



**UNDER EMBARGO UNTIL
NOVEMBER 13, 2018**

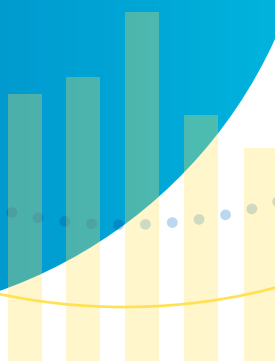


SYSTEM
PERFORMANCE
REPORTS

EXECUTIVE SUMMARY

Cancer System Performance

2018 Report





A person-centred look at progress

Performance of the cancer system along the patient journey

The *2018 Cancer System Performance Report* is the latest in a series of reports that shine a light on areas of Canada’s cancer system – from prevention and screening, through to treatment, survivorship and end-of-life care. It shows key areas where improvement is needed to help drive policy and practice changes to improve the delivery of cancer services and the patient experience.

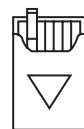
Prevention is the single most important strategy to reduce the burden of cancer for people today and for future generations. Minimizing risk factors for cancer—in particular, smoking, physical inactivity and excessive drinking—could help us prevent up to one-third of cancer cases.¹ However, it is not an easy task. For example, we have long known 85% of lung cancer cases are attributable

to smoking, which is why it has been and remains a key focus of prevention efforts.² Recently, Canada set a goal of reducing smoking rates to 5% of the population by 2035.³ Although smoking rates have dropped by more than half since the 1970s, nationally the rate is still high at 17.4%. However, rates across the country range from a low of 14.1% to 62.1%, depending on the jurisdiction. Clearly, there is a lot more work to do, but if we succeed in meeting the national smoking target from coast to coast, then by 2035 we could have 31,000 fewer people diagnosed with lung cancer and 20,000 fewer people dying from it.

Canadian jurisdictions also vary in other risk factors, including physical inactivity (from 31.8% to

Minimizing risk factors for cancer

Smoking



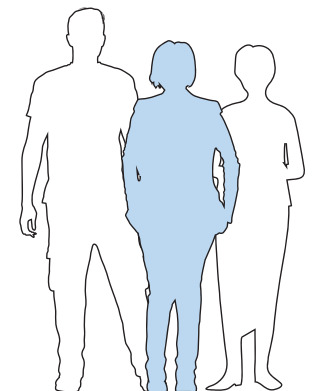
Physical inactivity



Excessive drinking



could help us
**prevent
cancer cases
by up to
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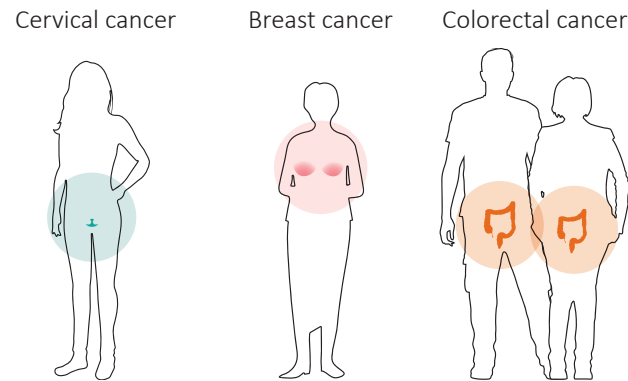


50.3%, depending on the jurisdiction). Excessive drinking is also a problem, ranging from 7.2% to 16.2%, by jurisdiction. These numbers translate to big differences in cancer incidence and a need to expand effective prevention efforts to reach people across Canada.

Despite the success of prevention efforts so far, one in two Canadians will receive a cancer diagnosis in their lifetime.⁴ Our goal for those Canadians is to **reduce the percentage who are diagnosed with late-stage cancer, when treatment is not as effective.** The way to do that is to improve early detection and access to population-based screening, which means administering cancer-screening tests to people considered at average risk for cancer (for example, administering screening mammograms every two to three years to average risk women aged 50-69).

Currently, Canada has population-based screening programs for cervical, breast and colorectal cancer.⁵ As screening programs mature and participation increases, the proportion of late-stage cancers being diagnosed decrease.⁶ Breast cancer screening started more than 20 years ago and has a national self-reported participation rate of 72% of women. Currently, 8.8 times more breast cancer patients are diagnosed at Stage I than at Stage IV. Compare that to population-based colorectal cancer screening, which began after 2007. Only 51% of Canadians in the target age group are screened, and colon cancer is still most commonly diagnosed at Stage III in many reporting jurisdictions, with 1.3 times more patients diagnosed with Stage III than Stage I.

Canada has population-based screening programs for:



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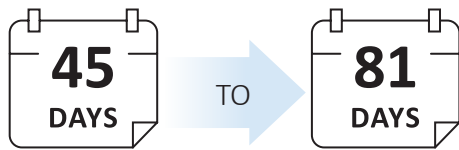
We do expect the proportion of late-stage colorectal cancers diagnosed will decrease in the future as current programs mature and new programs are implemented in two more jurisdictions. As those changes take hold, we anticipate the impact of colorectal screening will come to resemble that of breast cancer screening and lead to substantial improvement in survival.

Screening is most effective at the population level when it follows evidence-based guidelines. Focusing on target populations as per the guidelines increases the chance of actual cancer being caught and lowers the likelihood of false positives, which can result in unnecessary and potentially harmful follow-up tests and procedures. That is why routine mammography

screening of average risk women aged 40–49 is not recommended: compared to older women, the benefits of screening—reducing illness and death—are lower for that age group, while the risk of a false positive is higher.⁷

It is estimated that **every year in Canada, 450,000 mammograms are performed outside of guidelines** on women aged 40–49. If we could reduce that number by just 15%, 7,500 women could avoid the anxiety and potential harm from additional testing that is brought on by false positives, and about \$6.6 million could be redirected to other health care services.

Median wait times between an abnormal fecal test and a follow-up colonoscopy remain long across the country, from



depending on the jurisdiction

After being screened for cancer, a certain number of people are told their test showed an abnormal finding which warrants additional exams. **Waiting to hear back about follow-up tests is one of the highest anxiety periods for patients**, and it is that much worse for those who wait several weeks or months to receive their diagnosis—which too many do.⁸ Take colorectal cancer screening as an example. Depending on the jurisdiction, only 28.8% to 76.4% of people have a follow-up colonoscopy within 60 days after an abnormal fecal test, which means there is still a long way to go to reach the target of 90% of people having a follow-up colonoscopy within 60 days. We need to increase our efforts to coordinate cancer screening and diagnosis, so Canadians spend less time living with the uncertainty and anxiety of not knowing whether they have cancer.

As well as a prompt diagnosis, patients need accurate staging of their cancer, as it has

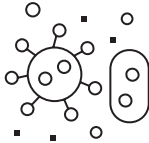


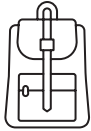
implications for selecting appropriate treatment. Checking for the spread of cancer to the lymph nodes is an important element of staging, and is done by a pathologist, who looks for evidence of cancer in the lymph nodes taken from tissue samples removed by the surgeon. With an insufficient sample, a definitive assessment of the cancer spread may not be possible. Evidence-based guidelines suggest a minimum of 12 nodes need to be examined to ascertain lymph node spread in colon cancer.⁹ Canada is doing reasonably well in this regard: eight in 10 patients with colon cancer had 12 or more lymph nodes removed and examined by a pathologist (ranging from 71.4% to 91.0% across the country).

Investing in innovative research, and having patients participate in clinical trials, are essential for developing new treatments for more effective cancer care. However, few Canadians take part in trials, with participation by adults ranging from less than 1% to 5.8% of incident cases, depending on where they live. We need to work harder to expand the number of clinical trials for cancer in Canada and to increase patient awareness and participation in them.

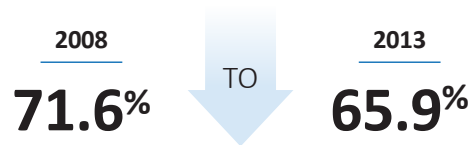
Evidence from clinical trials is also used to develop guidelines for cancer diagnosis and treatment. **In Canada, adherence to evidence-based guidelines is relatively high, but it can be better.** The percentage of patients with Stage II or III rectal cancer, for example, who receive the pre-operative radiation therapy recommended in guidelines remains at 54.8% (ranging from 52.5% to 64.7% by jurisdiction).¹⁰ Data suggest some patients diagnosed with rectal cancer are not referred by their surgeon to an oncologist to be considered for pre-operative radiation.¹¹ Another example is the percentage of patients with locally advanced lung cancer who receive the post-operative chemotherapy that guidelines call for, has stagnated at 46.4%, and even decreased in patients aged 18-59. However, it should be remembered that while guidelines are important, other factors are considered when clinicians are discussing treatment options with their patients. Patients’ preferences, other illnesses and ability to tolerate the treatment regime are all reasons guideline-recommended therapy might not be given.

A high-quality cancer care system is one that is focused on the person, not only on treating the tumour. In addition to their physical symptoms,

After treatment, patients experience diverse physical, emotion and practical challenges such as:

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| | | For younger patients | |
|  |  |  |  |
| worrying the cancer will return | problems with sexual intimacy | concerns about fertility | returning to school or work |

The percentage of cancer patients dying in hospital decreased from



Resources and supports for end-of-life care include:



pain control



supportive home care

The cancer care and broader health care systems should ensure resources and supports for end-of-life care are available to cancer patients who choose to be at home.

people with cancer experience emotional and practical concerns before, during and after treatment. Health care professionals can only respond to those needs if they are aware of them and have the resources and support to do so. Tools that encourage patients to describe their quality of life, treatment symptoms and side effects (such as the Edmonton Symptom Assessment System–revised) allow patients to report regularly on the nature and intensity of their symptoms.¹² **Fatigue is the most common symptom of distress reported by patients while receiving cancer treatment (75.6%), followed by anxiety (56.5%).** Health care providers can use this information to recommend resources for alleviating symptoms and to have meaningful and supportive conversations with patients.

After treatment is complete, patients continue to experience physical, emotional and practical challenges such as worrying about whether the cancer will return, problems with sexual intimacy, and for younger patients, concerns about fertility and returning to school or work.⁸ Some people feel like they are on their own after

cancer treatment ends, with no clear pathway for support from the general health care system (including community and primary care). **One-third of people report waiting more than a year to get help** for the most difficult physical, emotional or practical concern they face after completing treatment. There is clearly a major need to improve how we care for and support patients in their transition to a new normal after treatment ends.

In cases where cancer is advanced, patients, families and their health care providers need to discuss advanced care options to manage symptoms. This is called palliative care and includes treatment and support that is focused on providing the best possible quality of life in accordance with the preferences and values of patients and their families. **Patients often prefer to spend their last days at home surrounded by their loved ones, not in a hospital.**¹³ The percentage of cancer patients dying in hospital decreased from 71.6% in 2008 to 65.9% in 2013. That’s moving in the right direction, but to continue this progress, the cancer care and

broader health care systems should ensure resources and supports for end-of-life care, including pain control and supportive home care, are available to cancer patients who choose to be at home.

In summary, **Canada’s cancer control system has made substantial progress** in reducing the risk of cancer, and in improving the experience and outcomes of care for those affected by it. However, as outlined in the report, **there is still considerable room for improvement.** We need to expand the availability and use of health system data and keep measuring and monitoring our progress if we are to continue to improve the quality and effectiveness of cancer control in Canada and respond to the challenges that lie ahead.