CANCERTAINTY

EQUAL AND FAIR CANCER TREATMENT FOR ALL

Cancer in Ontario:

OPEN FOR BETTER

CanCertainty's Vision and Recommendations

for the 2024-28 Ontario Cancer Plan

November 2023

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1. About CanCertainty

The CanCertainty Coalition is the united voice of more than 30 Canadian patient groups, cancer health charities and caregiver organizations working with oncologists and cancer care professionals to improve the affordability and accessibility of cancer treatment.

CanCertainty Coalition Members include:

- Aplastic Anemia and Myelodysplasia Association of Canada (AAMAC)
- Best Medicines Coalition
- Bladder Cancer Canada
- Brain Tumour Foundation of Canada
- Canadian Breast Cancer Network (CBCN)
- Canadian Cancer Survivor Network
- Canadian Liver Foundation
- Canadian Skin Cancer Foundation
- Canadian Skin Patient Alliance
- Cancer Advocacy Coalition of Canada (CACC)
- Cancer Fight Club: Facebook
- Canadian Neuroendocrine Tumour Society (CNETS)
- Chronic Myelogenous Leukemia Society of Canada (CML Society)
- CLL Canada
- Colorectal Cancer Canada
- Colorectal Cancer Resource & Action Network
- Gastrointestinal Society
- GIST Sarcoma Life Raft Group Canada
- Hope and Cope
- Kidney Cancer Canada
- Leukemia and Lymphoma Society of Canada
- Lung Cancer Canada
- Lymphoma Canada
- Melanoma Canada
- Myeloma Canada
- Ovarian Cancer Canada
- Pancreatic Cancer Canada
- Rethink Breast Cancer
- Save Your Skin Foundation
- Testicular Cancer Canada
- The Canadian CML Network

- Thyroid Cancer Canada
- West Island Cancer Wellness Centre
- Young Adult Cancer Canada

CanCertainty is also supported by the following organizations:

- Anal Cancer Support Group
- Physician Alliance for Cancer Care and Treatment (PACCT)
- Canadian Breast Cancer Support Fund
- Glad of Hope
- Life Saving Therapies Network

CanCertainty received support from Merck Canada to hold a virtual stakeholder roundtable on cancer care in September 2023 to help inform the development of this vision paper.

2. Why we need a new vision for cancer care in Ontario

Ontario, like the rest of Canada, is facing a cancer crisis.

As of January 1, 2018, a total of 678,545 cases had been diagnosed in Ontario over the previous 25 years, representing about 40% of all cancer cases in Canada.[1] In the past five years there have been hundreds of thousands more.

In 2023, a total of 94,100 new cases of cancer are expected to be diagnosed in Ontario, one case for every 187 residents of the province, a rate higher than for any province west of Ontario and 15% higher than the incidence rate in British Columbia.[2]

Across Canada, cancer is the leading cause of death, responsible for more than one in four of all deaths – 82,822 of a total of 311,640 in 2022 and an increase of 3.5% from the number four years earlier in 2017.[3] It is estimated that cancer will cause 32,200 deaths in Ontario in 2023 – about 88 per day.[4]

Additional measures and resources need to be deployed to improve these numbers as quickly as possible.

Adding to the toll cancer has taken for many years is the impact of the COVID-19 pandemic which delayed many tests and preventive screenings for cancer as well as adding to ongoing pressures on the operation of the public health system. The result is already evident with the

[1] Canadian Cancer Society, *Canadian Cancer Statistics: A 2022 special report on cancer prevalence*, Prevalence by geographic region, p. 18.
[2] Canadian Cancer Society, *Canadian Cancer Statistics 2023*, Incidence by geographic region, p. 16.
[3] Statistics Canada, *Leading causes of death, total population, by age group*, Aug. 28, 2023.
[4] Canadian Cancer Society, *Canadian Cancer Statistics 2023*, Table 2.5 Geographic distribution of projected cancer deaths and age-standardized mortality rates (ASMR), by province and territory, both sexes, Canada, 2023, p. 40.

finding that in 2020, the first year of the pandemic, new cancer cases in Canada declined by 6.9% rather than increasing, as expected, by 3%.[5] This is not good news because those "missing" cancer cases have not vanished but instead will be diagnosed later than they would have otherwise.

The cumulative effect of this is, according to the Canadian Partnership Against Cancer: "A higher than normal number of new cancer diagnoses is anticipated over the next couple of years due to pandemic-related screening delays, suspensions of elective cancer-detecting procedures such as biopsies and scopes, travel disruptions that prevented people from seeing healthcare providers, and patients' reluctance to see their primary care providers in person."[6]

Other jurisdictions in Canada have recently adopted cancer plans with concrete goals and measures to improve their cancer care system.

In British Columbia, the government launched a new action plan in February 2023 to better detect, treat and prevent cancers. The plan is supported by an initial investment of $440 million to expand cancer care teams and service hours, to improve cancer screening programs, support cancer research, increase Indigenous patient support positions, support patients who must travel for care from rural communities and to introduce revised pay structures to attract more cancer care professionals to the province. The plan also provides a grant to the BC Cancer Foundation for new cancer research and to help integrate new research findings into cancer care in the province.[7]

Prince Edward Island – Canada's smallest province – released in March 2023 a five-year action plan that provides a path to reduce cancer risks, advance high-quality care and support the province's residents with cancer. Titled "Making a Difference Together," the plan outlines how the cancer care system will be strengthened and people with cancer given more support.[8]

The Ontario government has an excellent opportunity to strengthen its approach and to improve cancer care through its sixth Ontario Cancer Plan, for 2024-28, expected to be released in spring 2024.

This vision paper was developed by CanCertainty to help inform Ontario's new cancer plan. CanCertainty held a multi-stakeholder roundtable in September 2023, which included patient organizations, patient advocates and health professionals, including oncologists and a

[5] Canadian Partnership Against Cancer, *Road to recovery: Cancer in the COVID-19 era,* Impacts on cancer diagnoses.
[6] Canadian Partnership Against Cancer, *Road to recovery: Cancer in the COVID-19 era*, With cancer, time is of the essence.
[7] BC Cancer, B.C. launches action plan to better detect, treat, prevent cancers, news release, Feb. 24, 2023.
[8] Prince Edward Island, PEI Cancer Action Plan to improve cancer prevention and care, news release, March 3, 2023.

pathologist (see Appendix A for the list of participants)[9] to seek input on the four key elements of this vision:

A. **The best cure: Prevention**
B. **The best prognosis: Screening to ensure earlier diagnosis**
C. **The best patient journey: Diagnosis, care and treatment**
D. **How to get there: Governance, accountability and funding**

This vision paper was also shared for input with CanCertainty member organizations (see the list on pages 3-4).

Action on all four key elements outlined above is urgently needed. We are counting on Ontario to be open to providing better cancer care to patients by adopting a comprehensive new cancer plan with ambitious goals, concrete measures, appropriate funding and a commitment to tracking and publicly reporting on progress achieved.

3. Recommendations of the new vision for cancer care

A. The best cure: Prevention

The best type of cancer care is preventing it from happening at all. Prevention is therefore a foundational and imperative element of an effective cancer care system.

Reducing cancer risk factors

There are several ways in which individuals can reduce their likelihood of getting cancer, including stopping smoking or never smoking to prevent certain forms of lung cancer, avoiding the inhalation of or exposure to known carcinogens, using sunscreen and limiting sun exposure to help prevent skin cancer, maintaining a healthy body weight as well as following a healthy diet with moderate intake of things such as alcohol and unhealthy foods. All these actions should be encouraged among the broad population through continuous education. As well, we need to ensure wide and equitable access to public health programs and primary care as mechanisms to prevent cancer, particularly with remote, Indigenous, underserved and disadvantaged populations.

Addressing social determinants of health

A key aspect of cancer prevention is also addressing social determinants of health, such as safe housing, access to quality food and health services, access to educational and job opportunities and historical trauma and ongoing racism and discrimination.[10] These issues contribute to

[9] The goal of the roundtable was to help inform CanCertainty's input – it was not to achieve consensus among all participants.
[10] Canadian Partnership Against Cancer, Lung Cancer and Equity Report (2020): https://s22457.pcdn.co/wp-content/uploads/2020/11/Lung-cancer-and-equity-report-EN.pdf.

cancer cases and increase the risk of death. In particular, smoking, obesity and misuse of alcohol, which disproportionally affect lower socioeconomic groups, are all risk factors for cancer.[11]

If we are serious about preventing and reducing the incidence of cancer, we need policies in place aimed at improving the health and life conditions of Ontarians.

HPV vaccination and other new cancer vaccines

More direct action to prevent cancer can be taken thanks to the development of vaccines. Vaccination programs are in place for Ontario's young people against the human papillomavirus (HPV), which is the cause of nine out of 10 cases of cervical cancer in women, and causes other cancers in both men and women.[12] In fact, among females, cervical cancer is the fastest increasing cancer (+3.7% per year since 2015), and this cancer can be prevented through vaccination as almost all cervical cancers are caused by HPV.[13]

However, HPV vaccinations, as with other school-based vaccination programs, suffered because of the COVID-19 pandemic. Based on the latest available information, for the 2020-21 school year cohort, only 23.4% were up to date with their immunization against HPV,[14] far off Canada's international commitment to achieve a 90% rate of vaccination of young people for HPV.[15] Steps must be taken to improve this performance and reach the global target.

There are also some exciting late-stage research developments for new personalized mRNA vaccines to treat cancer. Ontario should be preparing now for how it will manage the use of these new cancer vaccines, which will be more like treatments than the preventative role historically associated with vaccines.

Cancer screening for prevention

It is also important to remember that for some cancers, screening programs (discussed more fully in the following section) are not just tools for early diagnosis but also for prevention. This is particularly true for colorectal cancer because polyps identified by screening can be removed before they become malignant. This is evidenced by the marked reduction of colorectal cancer cases within the target population since screening programs were adopted throughout Canada beginning in 2007, resulting in the incidence decreasing by 15% in the 50-64 age group and by 23% in the 65+ age group.[16]

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[11] Health Policy Partnership, February 2023, Why addressing the social determinants of health is essential in cancer policy.
[12] HPV infection is related to: 80% to 90% of anal cancers; 40% of vaginal and vulvar cancers; 40% to 50% of penile cancers; 25% to 35% of mouth and throat cancers. See Canadian Cancer Society, Human papillomavirus.
[13] Canadian Cancer Society, November 2023, Media release.
[14] Public Health Ontario, Immunization Coverage Report for School-Based Programs in Ontario: 2019-20, 2020-21 and 2021-22 School Years with Impact of Catch-up Programs, January 2023.
[15] Government of Canada, Vaccination Coverage Goals and Vaccine Preventable Disease Reduction Targets by 2025.
[16] Canadian Partnership Against Cancer, Key statistics on colorectal cancer screening in Canada.

Recommendations for prevention:

1) Strengthen policies and programs to **address and improve the social determinants of health** and therefore contribute to cancer prevention.

2) Continue and **increase public health education campaigns** to promote smoking cessation, reduced alcohol consumption, use of sunscreen, healthy eating and maintaining a healthy body weight to assist in cancer prevention efforts over the long term. Education on healthy lifestyle should start early in school and innovative ways should be explored for campaigns to reach larger and more diverse populations.

3) Specifically, **reinstitute the Smoke-Free Ontario Strategy Monitoring Report**, which has not been issued since 2018,[17] to raise awareness about progress in reducing tobacco use and to drive further new initiatives.

4) **Develop an alcohol use strategy**, including ensuring that the Ontario government does not expand locations where alcohol can be sold and ensuring the Ontario public health guidance on alcohol consumption is consistent with new guidance from Canada's Guidance on Alcohol and Health led by the Canadian Centre on Substance Use and Addiction[18] to avoid mixed messages to the public, and further publicize that guidance to promote awareness of cancer risk associated with alcohol.

5) **Adopt the following measures to help achieve Canada's commitment to the global HPV vaccination goal of 90%:**

    a. Implement annual targets for HPV vaccination rates and monitor / report on progress

    b. Expand the HPV vaccination program and eligibility timeframe to high schools to allow students who missed shots to catch up

    c. Direct public health units to focus on HPV catch up campaigns

    d. Allow pharmacies to administer HPV vaccinations

    e. Implement a centralized electronic immunization registry to track vaccinations across the province

    f. Adopt a robust communications plan to increase public awareness of the need for vaccinations to prevent cancer and how to get these vaccines.

6) **Further publicize screening for colorectal cancer,** emphasizing its importance not just to find the disease at early stages but to actually prevent it by having non-cancerous polyps removed before they can develop into cancer.

[17] Smoke-Free Ontario Strategy Monitoring Report.
[18] Canadian Centre for Substance Use and Addiction, Canada's Guidance on Alcohol and Health, 2023.

B. The best prognosis: Screening to ensure earlier diagnosis

After preventing cancer from occurring in the first place, the next best option is effective screening to find cancer at the earliest possible stage when it is the most easily treatable and the prognosis for the patient is generally best.

As with vaccinations, cancer screening efforts suffered during the pandemic and, as a result, there have been reports and concerns of more later-stage cancers being diagnosed.[19] While the government of Ontario did make additional investments to address wait times exacerbated by the pandemic, more needs to be done to accelerate cancer screening efforts and diagnosis of cancer.

CanCertainty believes that taking all possible measures to increase screening, and therefore early diagnosis, should be evaluated for rapid implementation in Ontario. Outlined below are several ways in which the government should consider expanding its screening programs. We also need to facilitate and accelerate access to these programs by removing, where possible, requirements to go through primary care providers given the challenges and delays in seeing a family doctor, especially for Ontarians who live in more remote areas.

Lung cancer screening

Screening programs have been developed in recent years for Canada's (and Ontario's) deadliest cancer, lung cancer. An Ontario Lung Cancer Screening Program exists, growing out of a pilot project which ended in March 2021.[20] To meet demand and to further encourage screening to find lung cancer at the earliest stages, Ontario should implement a much wider program geographically and make it more accessible, as it has been done in other provinces, such as British Columbia.[21]

Ontario should also consider adopting a patient self-referral approach to lung cancer screening as was implemented in Alberta. This would allow patients to be referred to lung cancer screening when they know they meet all the criteria rather than waiting to be referred by a physician under the current approach.[22]

The adoption of certain best practices to promote lung cancer screening would also have a very positive impact. For example, the Arnprior and District Family Health Team has demonstrated substantial increases in referrals of qualified patients for lung cancer screening by recording patients' smoking status on their electronic health records and then sending letters about the availability of the provincial lung cancer screening program to potentially eligible patients.

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[19] Duong D, Doctors warn of late diagnoses as cancer screening backlog grows, *CMAJ,* May 31, 2021, 193 (22) E811-E812. See also All.Can (Canada), Optimizing Diagnosis in Canadian Cancer Care.
[20] Cancer Care Ontario, Lung Cancer Screening Program.
[21] BC Cancer, BC Cancer Screening, Get Screened.
[22] Alberta Health Services, Screening for Life.ca, Lung, Get Screened.

Breast cancer screening

Currently in Ontario, breast cancer screening is recommended for high-risk women from age 30-69 using MRI or ultrasound. High-risk is defined by a physician or genetic counselor and is based on family history.[23] For individuals who do not qualify as high-risk, Ontario announced in October 2023 that it was reducing the start age for breast cancer screening from 50 to 40 years old. Therefore, as of fall 2024, eligible individuals aged 40 to 74 will be able to self-refer for a mammogram every two years.[24]

In addition to lowering the age of routine screening for breast cancer and publicizing this important change, education about breast density and its implications in diagnosis should be a routine part of screening visits. The Ontario government recently made a positive policy change by mandating that all patients who have a routine mammogram be notified of their breast density. We also encourage the government to offer additional screening, such as an ultrasound, to women with dense breasts. [25] This will help detect breast cancer in some women with dense breasts, whose cancer may have otherwise been missed in a mammogram.

We also need to address the barriers and inequities for women who are currently eligible for breast screening but who are not getting screened, especially those in racialized and Indigenous communities and those living with low-income and in rural-remote areas.

It is also important to ensure there is good data collection to study the uptake of screening by different populations and its impact on diagnosis trends to inform breast screening programs. To ensure future demands are met, planning must be done to provide appropriate financial, equipment and human resources.

Cervical cancer screening

Several jurisdictions are moving away from physician-conducted PAP tests for cervical cancer towards adopting instead HPV DNA tests. Ontario Health has indicated it is working towards implementing HPV testing, "which is reflective of the latest research and advances in technology."[26] While this is a positive step forward, Ontario Health should also ensure this screening program includes the self-collection of samples (i.e., having participants take their own samples via HPV DNA tests and sending samples by mail). Research suggests that test results from patient-collected samples are of comparable accuracy to clinician-collected samples in detecting moderately to severely abnormal cervical lesions.[27] There is potential for

[23] Ontario Health and Wellness, Breast cancer testing and prevention.
[24] Government of Ontario, Ontario Connecting More Women to Breast Cancer Screening Earlier, news release, October 30, 2023.
[25] Dense Breasts Canada, July 2023, Ontario changes policy to mandate notification of breast density.
[26] Global News, July 2023, Cervical cancer screening for Canadians is changing. Where provinces stand.
[27] Canadian Partnership Against Cancer, HPV primary screening and abnormal screen follow-up, Clinician-collected versus patient-collected samples.

Ontario to increase the levels of cervical cancer screening by encouraging this self-sampling process, especially given the challenges in accessing primary care doctors.[28]

Colorectal cancer screening

Ontario has a low participation rate in its population-based screening program for colorectal cancer, with just 43% of eligible Ontarians having completed a fecal immunochemical test (FIT) within the past two years versus a Canadian participation target rate of 60%. There are significant gaps in uptake of screening related to socioeconomic determinants of health, which should be considered when measures are implemented to improve this low participation rate.[29]

Ontario may also want to consider best practices adopted in other provinces to help increase the participation rate. For instance, the Nova Scotia Colon Cancer Prevention Program does not rely on Nova Scotians to ask their doctors about screening or to arrange it on their own. The program mails home screening FIT every two years to all Nova Scotians aged 50 to 74, starting soon after a person's 50th birthday. It is automatic and there is no need for anyone to apply.[30] As of September 2017, the Nova Scotia Colon Cancer Prevention Program reported that it had identified about 500 individuals with cancer and over 4,000 who had precancerous polyps detected and removed as a result of this program.[31]

Ontario Health (Cancer Care Ontario) at present sends letters to Ontarians in the same age group (50 to 74) inviting them to ask their doctor about getting a FIT kit but does not send the test kit directly to patients.[32] Given that Ontario has a population about 15 times larger than Nova Scotia, achieving a screening result similar to Nova Scotia in Ontario might have identified 7,500 individuals with cancer over the same period.

This is one illustration of what type of positive results can be achieved by emphasizing cancer screening programs and making them more accessible to patients.

The Ontario government should also consider lowering the current eligible age from 50 to 45 to detect colorectal cancer sooner, especially given the recent surge in young patients being diagnosed with this type of cancer.[33]

[28] Alternatively, there are other innovative ways screening for breast or cervical cancer can be brought to patients directly, including mobile clinics able to visit small and isolated communities and those without regular access to a family physician, such as this example from Renfrew County.
[29] Canadian Partnership Against Cancer, Equity-focused interventions to increase colorectal cancer screening.
[30] Nova Scotia Health, Colon Cancer Prevention Program.
[31] Nova Scotia Health Authority, Nova Scotia Cancer Care Program, Cancer Screening Programs.
[32] Cancer Care Ontario, Screening for Colorectal Cancer.
[33] The U.S. Preventive Services Task Force changed its recommendation on colorectal cancer screening in May 2021 to suggest starting to screen people from ages 45-49.

Prostate cancer screening

Ontario is an outlier among the provinces in that it does not currently cover the Prostate Specific Antigen (PSA) test upon referral by a healthcare provider to screen asymptomatic men for prostate cancer.[34] While tools such as PSA tests have similar benefits and limitations as other tests and procedures, it is an inexpensive and straightforward screening tool that Ontario should consider covering for asymptomatic men who make an informed decision with their healthcare provider to take a PSA test to detect early signs of prostate cancer.[35]

Genetic testing

Another aspect of screening and achieving earlier diagnosis involves cancers that are highly hereditary. It is now possible, through gene sequencing, to identify family members of people who have had such cancers who would be highly likely to also get that cancer. By doing so, people either take preventive measures (such as a mastectomy to help prevent a hereditary form of breast cancer) or have very regular testing undertaken to find the cancer at the earliest possible stage.

However, at present in Ontario, genetic testing eligibility criteria are quite strict and there is a shortage of genetic counsellors and gene sequencers as Ontario Health is not paying for them. A Provincial Genetics Program has been established to oversee "the delivery and quality of genetic services across the lifespan for people and families in Ontario."[36] However, this program has only been implemented to date at a few hospitals. In contrast, genetic testing services are readily available for most Ontarians with private insurance, creating a health equity gap between those who rely on the public health system and those with private insurance.

Recommendations for screening:

1) **Increase publicity to promote use of cancer screening services**, including educating Ontarians in the workplace and partnering with patient groups on screening promotion activities. This should also include specific measures to better address the needs of Indigenous and underserved populations.
2) Thoughtfully **evaluate the age requirements associated with screening eligibility**, and the appropriateness of this criterion given the latest evidence of a growing epidemic of early age onset cancers, potentially allowing self-referrals for screening by those outside the designated age range who consider themselves at risk.
3) **For lung cancer screening:**
    a. **Expand the number of lung cancer screening sites** across the province to make it more accessible to all Ontarians at risk.

[34] Cancer Care Ontario, Prostate Cancer Screening with the Prostate Specific Antigen (PSA) Test.
[35] Canadian Cancer Society, Prostate-specific antigen (PSA) test.
[36] Ontario Health, Provincial Genetics Program.

   b. **Allow patient self-referral for lung cancer screening** to both promote increased use of screening and to save the need for a family physician consultation during this time of serious health human resources shortages.

   c. **Encourage Family Health Teams to record patient smoking status on electronic health records** to facilitate referrals of appropriate patients for possible lung cancer screening.

4) **For breast cancer screening:**

   a. **Implement a high-visibility campaign to publicize the lowering of the age of routine breast cancer screening to 40** when it comes into effect in the fall of 2024 with particular emphasis towards communities in which screening rates are low and/or breast cancer rates high.

   b. Ensure **education about breast density** is included as part of screening visits and **change guidelines** to call for those with dense breasts to have additional screening, such as an ultrasound, after their mammogram screening.

   c. **Improve data collection** about screening and subsequent diagnoses to inform future changes in screening recommendations, and **plan in advance for adequate human, equipment and financial resources** to meet screening demands.

5) The implementation of HPV DNA tests to screen for **cervical cancer** should include **self-sampling via mailout kits**, as has been done effectively in other jurisdictions and which would save health human resources. Such a change would also help address health equity issues by being a more accessible cervical cancer screening tool for both larger populations as well as promoting rural/urban health equity.

6) **Proactively mail FIT tests** for colorectal cancer screening to eligible residents to increase uptake of the program, including messaging about the test's role not just in detecting the cancer earlier but in preventing it.

7) **Fund PSA tests for asymptomatic men upon referral** by a healthcare provider to help detect early signs of prostate cancer.

8) Facilitate **greater access to genetic screening and testing** for those at risk of hereditary cancers. This should include increasing public awareness and access to gene sequencing as well as to the services of genetic counsellors. This is an area of disparity at present between those with private health insurance and those relying on the public plan exclusively.

C. The best patient journey: Diagnosis, care and treatment

The advances in all aspects of cancer treatment in recent years is a real good-news story. Many types of treatment have been discovered, developed and become available that allow much more targeted and successful treatment of many forms of cancer.

Such developments have important implications for our public health system because there is now so much more that can – and must – be done for patients who receive a cancer diagnosis, such as:

- Tumours need to be screened molecularly and/or genetically to determine their exact type as this has important implications for potential treatment options. This means tumours are not just examined by a pathologist looking physically at it through a microscope but also by conducting molecular and genetic pathology to determine its exact type.
- In the treatment of many cancers, important learnings have been made about the benefits of providing certain other treatments (radiation, immunotherapy or other treatments) prior to surgery and after cancer surgery.
- More patients need to be examined with advanced scanning images to complete the diagnosis process and cancer staging to allow a proper and informed evaluation of all the potential treatment options.
- Given the number of treatment options now available, there needs to be more discussions between a patient and his/her medical team to help determine the best treatment for that patient based on personal values and goals and overall health.

All these developments are either new or greatly advanced (either in terms of technology or numbers of patients involved) since the time the province prepared its last Ontario Cancer Plan. This has important implications for the structure of the health system and its need to be as efficient as possible so that patients can be diagnosed and treated as quickly as possible.

In this context, we have outlined below key areas of the cancer care system that should be improved.

Primary care education

Given the pivotal role family physicians play in the healthcare system and overall management of patients, it is important to ensure they are provided with updated education and information related to cancer and their patients.

They need to understand and to be up to date on cancer screening criteria and protocols so they can encourage as many patients as possible to get screened if eligible.

They also need to be trained to help manage routine care of their patients following a cancer diagnosis and during and post treatment to alleviate some of the care burden from the cancer teams.

Finally, primary care providers should be educated on the rising rates of early-age onset cancers, so that symptoms are not dismissed as something more benign based on a patient's age and the cancer can be diagnosed and treated at the earliest stage possible.

Accelerating diagnosis

It is crucial that the whole diagnosis process be completed as quickly as possible so treatment strategies can be determined, choices made and treatment started. Ontario has adopted some best practices that have helped reduce diagnosis wait times, such as the implementation of its Diagnostic Assessment Program (DAP) throughout the province of Ontario. We need to build on this and address some of the outstanding gaps outlined below, especially given wait times that have been exacerbated due to the COVID pandemic.[37]

Ontario, and Canada as a whole, has far too few medical scanning devices and other diagnostic tools such as colonoscopy equipment to meet both the needs of a rapidly increasing and aging population as well as the increased uses being made of such devices.[38] More scanners and other diagnostic equipment are needed to speed the assessment of cancer patients. These assessments must be done prior to initiation of the treatment for individual patients. For patients with potentially curable cancers, the probability of cure drops by 1-3% for every week of delay in initiation of therapy.[39] For patients with metastatic malignancies, speed of therapy initiation is also crucially important. For example, 4% of remaining patients with metastatic non-small cell lung cancer will die each week that therapy initiation is delayed[40] and many others will deteriorate to the point that they can no longer tolerate therapy.

Compounding the shortage of scanners is the shortage of staff to run them, resulting in the small number of available scanners not being run as much as they could to speed up cancer diagnoses. Not only is there a shortage of technicians, nurses and others to run this equipment, but Canada is also near the bottom of the rankings of OECD countries in number of medical specialists per million population.[41] These specialists are essential not just for providing

[37] All.Can (Canada), Optimizing Diagnosis in Canadian Cancer Care.
[38] The numbers of such scanners per capita in Canada is one of the lowest in the developed world. For example, Canada has just 1.7 MRI scanners in ambulatory care settings per million inhabitants, compared to 28.5 per million in Greece and 22.1 per million in Germany. Canada has just 1 CT scanner per million inhabitants compared to 20 per million in Germany. See OECD data: Magnetic resonance imaging (MRI) units and Computed tomography (CT) scanners.
[39] Khorana A et al, Time to initial cancer treatment in the United States and association with survival over time: An observational study, *PLOS One*, March 2019.
[40] Stewart DJ et al, The need for speed in advanced non-small cell lung cancer: A population kinetics assessment, *Cancer Medicine*, Nov. 11, 2021.
[41] For example, in 2021 there were 3,490 physician specialists per million population in Germany, 2,360 in the United Kingdom and 1,960 in Australia versus 1,470 in Canada. See OECD data: Physicians by Categories, 2021.

treatment but also for diagnostic and staging procedures. All of this slows the cancer evaluation and staging processes that are needed prior to initiation of treatment – all to the detriment of the physical and mental health of cancer patients.

A new but rapidly progressing development is with liquid biopsies – being able to learn about cancer tumours from blood samples. This new technology could allow rapid changes to the process of cancer diagnosis as it gets perfected and its common use in the near future should be planned for.

There also needs to be better coordination of diagnostics and laboratory testing to prevent unnecessary delays for patients. This is not just for the first diagnosis – testing needs to be far more accessible and efficient throughout the progression and treatment of cancer. If follow-up scans cannot be done in a timely fashion for patients being treated for advanced malignancies, detection of tumor progression on treatment may be delayed. This results in continuation of a therapy that is ineffective for a given patient, which is very expensive and potentially toxic.

As well, genomic testing, which finds genes, proteins and other substances in the cancer to guide treatment decisions, has become standard of care in oncology. Ontario lags in terms of providing timely access to these tests and reporting results when they are conducted to inform clinical decisions in a timely manner. A recent report identified the following measures for Ontario to optimize access to genomic testing:[42]

- "Ontario must shift away from the Ministry [the health ministry] acting as a decision-maker for the funding of individual tests, and toward a system of Ministry as a steward. This will ensure expenditure and care quality are driven by needs of the clinical community and avoid unnecessary patient delay.
- Ontario has numerous, loosely connected systems of evaluation of testing. It must consolidate evaluation processes and adopt a single-entry approach, supported by horizon scanning.
- Ontario must create an integrated laboratory information system integrated with clinical health records to provide genetic testing that will most benefit patients and care providers while reducing unnecessary expenditure."

Regarding genomic testing, a low-hanging fruit would be to standardize how results are being reported and ensuring that they are, at minimum, included in pathology reports. Standardization of quality assurance procedures would also be useful.

As well, genomic testing for oncology currently falls under a broad genetic testing program that also includes hereditary genetics. The program is therefore not tailored to the needs of oncology. For example, in testing for and managing hereditary genetics, there is too much focus on perfection over speed and privacy technicalities over timely communication to oncologists. It is important for the delivery of precision medicine that genomic testing for oncology be

[42] Ontario: Towards the routine use of genome-based testing in Canada: State of Readiness Progress Report.

separated from the broader genetic testing system and to increase local capacity within Ontario to meet this demand.

There is also a severe and rate-limiting shortage of medical laboratory technologists. These are allied health professionals who work in the laboratory and assist in both basic diagnosis as well as advanced genomic testing. Many more are needed but not enough are being trained and working conditions, as well as remuneration levels, are very poor.

Finally, as with other steps in the continuum of cancer care, performance measures need to be set and measured to ensure timely diagnoses for each type of cancer. All.Can (Canada) has developed the beginnings of a quality framework to help facilitate measurement of diagnosis outcomes that matter to patients.[43] As part of this process, it is important for everyone to have reasonable timelines that can be expected to finalize specifics of the diagnosis and start first-line treatment in each type of cancer. These should be known to care providers so they can set patient expectations and advocate on their behalf to ensure they are met.

Better and more coordinated care

The number of people with cancer requiring care and treatment is increasing due to the aging and growing population but also since people with cancer are living longer. This is good news but puts more strain on healthcare resources. New ways need to be identified to keep up with the demand and provide quality and timely cancer care, including a survivorship care plan.

In this context, and as previously mentioned, primary care providers could be asked to play a larger role in cancer care. We could train family doctors in oncology so that they can help better recognize symptoms and accelerate diagnosis but also to help manage a broader range of some aspects of care and treatments for cancer patients.

As well, at present too few nurses and physician assistants are funded via cancer care budgets. They are often supported through philanthropy funding and other hospital budgets. We need to increase and fund more nurses, nurse practitioners and physician assistants in oncology to help better coordinate and manage care. This would also help oncologists focus more of their time on treating patients rather than filling out paperwork and inputting information in the electronic system.

Another need is to better centralize referrals, as there are currently 58 health teams in Ontario. Blocks of specialists must be better matched to needs.

There also needs to be better coordination and sharing of data so patients don't have to retell their story and bring all of their documents with them when they meet new doctors or specialists. A better system should be implemented to connect all files. A low-hanging fruit would be to at least require all cancer centres to participate in "Connecting Ontario" so that health professionals can access test results from other hospitals and clinics. "Connecting

[43] All.Can (Canada), Optimizing Diagnosis in Canadian Cancer Care.

Ontario" should also be modernized. It is a step in the right direction but is slow and cumbersome.

It is also important for the Ontario cancer system, and all its players, to know what is going on in the system. Such data can drive rapid improvements in areas that are falling behind and can also guide the allocation and re-allocation of resources to effectively and quickly meet changing needs. The essential tool for this is reliable and timely data. As a result, patient registries are the key building block for improvements and care coordination. Investment in both the technology and development of processes to streamline the collection and use of data is vital to allow the collection and use of meaningful information that can help guide and transform patient care.

Finally, it is important that the Ontario cancer care system recognize and focus special efforts on vulnerable and underserved populations and communities to equalize the provision of care to the greatest extent possible. This may take extra resources, but it is a responsibility we have as a society. Additionally, resources should be committed for the technology that today can bring high-level medical care virtually to almost any location. The geography of Ontario offers the opportunity for the province to become a world leader in this important area.

Additional cancer care guidelines

Cancer Care Ontario has a rigorous process in place, which involves key treating oncologists and other clinicians, to develop evidence-based guidelines for the diagnosis and management of cancers. However, the province should ensure resources are available so that Cancer Care Ontario can develop additional guidelines and regularly update existing ones to ensure greater consistency of high-quality care throughout the provincial system. These guidelines and care pathways should also incorporate the concept of "shared decision-making", to ensure patients, families and their care team understand treatment options and can be involved in care decisions.

Increased psycho-social support

Given that cancer diagnosis takes a toll on patients and their families, they will often require psycho-social support to help them cope with this challenging time. However, it is currently very difficult to obtain this type of support and wait times are much too long.

Fortunately for cancer patients and their families and friends, a lot of excellent support and resources are available to them through many patient or advocacy groups, either for cancer patients generally or for those with specific cancers, and working at the local, provincial and national levels. These groups, small and large, provide an essential element of cancer care in Ontario and should be encouraged, as should the large but informal support provided by family and friends.

A potential model to be encouraged in Ontario would be that of the West Island Cancer Wellness Centre on the western portion of the Island of Montreal but serving also the western part of Quebec and residents of far eastern Ontario. This facility works closely in support of the

medical system to assist patients with non-medical aspects of their care encompassing the full spectrum of wellness that, along with physical elements includes spiritual, emotional, informational, social, systemic and practical needs, also known as the seven pillars of cancer wellness.[44]

The medical cancer system in Ontario should do all it can to encourage the work and contribution of cancer patient groups and wellness centres that provide an important element of cancer care to Ontarians.

Prioritizing home care and palliative care

A key element of cancer care to be considered in the new cancer plan is how and where it is delivered. More care now should be delivered outside of hospitals. Patients want it and technology makes it possible. "Hospital at home" and home care programs that provide cancer care outside the hospital are not only beneficial for suitable patients and their families but also for the healthcare system and its limited physical and human resources.

This includes the provision of palliative care services at home or in standalone palliative care facilities, which should be encouraged. There is also a need to standardize palliative care to ensure that the services that individuals are receiving are equitable, regardless of where they live in Ontario. It is important to recognize that the provision of palliative care goes beyond providing end-of-life services and includes the provision of services at all stages of a potentially life-limiting illness to control symptoms, minimize pain and provide patients greater comfort.

An October 2023 report by the Canadian Cancer Society on palliative care services across Canada noted that while the Auditor General of Ontario has recommended the province have seven hospice beds per 100,000 people, Ontario at present has just half that number (3.47) and less than the national average of 3.97.[45]

Faster publicly funded access to medicines

Many cancer treatments can now be taken in pill form or by subcutaneous injection by patients at home. However, unlike most other Canadian jurisdictions, Ontario only publicly reimburses these treatments for patients over the age of 65. Many essential take-home therapies are not funded for younger Ontario patients because they are not hospital-administered. This should be immediately changed, as Ontarians should not be prevented from accessing cancer therapies because they cannot afford it.

Ontarians also wait far too long before they can access new cancer treatments compared to some other provinces (e.g., Quebec) and compared to many other developed countries.[46]

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[44] West Island Cancer Wellness Centre, The House the Community Built.
[45] Canadian Cancer Society, October 2023, Analyzing Hospice Palliative Care Across Canada: A report on federal, provincial, territorial and community actions.
[46] Glennie J et al, Assessment of listing timeframes for oncology products in Canada, *Provincial Reimbursement Advisor*, IQVIA, Vol. 25, Issue 1, Feb. 2022; and Innovative Medicines Canada, Access to medicine.

Countries like the United Kingdom, Germany, Italy and France provide rapid and early access to cancer medicines and sometimes even before regulatory approval. Canada instead delays public funding for new cancer medicines, taking on average of 1.5 years following Health Canada approval to reimburse these treatments.[47] In fact, Canada ranks 19th out of 20 OECD countries when it comes to public funding of new medicines.[48]

Effective new therapies can alleviate patient suffering by shrinking advanced cancers, yet Ontario patients are denied access to many of these new therapies. These medicines can also prolong high-quality life for cancer patients. Funding delays lead to a very large number of potential life-years lost.[49] The delays are due to the fact that new medicines, once approved by Health Canada, have to go through a complex multi-step and lengthy process before they can be reimbursed by the province.

In particular, the pan-Canadian body responsible for negotiating the prices of all new medicines in Canada, the pan-Canadian Pharmaceutical Alliance (pCPA), takes on average 10 months to complete negotiations. The pCPA, which is accountable to the province of Ontario and the other Canadian provinces, often fails to meet its negotiation performance targets.[50] As well, following the conclusion of a pricing agreement with the pCPA, Ontario often takes additional months to fund a new cancer medicine.

There is no reason why cancer patients should wait for a potentially life-saving therapy after Health Canada approval while prices and reimbursement are negotiated. Getting such therapies to patients should be the top priority of the drug evaluation and reimbursement system. This is especially relevant in cases of metastatic or stage IV cancers where time to treatment is of critical importance.

Ontario's new cancer plan must therefore include measures for the Ontario government to streamline reimbursement processes for cancer medicines and set quicker timeframes for their completion. In this regard, more specific measures on how to optimize and accelerate access to new medicines are outlined in a recent report published by CONECTed.[51]

Providing faster access to new approved cancer therapies will also help promote an environment that encourages their early launch as well as the conducting of clinical trials in Canada and Ontario. The latter provides important benefits to patients, up to and including access to life-saving therapy for some.

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[47] IQVIA data, 2023.
[48] Innovative Medicines Canada, Access to medicine.
[49] Gotfrit J et al, Potential Life-Years Lost: The Impact of the Cancer Drug Regulatory and Funding Process in Canada, *The Oncologist*, 2020: Jan;25(1):e130-e137.
[50] pCPA, May 2023, pCPA dashboard.
[51] CONECTed, Getting Better, Faster The Case for Optimizing access to Precision Medicine in the wake of the Revolution in Cancer Care.

Finally, there are other structural and physical changes that should be made to allow better and faster use of cancer therapies. One important aspect would be to enhance "chair capacity" required to administer some cancer treatments. This could be done by extending current hours of operations on weekdays and expand to the weekends to reduce wait times and allow for full utilization of existing physical space and equipment. Addressing health human resource issues therefore becomes an important factor to allow such needed expansion of service for cancer patients. In the future, chair capacity challenges may be alleviated in part by the increasing number of effective new monoclonal antibodies that can be subcutaneously self-administered by patients at home, rather than requiring intravenous administration at a cancer centre.

As well, more hospital beds are needed for some of the new therapies, like CAR-T treatments, which requires patients to stay overnight in hospital while the treatment is being administered. Similarly, there are several promising new "bispecific T-cell engagers" that require in-patient administration to manage acute, short-term toxicities.

Recommendations for diagnostic, care and treatment:

1) To facilitate prompt complete diagnosis for cancer patients – and therefore speed up the start of the most appropriate treatment – **provide adequate medical specialists and personnel and maintenance funding to ensure existing MRI/PET/CT scanners** can work to their maximum capacity and at least to the same levels as comparable countries.
2) Prepare both system resources and personnel for the coming increased demands for **liquid biopsies** in cancer care.
3) **On genomic testing**, Ontario should:
    a. Ensure **adequate resources for pathology departments** (personnel and equipment) to keep pace with the demands of genomic testing and genetic sequencing of tumours to determine optimal therapy options, including the development of additional Ontario-based resources to conduct these tests. This includes increasing medical laboratory technologists who assist in both basic diagnosis as well as advanced genomic testing.
    b. **Adopt a genomic testing and quality assurance standard policy** to improve the quality and equity across the province and set and publicize the expected timelines for such testing to take place for different types of cancer. Ontario should consider building upon the "tumour first" strategy adopted in British Columbia with the adoption of comprehensive genetic profiling to help identify actionable mutations or alterations so that metastatic cancers can be more effectively treated with the right precision medicine at the right time, improving patient outcomes and quality of life, while reducing overall costs to the healthcare system.
    c. **Separate out genomic testing for oncology** from Ontario's broader genetic testing system.

   d. **Shift away from the health ministry acting as a decision-maker for the funding** of individual tests, and toward a system of health ministry as a steward, consolidate evaluation processes and adopt a single-entry approach and create a laboratory information system integrated with clinical health records. A **low-hanging fruit** would be to at least standardize how results are being reported and that, at minimum, they are included in pathology reports.

4) Invest in **training family physicians** to better recognize cancer symptoms and to be aware of increasing rates of early-age onset cancers to accelerate diagnosis and to manage routine health issues of cancer patients and some aspects of cancer care.

5) **Increase the number of nurses, nurse practitioners and physician assistants** to provide faster, better and more coordinated care and allow oncologists to focus on caring for patients.

6) Better leverage **AI to reduce paperwork** to allow health professionals to focus on caring for the patients and reduce the risk of staff burnout.

7) Develop **a plan to better centralize referrals** and match block of specialists to needs.

8) Implement **a new data system to connect all patient files/test results**. A **low-hanging fruit** would be to at least require all cancer centres to participate in "Connecting Ontario" and to improve the efficiency of "Connecting Ontario".

9) Facilitate the **collection of data about the cancer system with an integrated and comprehensive patient registry system** that minimizes delays and time/bureaucracy caused by privacy protection concerns while also protecting them.

10) **Regularly review and use the data collected in comprehensive patient registries** to course-adjust based on the most recent findings – don't wait for set biannual or other planning cycles.

11) Commit the necessary resources to provide **underserved and vulnerable populations and communities** the cancer care and services they are entitled to, using the latest technology to reach isolated communities in innovative ways.

12) Provide additional resources to Ontario Health (Cancer Care Ontario) so that it can **develop new cancer care guidelines and regularly update existing ones** to ensure greater consistency of high-quality care throughout the provincial system.

13) Allocate more resources **to reduce long wait times to obtain psycho-social support** for cancer patients and their families.

14) Create a working group charged with facilitating, as quickly as possible, the development of additional services and resources **for more home cancer care**, including palliative care, utilizing the latest technology to provide comprehensive "hospital at home" services, thus both meeting patient/family desires and alleviating pressure on the hospital system.

15) Provide immediate **funding so that all cancer medicines, whether administered in hospital or at home, are paid fully through the public health system** without charge to any cancer patient.

16) Work with the federal government, other provincial/territorial jurisdictions and the pharmaceutical industry to develop in the very near future **a plan to provide without cost to the patient any Health Canada-approved cancer therapy, while pricing/reimbursement discussions take place**. A **low-hanging fruit** would be for the province to ensure that it reimburses cancer medicines within one month of an agreement with the pCPA.

17) **Other structural and physical changes** should be made to allow better and faster use of cancer therapies, such as optimizing "chair time" for infusion cancer treatments and providing more hospital beds for CAR-T therapies.

D. How to get there: Governance, accountability and funding

There are several issues related to the governance, accountability and funding of the cancer care system in Ontario that should be addressed in the upcoming Ontario Cancer Plan 2024-28 in order to implement the recommendations set out in the three sections immediately above.

Governance

Ensuring appropriate governance and oversight of the implementation of the cancer plan is important to achieve concrete results. This responsibility needs to be centralized so it is clear where accountability rests. We recommend that the health minister along with the CEO of Ontario Health be clearly identified as the ones responsible for the success of the new cancer plan. As well, the Ontario government could consider appointing an expert advisory panel as was done in British Columbia to ensure the best governance structures and accountability measures are in place to achieve the goals set by the province.[52]

As well, with good governance comes better planning and forecasting to anticipate the cancer needs of Ontarians and be able to meet them. Too few and infrequent overviews of the whole fast-changing cancer environment and technological developments are conducted to allow proper forecasts to be made of the resources that will be needed and when. As a result, the health system, including the cancer care system, is always playing catch-up and not providing the optimal treatment possible to the largest number of patients because adequate resources (human, physical and technological) are not available and/or are not being used efficiently.

For example, we know the needs within the health system to prevent, diagnose and treat cancer are increasing significantly because of the aging of the population and delayed cancer diagnosis due to the pandemic. Forecasting based on demographics and population changes

[52] BC Cancer, October 26, 2023, Expert advisory.

should be conducted and planning should be undertaken to respond to the increased demand for cancer care. Overall budgets and human resources must be expanded, including for Cancer Care Ontario.

Accountability

In order to appropriately measure the success of the cancer plan and of the cancer care system more broadly, clear and specific performance indicators need to be determined. We need to be able to assess progress made against the goals of the plan, identify any outstanding gaps and develop solutions to address them.

Further, to ensure accountability, there needs to be up-to-date, transparent data and reporting that is easily accessible to monitor and track progress of the cancer system. A best practice to consider in this area is Quebec's health system performance dashboard, which includes updates on cancer care performance and is published online and publicly available.[53]

Public reporting and transparency of Ontario's cancer data presents an opportunity for improvement. Since Cancer Care Ontario merged with Ontario Health in 2019, cancer data and reporting has become difficult to access. Furthermore, annual cancer reports via the Cancer Quality Council of Ontario have not been publicly available since 2021.

Finally, to promote accountability and respond to patient and care system needs in oncology, there needs to be ongoing engagement with the broader cancer stakeholder community, including patient groups, clinicians, health providers, researchers and industry. For instance, while Cancer Care Ontario engaged the patient and family advisory committee, clinical leads, provincial clinical heads, regional cancer programs and other selected stakeholders in the development of the sixth cancer plan, there were no formal opportunities for input nor forums to engage the broader cancer community.

Funding

Allocating appropriate funding to support the implementation of this strategy and improving cancer care in the province is key. For instance, the British Columbia government allocated targeted funding to help implement its recently adopted cancer strategy. Specifically, the additional funding that the Ontario government receives through the Canada Health Transfer should be prioritized for cancer care, given cancer is the leading cause of death in Ontario.

As well, when it comes to funding of cancer care, one of the current challenges is that the drug portfolio is split between Cancer Care Ontario and Ontario Public Drug Programs which causes inefficiencies and delays. Further, Cancer Care Ontario does not have control over scanners for use in the cancer system. This should be rectified so cancer diagnostics can be planned and carried out more effectively. A more independent Cancer Care Ontario should also model to plan more effectively the funding and personnel needs for cancer care and should have more control over creating its own model for funding and availability of cancer medicines.

[53] See the Quebec healthcare dashboard here.

Recommendations for governance, accountability and funding:

1) Charge Ontario Health with **meeting specific cancer care targets** and to be held accountable to the citizens of Ontario annually for their performance.

2) Direct Ontario Health to **publish annual reports on cancer care** that provide updates on successes and challenges in implementing the cancer plan, including performance indicators and evaluation outcomes.

3) Implement a **cancer care performance dashboard** that is publicly available and that provides timely updates on key performance indicators for cancer care (e.g., number of Ontarians screened for cancer and timelines for screening, wait time for referral to specialists, wait time for cancer diagnostic procedures/testing such MRI/PET/CT scans, genomic tests, wait time for start of treatment, etc.). This dashboard should include both province-wide and regional/city data to better understand the performance of the system.

4) Conduct **regular studies of the complete cancer care network and coming changes** to plot needs for new personnel, equipment and other resources based on predictable demand, rather than constantly playing catch-up.

5) **Create systems and procedures for cancer care independent of other parts of the health system** such as its own processes in deciding what cancer drugs to provide and when, dedicated diagnostic services such as scanners and the personnel to use them, other dedicated hospital services, innovative home care services and services for isolated and/or underserved communities.

6) Task Ontario Health (Cancer Care Ontario) with **holding consultations with the broader cancer community, including patient groups, clinicians, health providers, researchers and industry,** to help inform the development of cancer plans as well as to continuously engage the community to assess progress of the plans and adjust course when needed.

7) **Allocate appropriate funding** to support the implementation of the new cancer plan and to improve cancer care in the province. Part of the additional funding the province receives through the Canada Health Transfer should be used for this purpose.

4. Conclusion

Cancer care in Ontario needs a comprehensive plan and funding to meet the reasonable expectations of Ontarians that our public health system will be there for them when their worst fears become reality with a cancer diagnosis.

What we want to achieve in Ontario – what we need to achieve – is the greatest possible chance of success for every person in Ontario who gets cancer, while also decreasing that number by more effective prevention and screening.

The challenges facing the Ontario cancer care system are great, but so are the opportunities. We can, through Ontario Cancer Plan 2024-2028, create a better cancer care system that offers all Ontarians the promise of unexcelled care, prompt and effective treatment and survivorship.

5. Summary of recommendations

A. The best cure: Prevention

1) Strengthen policies and programs to **address and improve the social determinants of health** and therefore contribute to cancer prevention.

2) Continue and **increase public health education campaigns** to promote smoking cessation, reduced alcohol consumption, use of sunscreen, healthy eating and maintaining a healthy body weight to assist in cancer prevention efforts over the long term. Education on healthy lifestyle should start early in school and innovative ways should be explored for campaigns to reach larger and more diverse populations.

3) Specifically, **reinstitute the Smoke-Free Ontario Strategy Monitoring Report**, which has not been issued since 2018, to raise awareness about progress in reducing tobacco use and to drive further new initiatives.

4) **Develop an alcohol use strategy**, including ensuring that the Ontario government does not expand locations where alcohol can be sold and ensuring the Ontario public health guidance on alcohol consumption is consistent with new guidance from Canada's Guidance on Alcohol and Health led by the Canadian Centre on Substance Use and Addiction to avoid mixed messages to the public, and further publicize that guidance to promote awareness of cancer risk associated with alcohol.

5) **Adopt the following measures to help achieve Canada's commitment to the global HPV vaccination goal of 90%:**

    a. Implement annual targets for HPV vaccination rates and monitor / report on progress

    b. Expand the HPV vaccination program and eligibility timeframe to high schools to allow students who missed shots to catch up

c. Direct public health units to focus on HPV catch up campaigns

d. Allow pharmacies to administer HPV vaccinations

e. Implement a centralized electronic immunization registry to track vaccinations across the province

f. Adopt a robust communications plan to increase public awareness of the need for vaccinations to prevent cancer and how to get these vaccines.

6) **Further publicize screening for colorectal cancer,** emphasizing its importance not just to find the disease at early stages but to actually prevent it by having non-cancerous polyps removed before they can develop into cancer.

B. The best prognosis: Screening to ensure earlier diagnosis

1) **Increase publicity to promote use of cancer screening services**, including educating Ontarians in the workplace and partnering with patient groups on screening promotion activities. This should also include specific measures to better address the needs of Indigenous and underserved populations.

2) Thoughtfully **evaluate the age requirements associated with screening eligibility**, and the appropriateness of this criterion given the latest evidence of a growing epidemic of early age onset cancers, potentially allowing self-referrals for screening by those outside the designated age range who consider themselves at risk.

3) **For lung cancer screening:**

   a. **Expand the number of lung cancer screening sites** across the province to make it more accessible to all Ontarians at risk.

   b. **Allow patient self-referral for lung cancer screening** to both promote increased use of screening and to save the need for a family physician consultation during this time of serious health human resources shortages.

   c. **Encourage Family Health Teams to record patient smoking status on electronic health records** to facilitate referrals of appropriate patients for possible lung cancer screening.

4) **For breast cancer screening:**

   a. **Implement a high-visibility campaign to publicize the lowering of the age of routine breast cancer screening to 40** when it comes into effect in the fall of 2024 with particular emphasis towards communities in which screening rates are low and/or breast cancer rates high.

   b. Ensure **education about breast density** is included as part of screening visits and **change guidelines** to call for those with dense breasts to have additional screening, such as an ultrasound, after their mammogram screening.

   c. **Improve data collection** about screening and subsequent diagnoses to inform future changes in screening recommendations, and **plan in advance for adequate human, equipment and financial resources** to meet screening demands.

5) The implementation of HPV DNA tests to screen for **cervical cancer** should include **self-sampling via mailout kits**, as has been done effectively in other jurisdictions and which would save health human resources. Such a change would also help address health equity issues by being a more accessible cervical cancer screening tool for both larger populations as well as promoting rural/urban health equity.

6) **Proactively mail FIT tests** for colorectal cancer screening to eligible residents to increase uptake of the program, including messaging about the test's role not just in detecting the cancer earlier but in preventing it.

7) **Fund PSA tests for asymptomatic men upon referral** by a healthcare provider to help detect early signs of prostate cancer.

8) Facilitate **greater access to genetic screening and testing** for those at risk of hereditary cancers. This should include increasing public awareness and access to gene sequencing as well as to the services of genetic counsellors. This is an area of disparity at present between those with private health insurance and those relying on the public plan exclusively.

C. The best patient journey: Diagnosis, care and treatment

1) To facilitate prompt complete diagnosis for cancer patients – and therefore speed up the start of the most appropriate treatment – **provide adequate medical specialists and personnel and maintenance funding to ensure existing MRI/PET/CT scanners** can work to their maximum capacity and at least to the same levels as comparable countries.

2) Prepare both system resources and personnel for the coming increased demands for **liquid biopsies** in cancer care.

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   a. Ensure **adequate resources for pathology departments** (personnel and equipment) to keep pace with the demands of genomic testing and genetic sequencing of tumours to determine optimal therapy options, including the development of additional Ontario-based resources to conduct these tests. This includes increasing medical laboratory technologists who assist in both basic diagnosis as well as advanced genomic testing.

   b. **Adopt a genomic testing and quality assurance standard policy** to improve the quality and equity across the province and set and publicize the expected timelines for such testing to take place for different types of cancer. Ontario should consider building upon the "tumour first" strategy adopted in British Columbia with the adoption of comprehensive genetic profiling to help identify

actionable mutations or alterations so that metastatic cancers can be more effectively treated with the right precision medicine at the right time, improving patient outcomes and quality of life, while reducing overall costs to the healthcare system.

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11) Commit the necessary resources to provide **underserved and vulnerable populations and communities** the cancer care and services they are entitled to, using the latest technology to reach isolated communities in innovative ways.

12) Provide additional resources to Ontario Health (Cancer Care Ontario) so that it can **develop new cancer care guidelines and regularly update existing ones** to ensure greater consistency of high-quality care throughout the provincial system.

13) Allocate more resources **to reduce long wait times to obtain psycho-social support** for cancer patients and their families.

14) Create a working group charged with facilitating, as quickly as possible, the development of additional services and resources **for more home cancer care**, including palliative care, utilizing the latest technology to provide comprehensive "hospital at home" services, thus both meeting patient/family desires and alleviating pressure on the hospital system.

15) Provide immediate **funding so that all cancer medicines, whether administered in hospital or at home, are paid fully through the public health system** without charge to any cancer patient.

16) Work with the federal government, other provincial/territorial jurisdictions and the pharmaceutical industry to develop in the very near future **a plan to provide without cost to the patient any Health Canada-approved cancer therapy, while pricing/reimbursement discussions take place**. A **low-hanging fruit** would be for the province to ensure that it reimburses cancer medicines within one month of an agreement with the pCPA.

17) **Other structural and physical changes** should be made to allow better and faster use of cancer therapies, such as optimizing "chair time" for infusion cancer treatments and providing more hospital beds for CAR-T therapies.

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7) **Allocate appropriate funding** to support the implementation of the new cancer plan and to improve cancer care in the province. Part of the additional funding the province receives through the Canada Health Transfer should be used for this purpose.

APPENDIX A

Stakeholders who participated in the roundtable on cancer care organized by CanCertainty in September 2023 included:

- Robert Bick, Co-Lead of CanCertainty and Board Member of Kidney Cancer Canada
- Hillary Buchan-Terrell, Advocacy Manager, Canadian Cancer Society
- Marcus Butler, Medical Oncologist, Princess Margaret Cancer Centre
- MJ Decoteau, Executive Director and Founder, Rethink Breast Cancer
- Anris Kica, Co-CEO, Life-Saving Therapies Network
- Cassandra Macaulay, Senior Manager of Programs and Education, Colorectal Cancer Resource & Action Network (CCRAN)
- Lisa Machado, Founder, Canadian CML Network
- Patty Milburn, Treasurer, Canadian VHL Alliance
- Stephen Piazza, Director of Advocacy, Canadian Cancer Society
- Sandeep Sehdev, Medical Oncologist, Ottawa Hospital Cancer Center
- Brandon Sheffield, Pathologist, William Osler Health System
- Robby Spring, Patient with lived experience
- Dave Stewart, Medical Oncologist, Ottawa Hospital Cancer Center
- Yvonne Ta, Medication Reimbursement Specialist, Princess Margaret Cancer Center

CanCertainty would like to also acknowledge the following individuals who were consulted in the preparation of the roundtable and the development of this vision paper:

- Louise Binder, Health Policy Consultant, Save Your Skin Foundation
- Christine Collins, Executive Director, Kidney Cancer Canada
- Peter Glazier, Senior Advisor - Public Affairs, Communications & Strategy, Lung Cancer Canada
- Dorothy Lo, Medical Oncologist, St. Joseph's Health Center
- Keith McIntosh, Health Policy Consultant
- Stéphanie Michaud, President and CEO of BioCanRX
- Bill VanGorder, Chief Operating Officer & Chief Policy Officer, CARP