultation teams (of surgeons and other health-care workers) be created to deal with individual cases.
- Centralizing some services within regions, especially complex cancer surgery.
- Sending top surgeons across the province to share best practices with colleagues in small centres.

The agency has often said that waiting times for surgery and quality of care vary across the province, especially in smaller centres that deal with fewer cases.

The province gives Cancer Care Ontario about $400-million a year to dispense to hospitals for chemotherapy and radiation. The agency estimates that hospitals spend a further $1.6-billion a year on cancer patient care, including surgery and drugs. Since January, the agency has also given 25 hospitals extra funding for about 1,700 additional surgeries, part of the Ontario wait times initiative.

Tying its plan directly to funds it controls gives the agency more power to direct care at the hospital level. Surgeons currently make most decisions about hospital cancer surgery programs.

Cancer Care president Terry Sullivan said all indications are that hospitals and surgeons are happy to be part of a broader initiative to improve care.

"Far from feeling bristly, I think they are very keen to participate, with the sole fly in the ointment being the challenges of adding new capacity and the shortage of anesthesiologists, which is, I believe, affecting all surgical activity," Sullivan said.

Steve Orsini, vice-president of policy and public affairs for the Ontario Hospital Association, said hospitals have had funding tied to performance for years in certain services, such as in cardiac care.

"We welcome the standards and best practices that come with this funding," he said, citing the province's wait times initiative for the changes.

Reducing waiting times was a key pledge in the McGuinty Liberals' campaign platform. And last September, a national health accord came with a promise of $18-billion in federal funding to cut waiting times for health care in five key areas, including cancer care.

Traditionally, hospitals have a global budget with a fixed amount of money to spend. But faced with an aging population and increased need, the OHA is advocating for hospitals to be funded for the volume and complexity of services they provide, Orsini said.

Sullivan hopes the cancer plan will help unravel bottlenecks that have caused waiting times to soar.
For example, the wait between consultation and bowel resection surgery for a patient in Ontario with colorectal cancer -- the No. 2 cause of cancer death in Canada after lung cancer -- has almost doubled, from 16 days in late 2000 to a little less than 30 days in early 2004, he said.

Waiting times vary greatly across the province, something Sullivan wants to change. Until now, waiting times for cancer surgery have been "something of a mystery," he added.

"The whole business of access to surgery is not simple, but we do have some things we can measure now. We can measure wait times for consultation, investigations and for the procedure. Measure people on the lists, traffic and volumes."

The cancer agency currently tracks waiting time through provincial billing records. But in January, hospitals were given an electronic spreadsheet developed by the agency to track real waiting times for treatment, including how long it takes for pathology results to come back, tumour staging, and the time between diagnosis and surgery.

Hospitals will report results to the agency every four months. Their first report is due at the end of this month.

Catherine Barbetta knows how devastating waiting for diagnosis and treatment can be.

She has helped her sister, a 39-year-old mother of two toddlers, navigate through Ontario's health system, trying to understand why the young mom couldn't shake what the family doctor said was pneumonia.

"There was waiting all down the line," said Barbetta of her sister's experience. "You have to wait for everything, and it adds up to months."

Her sister didn't wish to be interviewed, so Barbetta is speaking out about their experience. It was Barbetta who, late last spring, encouraged her sister to ask her family doctor for an appointment with a specialist after she had been on antibiotics for months to treat pneumonia. In August, she finally got an appointment with a doctor based at a 905-area community hospital, who confirmed the family physician's diagnosis. Still skeptical, Barbetta, who works in the medical field, wanted another opinion.

She worked the phones and pushed to have her sister seen at a downtown teaching hospital. That appointment was at the end of October. Within six weeks, a respirologist diagnosed her with lung cancer.
"She's a non-smoker," said Barbetta. "No one in the family smoked."

Then the family had to wait an "emotionally devastating" five weeks before seeing an oncologist. "I can't tell you the stress we endured for those five weeks," she said. "When someone hears they've got an aggressive tumour growing inside them, that they aren't a candidate for surgery because it is so advanced. ... And, that is the last message a patient was left with."

Barbetta's sister is now in chemotherapy and the family is holding out hope.

Tying performance to funding is the key to success in speeding the progress of such cases, said Ottawa's Dr. Hartley Stern, the agency's head of surgical oncology, who led the team that developed the 25 indicators.

"This money allows us to basically say ... if you don't participate ... the likelihood is that in the next go-around, your institution will not receive funding for increased volumes for cancer surgery."

In the past, there was no way to measure the standard of care, and no way to influence how cancer services are organized or distributed, he said.

Under the agency's plan, every surgeon will be encouraged to form a consultation team with other health workers, which will assess each patient's case and discuss potential treatments. This is done routinely at larger teaching hospitals, but less commonly in smaller ones.

In areas where there are three or four hospitals next to each other that do five or 10 cancer surgeries a year, they'll now be compelled to think about combining those resources into one institution, Stern said.

This has already happened in Ontario by accident, notes Dr. Jonathan Irish, chief of surgical oncology at both the University Health Network and Mount Sinai Hospital. A drive to improve pancreas surgery results began after a group of surgeons showed death rates were higher in small-volume centres. Now, pancreatic surgeries are done in high-volume centres, just like surgeries on cancers of the head and neck, he said.

"That is a good example of how quality has driven practice."

The point is that this shouldn't be occurring by tradition or accident, Irish said. "By planning, CCO will drive the agenda, not be a pedestrian in what happens in cancer care services."

It's important to note the cancer agency is not talking about centralizing surgeries to a few hospitals, said Dr. Carol Sawka, who was vice-president of regional cancer services for Sunnybrook and Women's College Health Sciences Centre when she spoke with the Star. She now works for the cancer agency.

"This is about having a common approach within the region and a better understanding of which cases are so complex they need to be done in a tertiary centre, such as head and neck cancer, versus those cases that can be done safely and at high quality in community hospitals, like colorectal cancer."

Top surgeons are also being recruited to share their expertise across the province. For example, Dr. Andy Smith, a prominent colorectal cancer surgeon at Sunnybrook, will be travelling to community hospitals to share the newest surgical techniques.

Last year, the provincial health ministry promised $26.3-million to improve cancer care across the province. About $10-million was earmarked to improve wait times, $15 million to improve access to drugs and $1.3-million to provide radiation to 400 more patients at Princess Margaret Hospital.

But Sullivan warns that, as the ministry invests more money to move patients through surgery, the rest of the system could get clogged because the agency doesn't have money to beef up areas such as diagnosis and chemotherapy. As the population ages, cancer rates are expected to surge, from 54,000 cases this year to 74,000 by 2014.

In November, the cancer agency released a report calling for $600-million more to fight cancer over the next three years. It's awaiting a ministry response.

Workshop Focuses on Occupational Cancer Surveillance

Cancer Care Ontario recently hosted an occupational cancer workshop in support of the Occupational Cancer Research and Surveillance Project, a three-year initiative co-sponsored by Cancer Care Ontario and the Workplace Safety & Insurance Board.

The goals of the project are to: develop surveillance tools for both occupational cancers and occupational carcinogen exposures, identify research priorities, and establish relationships with various stakeholder communities. Occupational cancer is an area of research that has been relatively understudied. Scientific knowledge regarding the relationships between occupational exposures and cancer is limited. The Occupational Cancer Research and Surveillance Project is the first project of its kind in Ontario to examine the feasibility of carrying out surveillance of both occupational exposures to carcinogens and occupationally-related cancers.

The workshop brought together approximately 80 stakeholders with an interest in occupational cancer, including researchers, labour, industry, government and cancer society representatives, and health care professionals. The objective of the two-day meeting was to draw on wide-ranging expertise of the participants to help set priorities for surveillance of occupational exposures and cancers in Ontario.

The agenda allowed for formal presentation and large-group discussions, as well as smaller-group discussions in the form of break-out groups. Much of the break-out group discussions focused on how to build on the data and resources already available. For example, attention could be focused on exposures that are highly prevalent in Ontario or for which there are already data available. The workshop proceedings are currently being drafted and will be made available later in the spring.

The occupational cancer project team has also produced several information products as part of their ongoing research.

In December 2004, the team completed a systematic review of the published literature about the occupation of firefighting and cancer risk. The full report—*The Occupation of Firefighting and Cancer Risk: Assessment of the Literature*—may be found at: http://www.worksafebc.com/law_and_policy/policy_consultation/law_40_10_290.asp.

The team's findings have also been highlighted in two Ontario Cancer Facts:

- Rise in mesothelioma cases reflects past asbestos use

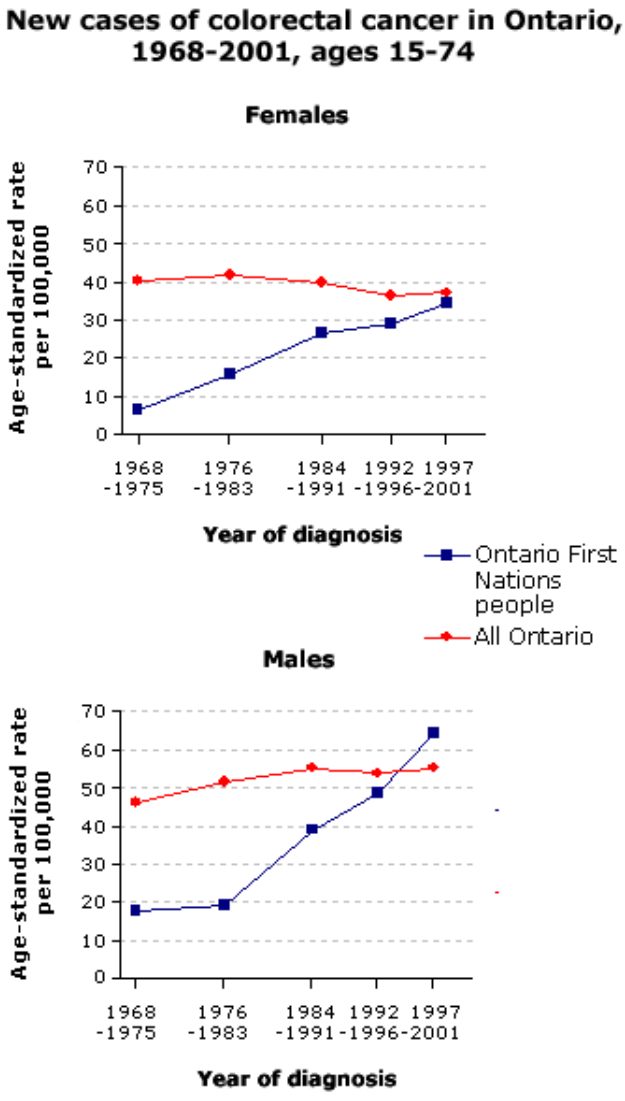
- Youth exposed to harmful substances at work

For more information about the project, contact Jennifer Payne at jennifer.payne@cancercare.on.ca or 416-971-9800 ext. 1266.

Ontario Cancer Facts

Colorectal cancer increasing in Ontario First Nations people

Colorectal cancer was much less common in Ontario First Nations people in the late 1960s and throughout the 1970s. Since then, incidence rates have increased in females to a level similar to the Ontario population. In males, the incidence rate is even higher. Ontario First Nations people have also experienced a dramatic increase in diabetes rates. Colorectal cancer and diabetes share several risk factors: obesity, physical inactivity, and some aspects of diet.



The overall cancer incidence rate in First Nations people, while still well below the rate for the general population, is rising more quickly. Much of this increase is due to the rise in colorectal cancer, and rapidly rising lung cancer rates. Smoking, the most important risk factor for lung cancer, is now established as a risk factor for colorectal cancer. Compared to the Ontario population as a whole, a high proportion of First Nations people smoke cigarettes. Aboriginal people have used tobacco for thousands of years for ritual, ceremonial and medicinal purposes. Widespread cigarette use is more recent.

These rising cancer rates among First Nations people have contributed to the development of Cancer Care Ontario's Aboriginal Cancer Strategy. The Strategy identifies several priority areas. One is to support community based processes that help develop "tobacco wise" communities. A tobacco wise community understands the difference between traditional and commercial tobacco uses and has the knowledge, commitment, resources and skills to mobilize and deploy strategies to promote and protect the well-being of its members.

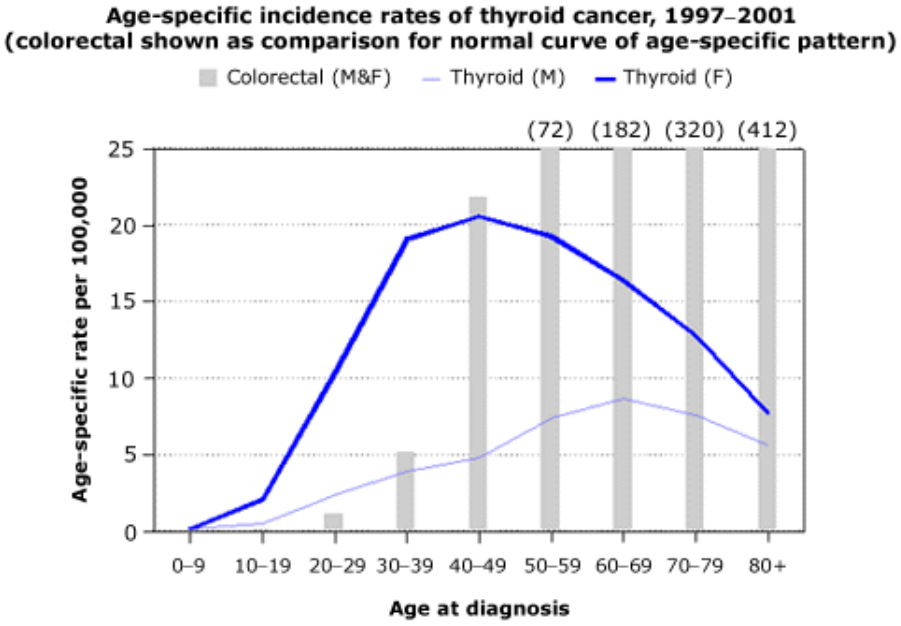
For more information, please contact Cancer Care Ontario's Aboriginal Cancer Care Unit at 416-971-5100, ext. 1261.

See also:

- Cancer in Ontario's First Nations people as compared with the general population (2002, September)
- First Nations Cancer Research and Surveillance Priorities for Canada (2003, September 23-24) PDF

Thyroid cancer most common in young women
Thyroid cancer affects mainly females in their reproductive years. The incidence rate rises steeply from age 10 to 19, peaks in women in their 40s, and then falls. Before age 50, thyroid cancer is at least four times more common in women than men. It ranks 12th among cancers in Ontario for males and females combined.

This pattern differs from that of many common cancers, such as colorectal cancer, which tend to be more common in men and to keep increasing at ages over 50.



Source: Cancer Care Ontario (Ontario Cancer Registry, 2005)

The thyroid gland, located under the larynx, requires iodine to produce thyroid hormone, which helps regulate growth and metabolism. Exposure of the thyroid gland to ionizing radiation, especially during childhood, is a well-established risk factor for thyroid cancer. Before the 1960s, high-dose radiation was used to treat some childhood conditions of the head and neck. Most people under 50 in Ontario today would not have had this type of treatment. Radioactive fallout, as experienced by some parts of the world after the Chernobyl nuclear accident, is also a potential source of radiation exposure. There is no evidence, however, of radioactive fallout in Ontario.

Too little iodine in the diet increases the risk of thyroid cancer. This may be why people with goitre (enlarged thyroid), which may be caused by insufficient iodine, have an increased risk. Goitre is more common in women, and the reason for this is not known. In Ontario, iodine is added to salt to reduce the chance of iodine-deficient diets.

Other causes of thyroid cancer and the reasons it mostly affects young women are largely unknown; a small number of patients with thyroid cancer may, however, have a genetic predisposition to develop the disease.

Thyroid cancer is becoming more common in Ontario. The main reason for this is probably that it is being diagnosed more frequently, even without any symptoms. Non-invasive techniques for investigating nodules that could be cancer have become more accessible. Before such techniques were available, many thyroid cancers could have remained undiagnosed, perhaps throughout the lifetime, without causing any serious symptoms or problems.

The vast majority of thyroid cancers are either follicular or papillary types, which generally has an excellent response to treatment. Most adults diagnosed with cancer confined to the thyroid have a lifespan similar to their peers without this disease.

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

People news

Kamini Milnes been appointed director of Informatics for Cancer Care Ontario effective March 21, 2005. Kamini comes to CCO from Sunnybrook & Women's College Health Sciences Centre, where she is the director of Decision Support. At CCO, Kamini will have overall responsibility for CCO's enterprise-wide informatics and data management strategy, and for the operations that support it.

The MOHLTC Health Results Team has appointed **Sarah Kramer** to chair its Wait Time Information Management Expert Panel. Sarah will report to Dr. Alan Hudson, head of the Wait Time Strategy. The panel will develop a strategy and implementation plan for a comprehensive information system to manage wait times and monitor access. Sarah also will continue in her capacity as provincial vice president and chief information officer at Cancer Care Ontario.

Coming this Spring ...

Next month, the Cancer Quality Council of Ontario, in partnership with Cancer Care Ontario, will release the first-ever Cancer System Quality Index for Ontario – a set of indicators that capture levels of quality and performance across the cancer system.

The goal of the initiative is to stimulate quality improvement by reporting to the public on cancer system performance. Arranged according to the strategic goals for the cancer system, the Index will report on Ontario's progress towards improving: access, outcomes, use of evidence, measurement, and efficiency. In addition to improving accountability through public reporting, the Cancer System Quality Index will support provincial priority setting and will be a key input into regional planning activities.

Contact Us

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