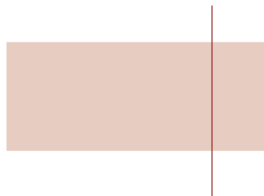
Comparative Overview Of Cancer Control Strategies In Selected Jurisdictions

Summary

AGENCE D'ÉVALUATION DES TECHNOLOGIES
ET DES MODES D'INTERVENTION EN SANTÉ

Québec



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Report prepared for AETMIS by

Lorraine Caron

with the collaboration of Mirella De Civita, Susan Law and Isabelle Brault

October 2007

Agence d'évaluation des technologies et des modes d'intervention en santé

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Mission

The mission of the Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS) is to help improve the Québec health-care system. To this end, it advises and supports the Minister of Health and Social Services and decision-makers in the health-care system with regard to the assessment of health services and technologies. The Agency makes recommendations based on scientific reports assessing the introduction, diffusion and use of health technologies, including technical aids for the disabled, as well as the methods of providing and organizing services. The assessments examine many different factors, such as efficacy, safety and efficiency, as well as ethical, social, organizational and economic issues.

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Preface

Comparative Overview Of Cancer Control Strategies In Selected Jurisdictions

Nearly ten years after its publication, the *Programme québécois de lutte contre le cancer* (Québec Cancer Control Program, PQLC) is still a leading-edge strategic base, thanks to its integrated, global approach, which takes the entire service continuum into account, and to its organizational vision, which seeks to provide high-quality care and services centred on cancer patients and their families. However, implementing such a program requires numerous changes to the way things are done, which, without any doubt, constitutes a huge challenge, both for the governance structures and to those who dedicate themselves on the ground.

It was in this context that the Centre de coordination de la lutte contre le cancer au Québec (CCLCQ), which was charged with providing leadership and coordinating the regional efforts to implement the program, asked AETMIS, in 2002, to conduct a review of the cancer control strategies and programs in selected countries and Canadian provinces. This review was requested to provide decision makers with solid, relevant information on the choices made by different public administrations regarding priorities, governance models, service organization and quality, and the factors of success for implementing change.

In 2003, the Minister of Health and Social Services made cancer control one of his priorities. The Groupe de travail ministériel en cancer (Ministerial Cancer Task Force, MCTF) was set up to improve the management and impact of the PQLC. In the course of its work, AETMIS submitted to the MCTF the preliminary findings of the review of cancer control strategies and programs. Following the MCTF's recommendations in 2004, the Minister of Health renewed the dedicated governance structure by creating the Direction de la lutte contre le cancer (DLCC), whose responsibilities were focused on the organization and quality of cancer services.

This report, which is based on a detailed literature search, interviews with key informants, and both a cautious and rigorous analysis, constitutes a hitherto unpublished knowledge base on cancer control strategies and programs. We hope this information will help better understand the similarities and differences between the approaches in the different countries and provinces covered by this report and help draw useful lessons for the continuous improvement of Québec's Cancer Control Program implementation.

Juan Roberto Iglesias, MD, MSc
President and Chief Executive Officer

The report in brief

This comparative overview of cancer control strategies (and programs) in selected countries and Canadian provinces is aimed at a better knowledge of the choices made by different public administrations regarding priorities, governance models, service organization and quality, and the factors of success for implementing change. The overview looks at England, France, Alberta, British Columbia, Nova Scotia, Ontario and Québec.

First, it emerges that while the priorities are different, the initiatives recommended in the current strategies overlap and have two main cancer-control objectives: to ensure the ability of the health-care system to deal with a growing demand for services and to ensure an optimal care pathway for known and suspected cancer patients. We find wide diversity in the means of implementation used, whether for service organization, the governance model or levers of change.

There are two underlying philosophies, depending on whether or not a disease management approach has been developed. In effect, while all of these countries and provinces are embracing better service integration through oncology networks and programs, the organizational configurations are characterized by the more or less extensive use of dedicated structures and infrastructures to meet quality requirements and the need to coordinate services.

As regards governance, we distinguish three approaches according to the degree of authority sharing and the degree to which responsibilities are assigned to central cancer control organizations by the Ministry of Health: 1) authority delegated to one agency (Alberta, British Columbia, Ontario); 2) authority shared with separate dedicated organizations (France, England); and 3) authority distributed within the ministry, which comprises a dedicated ministerial organization (Québec, Nova Scotia). However, these dedicated central organizations differ in their ability to take action on the full range of cancer control dimensions. It is in approaches 1 and 2 that these organizations have the greatest powers in this respect.

Lastly, the variable progress seen in service organization reforms may depend on the complexity of the recommended changes and the coexistence of more-global health-care system reforms, but most especially on the levers of change made available. Yet, the countries and provinces of interest are not all at the same level in terms of the actual availability of these critical levers. In short, five lessons are drawn from the analysis of the main findings:

1. Adopt a tailored approach specific to the particular context of a given health-care system in order to configure the organizational means required to ensure an optimal patient pathway in that system.

2. Obtain a clear commitment from the highest government authorities. This is an essential condition for implementing a strategy.

3. Assess the applicability of an “effective solution” from another country or region to the specific context of the health-care system before implementing it.

4. Go beyond the dichotomous view of “ministry or agency?” to better define the conditions for functional governance in which the organizations responsible have sufficient authority and adequate means to carry out their mandates and coordinate themselves in order to implement change.

5. Bring together all the critical levers—accountability and performance management systems, including evaluation and information gathering/management mechanisms—to ensure the implementation of service organization reforms.

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Lorraine Caron, PhD, consulting researcher at AETMIS and lead author of this report. She was responsible for designing and managing the second phase of this project (2005-2007) and for drafting this report and the reference document on which it is based (author monograph). She also played a substantial role in preparing a preliminary report submitted to the Ministerial Cancer Task Force (MCTF).

Mirella De Civita, PhD, project contributor, who played a substantial role in drafting the author monograph and in the data design, gathering and analysis for the monograph.

Susan Law, MHSc, project contributor, who played a substantial role in managing, designing and developing the first phase of the project (2002-2004), including conducting interviews, preparing the preliminary report submitted to the MCTF, and critically reading the author monograph.

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Maurice Soustiel, MD, Director of Cooperation with Developing Countries, Institut national du cancer, France.

Terry Sullivan, **PhD,** President and Chief Executive Officer, and **Helen Angus**, Vice President, Planning and Strategic Implementation, Cancer Care Ontario.

Simon Sutcliffe, **MD,** President, British Columbia Cancer Agency.

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CONFLICT OF INTEREST

None declared.

Terry Sullivan, **PhD,** President and Chief Executive Officer, and **Helen Angus**, Vice President, Planning and Strategic Implementation, Cancer Care Ontario.

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CONFLICT OF INTEREST

None declared.

Summary

Cancer: A Huge Burden On Health-care Systems And Society

Cancer has been the leading cause of death in Québec since 2000 and is the leading cause of premature death in Canada. The number of people living with, or having been diagnosed with, cancer is growing at roughly twice the rate of new cancer cases. Not only does cancer have dramatic consequences on patients and their families, it is also a very large economic and social burden. If the current trends continue, it is estimated that the direct costs associated with cancer to Canada's health-care system will exceed $176 billion over the next 30 years.

Cancer Control: A Fight On Several Fronts

Cancer control has changed substantially over the past few years. From an initially treatment-centred approach, the scope of cancer control has gradually been expanded by incorporating prevention and a range of care and services for better meeting the needs expressed by cancer patients and their families. Nowadays, cancer control efforts fall within a system perspective, combining research and public health and targetting a continuum of services ranging from prevention to palliative care. This approach is aimed at coordinating all the activities that help reduce the burden of cancer, which includes, in addition to providing services, research, fundraising, advocacy and education. The significant changes in the way that health-care systems operate that characterize the global approach to cancer control also apply to the management of chronic diseases.

Comparing And Better Understanding Experiences Here And Elsewhere

This report is a targetted, comparative overview of the cancer control strategies in seven countries and Canadian provinces. The purpose is to better understand the choices made with regard to priorities, governance models, service organization, strategies for ensuring high-quality clinical practices, and the factors of success for implementing change. The report covers England, France and five Canadian provinces: Alberta, British Columbia, Nova Scotia, Ontario and Québec. The comparative overview is based mainly on a detailed search of the gray literature and on interviews with key informants. It is aimed at providing policymakers with numerous points of reference for their consideration.

Main Findings From The Comparative Overview

1) **Similar objectives and approaches, with specific, context-tailored means of implementation**

   Strong similarities are noted in the objectives, principles and initiatives set out in the current strategies. For the most part, the recommended measures reflect a cancer control-based perspective. However, the choices made in terms of priorities, organizational configurations, governance structures and other means of implementation differ widely according to the country or province. These differences have to do with the context in each country or province. That context is characterized, among other things, by the geographic distribution of its population and the disease, the documented problems, the overall organization of services and their management within the health-care system.

2) **Governing approaches that differ by the degree of authority and responsibility sharing**

The description of governance in terms of the number of players involved shows a wide range of models, but three main approaches can be identified with regard to authority sharing and the degree to which responsibilities are assigned to "dedicated" organizations (i.e., organizations devoted specifically to cancer control). These approaches are as follows: 1) authority delegated to one dedicated agency (Alberta, British Columbia, Ontario); 2) authority shared with separate dedicated organizations (France, England); and 3) authority distributed within the ministry, which comprises a dedicated ministerial organization (Québec, Nova Scotia).

3) **Dedicated central organizations that differ in their ability to take action on all aspects of cancer control**

An examination of the authority and area of responsibility of the dedicated central organizations reveals that all do not have the same latitude for coordinated action on all aspects of cancer control. It is in governing approaches 1 and 2 that dedicated organizations have the greatest powers in this regard. The concentration of authority and responsibilities in one dedicated organization (approach 1) offers from the outset a greater potential for cohesive action. In approaches 2 and 3, a clear line of accountability and coordination between the dedicated organizations and the other players involved in governance are essential conditions for the optimal management of all aspects of cancer control. In all cases, and especially in approach 3, where the dedicated ministerial organization has the most limited authority, the Ministry of Health holds important powers, with the result that the priority that it attaches to the deployment of a global, integrated vision is a determining factor.

4) **Implementation that depends on different levers of change**

Implementing recommended measures is a complex process that requires many levers. Yet, not all seven countries and provinces are at the same level in terms of the actual availability of these levers. An examination of the progress made in implementing service organization reforms shows that a number of levers are critical and suggests that the key to success resides in coordinated implementation of these levers. While the government's clear commitment and its financial support are essential conditions for progress, other levers are especially important for sustaining change, such as the accountability system, the performance management system and, consequently, the information gathering and management systems, and the evaluation mechanisms.

5) **Implementation progress is associated with various governance models as long as those responsible have the necessary authority**

Significant progress in service organization is not observed only in cases where authority and responsibilities are centralized within a dedicated organization (agency). The example of England shows that it is possible to initiate service organization reforms through sharing and coordinating authority and responsibilities. However, in all cases, those responsible for implementing organizational reforms must have sufficient authority over the care and service providers.

Analysis And Lessons Drawn

The accomplishments of these countries and provinces regarding the cancer control strategies and programs documented in this report have mainly concerned the means of implementation, somewhat its progress (service organization) and not at all its effects. This is why the analysis does not enable us to identify any best practices or to assess the performance of these countries and provinces. The analysis allows to draw lessons from the diversity of approaches and practices that are preferred in each jurisdiction but it does not go as far as examining their applicability in the Québec context. A number of avenues for further research have nonetheless been identified, the results of which could lay the groundwork for an evaluative approach

Five lessons are drawn from the analysis of the main findings, an analysis which concerned the following aspects: 1) the preferred means of ensuring an optimal patient pathway in the health-care system; 2) the comparison of governance models; and 3) the critical factors for advancing the implementation of cancer control strategies. These lessons are about the means to be used to advance cancer control strategies while at the same time respecting the country's or region's particular context.

Lessons drawn

Lesson 1: Adopt a tailored approach specific to the particular context of a given health-care system in order to configure the organizational means required to ensure an optimal patient pathway in that system.

Lesson 2: Obtain a clear commitment from the highest government authorities. This is an essential condition for implementing a strategy.

Lesson 3: Assess the applicability of an «effective solution» from another country or region to the specific context of the health-care system before implementing it.

Lesson 4: Go beyond the dichotomous view of «ministry or agency?» to better define the conditions for functional governance in which the organizations responsible have sufficient authority and adequate means to carry out their mandates and coordinate themselves in order to implement change.

Lesson 5: Bring together all the critical levers—accountability and performance management systems, including evaluation and information gathering/management mechanisms—to ensure the implementation of service organization reforms.

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