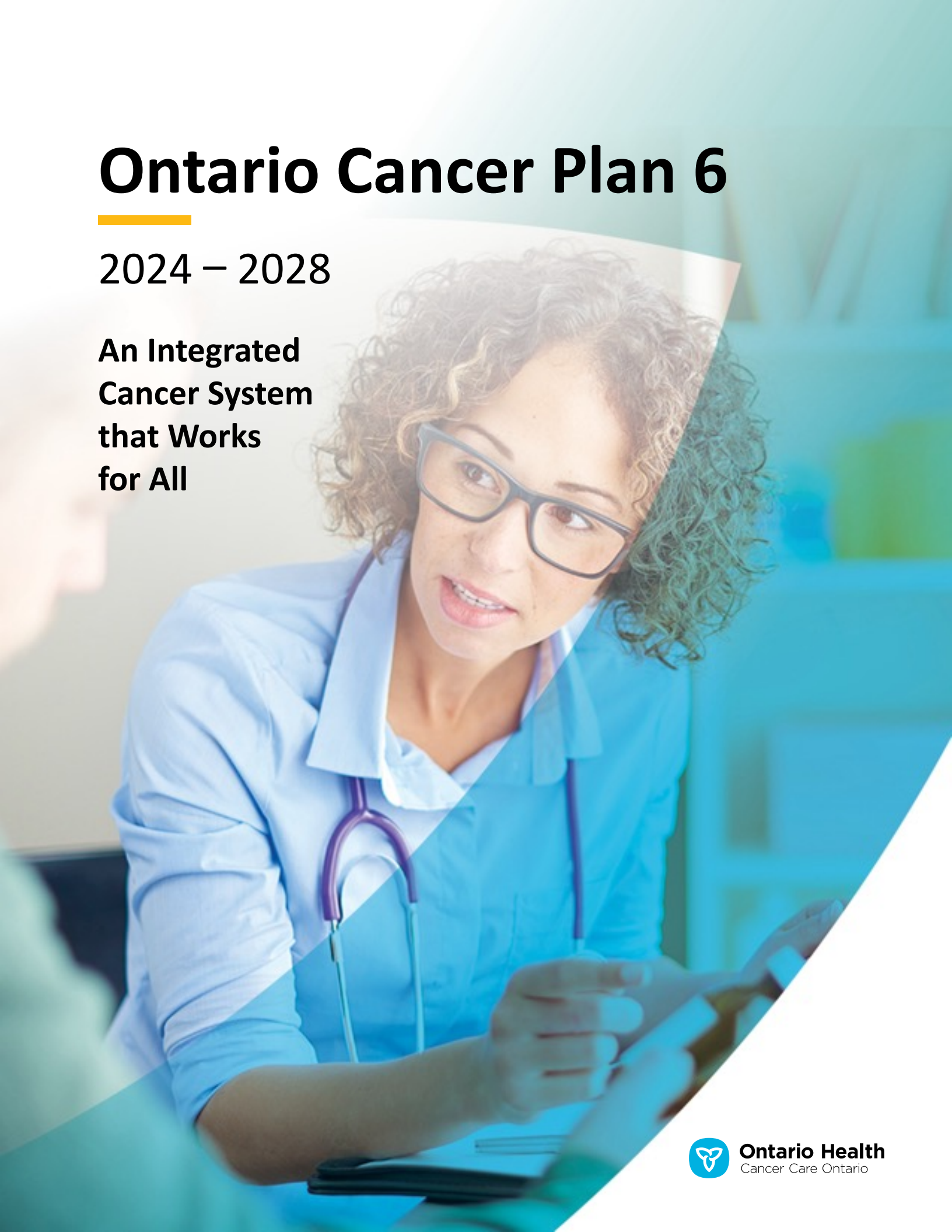
Ontario Cancer Plan 6

2024 – 2028

An Integrated Cancer System that Works for All



Ontario Health
Cancer Care Ontario

Contents

Ontario Health is an agency created by the Government of Ontario to connect, coordinate and modernize our province's health care system. We work with partners, providers and patients to ensure everyone in Ontario has equitable access to high-quality care, when and where they need it.

Ontario Health
500- 525 University Ave
Toronto, ON M5G 2L3
Toll Free: 1-877-280-8538
TTY: 1-800-855-0511
info@ontariohealth.ca

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca.
Document disponible en français en contactant info@ontariohealth.ca

Introduction

An Integrated Cancer System that Works for All

For the past 20 years, multi-year provincial cancer plans have provided a roadmap to improve the performance of the cancer system and outcomes for patients in Ontario. This plan, the sixth, builds on a solid foundation that has led to progressive advancements in the way cancer services are delivered across this province, including strong performance oversight and governance structures in our cancer system. Opportunities for improvement still exist, however. As more people are diagnosed, survive and live longer with cancer, the health system, patients and their care partners* will face new challenges. The Ontario Cancer Plan ensures that there is a system in place dedicated to reducing the risk of developing cancer, regularly screening for cancer and providing high-quality care if, when and where the people of Ontario need it.

Ontario Cancer Plan 6 clearly identifies our key priorities and what we need to accomplish together with the Regional Cancer Programs and our many health system and community partners over the next four years. The plan provides clinical advice and expertise to government on major initiatives that will improve health outcomes for Ontarians.

This plan is more than a refresh of our previous cancer plan, as much has changed in the health system since its release in 2019. That year, Cancer Care Ontario transferred into Ontario Health, an agency created by the Government of Ontario. Just one year later, in February 2020, the COVID-19 pandemic struck, with an immediate impact on the health system, including cancer services.

For example, Figure 1: Cancer Screening Test Volumes shows the impact of COVID-19 on cervical, breast and colorectal cancer screening. Cytology (i.e., Pap) test, mammogram and fecal test volumes decreased beginning in March 2020, reflecting the pause of routine cancer screening services based on the Ontario government's directive to pause non-emergent health services. These services were gradually resumed beginning in late May 2020, supported by guidance released by Ontario Health to Regional Cancer Programs, health care providers and health system partners. Although the speed of recovery varied by screening program, as of mid-2021/22, cervical, breast and colorectal cancer screening volumes met or exceeded pre-pandemic volumes.

* Care partners are individuals who provide unpaid essential and on-going personal, social, psychological and/or physical support and care, as deemed important to the person requiring care. This may include support in decision-making, care coordination, care delivery and continuity of care. The term implies a two-way relationship with a shared purpose, and it includes people who are identified as family, chosen family, an informal caregiver, or a friend.

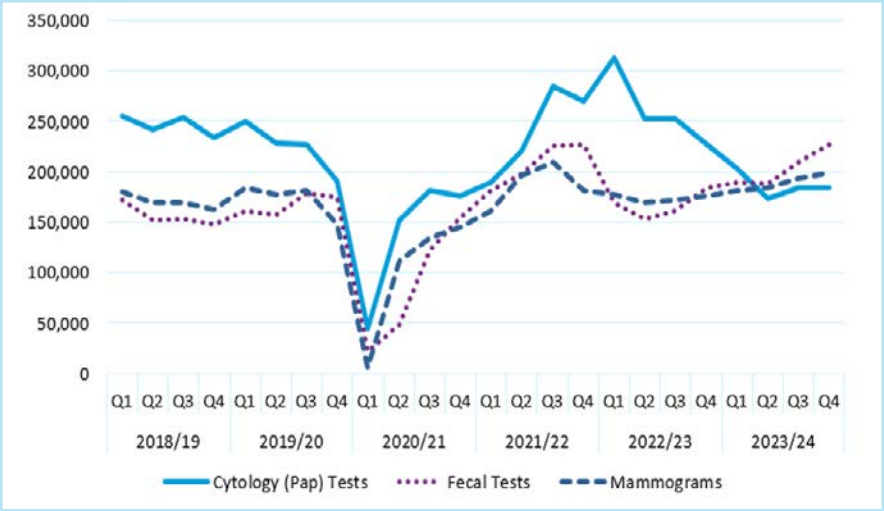


Figure 1: Cancer Screening Test Volumes

Note: The lower volume of cytology (Pap) tests in FY 2023/24 vs. FY 2018/19 is influenced by a decrease in cervical screening for people ages 21-24. This is a desired decrease, aligned with Ontario Health's recommendation to health care providers to delay initiating screening until the age of 25 in 2020. This recommendation will be formalized with the implementation of the HPV test as the primary cervical screening test in 2025.

Although most cancer screening and treatment service volumes have recovered to pre-pandemic levels, the cancer system – like the entire health care system – continues to experience challenges, including health human resources, rising demand for services, equitable access to timely care, and increasing complexity of cases. This Ontario Cancer Plan focuses efforts to address these challenges to build an effective, sustainable and patient-centred cancer system that provides care for everyone.

The goals and strategic objectives of this plan are aligned to and support the three strategic pillars of Your Health: A Plan for Connected and Convenient Care: Right care in the right place; faster access to care; and hiring more health care providers.

To support more care in the community, we are leveraging virtual care, developing new models of care, and improving integration with primary care providers, Ontario Health Teams, and other health care organizations. To help patients navigate faster and more easily through the system, we are leveraging digital health solutions, maximizing surgical capacity, expanding hospital and community bed capacity, advancing chronic disease prevention, and encouraging the timely adoption of care innovations (e.g., expanded genetic tests, take-home drugs, CAR-T therapy). Our focus on health care provider well-being, along with new models of care to maximize scope of practice, will help optimize our health care workforce.

JUDY LINTON

"For more than 20 years, Cancer Care Ontario demonstrated a commitment to improving the performance of Ontario's cancer system. Ontario Health builds on that legacy. As a single, integrated provincial agency, Ontario Health leverages the collective expertise, skilled resources, innovative solutions and digital programs of all our team members to better connect the health system to drive improved and equitable health outcomes, experiences and value."

Judy Linton is Executive Vice President, Acute and Hospital-Based Care and Chief Nursing Executive, Ontario Health

Developing this plan

In developing this plan, we used learnings from the province's response to the pandemic, as well as cancer performance data and extensive engagement with partners and stakeholders. We consulted with team members and program areas across Ontario Health, our clinical leaders, the Regional Cancer Programs, patient and family advisors, and health system partners across Ontario. We are grateful for their insights.

In our consultations, we heard optimal care described as that which ensures all patients' and care partners' needs are respected at every phase of the cancer continuum (see Figure 2: The Cancer Care Continuum). A continued focus on providing high-quality care that is person-centered, safe, efficient, timely, effective and equitable perspective was also highlighted.

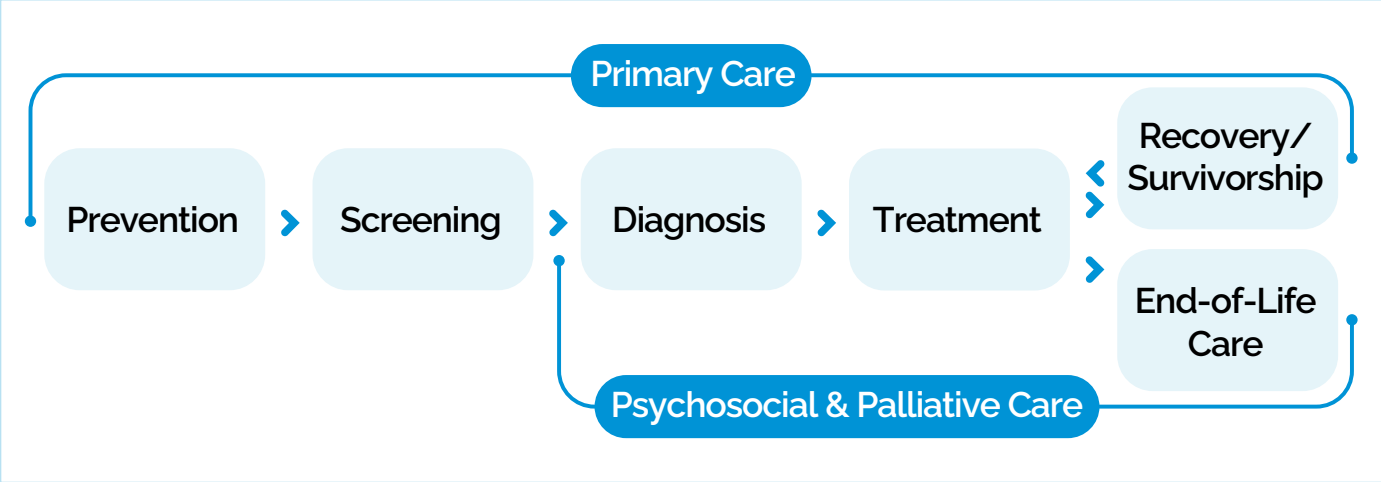


Figure 2: Cancer Care Continuum

With this plan, we want to better integrate our cancer system beyond the walls of our cancer centres and hospitals, and improve access to services for all Ontarians, especially as they transition into and out of the cancer system. While wanting to build on the advancements made under our previous cancer plans (see Ontario Cancer Plan 5: Our Progress Together, 2019 - 2024) we also looked to embrace evidence-based innovation†, prioritize value and promote health system sustainability.

† The World Health Organization defines innovations as "a new or improved solution with the transformative ability to accelerate positive health impact."

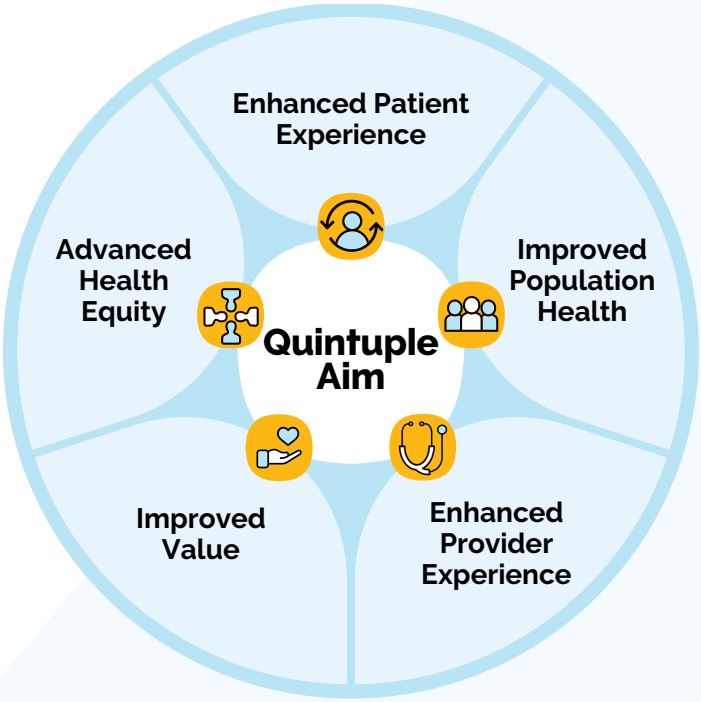
JONATHAN IRISH AND ELAINE MEERTENS

"Ontario Cancer Plan 6 guides our work to help people easily access the care they need and smoothly transition between the cancer system and primary care as they go through the cancer continuum. It addresses inequities in our cancer system to ensure safe, high-quality care for all. The plan also responds to the fact that as cancer treatments continue to improve, the number of cancer survivors in our province will significantly increase. Our responsibility is to ensure that people affected by cancer are not just living longer but also living better."

Dr. Jonathan Irish is Vice-President, Clinical, Cancer Programs, Ontario Health (Cancer Care Ontario)

Elaine Meertens is Vice-President, Cancer Programs and Genetics, Ontario Health (Cancer Care Ontario)

This Ontario Cancer Plan leverages and aligns with foundational and transformational work within Ontario Health (e.g., Ontario Health Teams, Primary Care Strategy, home care modernization, Data and Analytics Strategy, Equity, Inclusion, Diversity and Anti-Racism Framework, Black Health Plan, First Nations, Inuit, Métis and Indigenous Health Framework). Together we are building a more integrated system that enables our programs to work more effectively and seamlessly with our partners in the broader health system, including primary care, palliative care, mental health and others. This will help us address the acute and chronic health care needs of people within one well-coordinated health care system.



The goals of this plan are also guided by the five aims that are critical in the delivery of world-class health care services, known as the Quintuple Aim (adapted from the Institute for Healthcare Improvement):

- Enhancing patient experience
- Improving population health
- Improving provider experience
- Improving value
- Advancing health equity

Plan in action

The goals and strategic objectives of this plan will be made actionable through initiatives which will be outlined in our operating plans. In addition, there are several key enablers – the capabilities, conditions, concepts and especially the people – needed to successfully implement the initiatives of this plan. These include planning, information management, digital technology, partnerships and engagement, evidence and knowledge generation, value assessments, quality and performance improvement, knowledge transfer and exchange, and privacy policies.

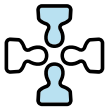
We look forward to working with our partners across the health system, including the Regional Cancer Programs, the Ministry of Health, clinicians, care providers, patients and care partners across the province to drive improved and equitable health outcomes, experiences and value for all.

BOB L.

"The value of lived experience and story telling was fundamental to the development of this cancer plan. More than 100 patients and care partners were engaged, with each person contributing their own unique perspectives. My wife and I appreciate that we were fortunate in our experiences with the cancer system. However, many people spoke of the barriers and limitations that exist – geographic, financial, racial, ethno-cultural, educational and technological. Their experiences are reflected in the final articulation of the goals and strategic objectives of this plan."

Bob L. has had prostate cancer twice and B cell lymphoma. He was also his late wife's care partner during her treatment for stage 4 metastatic breast cancer.

Ontario Cancer Plan 6 Goals



ADVANCE EQUITY IN THE CANCER SYSTEM

IMPROVE THE PATIENT, CARE PARTNER AND PROVIDER EXPERIENCE

ACHIEVE SEAMLESS AND EFFECTIVE INTEGRATION OF ALL CANCER SERVICES

IMPROVE CANCER OUTCOMES AND QUALITY OF LIFE FOR ONTARIANS

ENSURE SUSTAINABLE CANCER SYSTEM INFRASTRUCTURE AND WORKFORCE

Each goal is supported by strategic objectives, which are outlined in the plan. A one-page summary page of Ontario Cancer Plan 6 goals and strategic objectives is available online.

GOAL

Advance Equity in the Cancer System

Strategic Objectives

- Address barriers to improve equitable access to effective cancer treatments
- Improve equitable cancer planning and care delivery by collecting and using sociodemographic data
- Strengthen the cancer system by advancing equity, inclusion, diversity, and anti-racism and embedding culturally responsive, trauma-informed, person-centred care
- Address disparities in the cancer system by co-designing policies and programs and building trusting and reciprocal relationships with First Nations, Inuit, Métis and Urban Indigenous peoples, Black Ontarians and underserved populations
- Implement the fifth First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy with ongoing engagement with First Nations, Inuit, Métis and Urban Indigenous leadership, their health teams, and communities

People should not face barriers to attaining good health because of who they are, where they live or what resources they have. Yet some people continue to face barriers to care and experience poorer health outcomes. Addressing the social determinants of health must be part of the solution to achieve equitable health for Ontarians.

We are dedicated to Ontario Health's strategic goal of advancing health equity in all our work and improving patient experiences, health outcomes and access to person-centred, culturally safe and inclusive care. Initiatives supporting the plan strive to meet the needs articulated by and in collaboration with:

- First Nations, Inuit, Métis and Urban Indigenous peoples
- Black communities
- Francophone populations
- Adolescents and young adults, and elderly people
- Equity-deserving populations who continue to be disproportionately impacted by systemic barriers to care (e.g., with geographic disparities in access to care)

We will also work to understand and address the barriers for people whose health experiences and outcomes are influenced by:

- Lack of access to reliable technology (to book appointments, view records or access virtual care)
- Physical or structural barriers (e.g., inaccessible examination rooms or equipment)
- Out-of-pocket health care expenses, including cancer drugs
- Traveling far distances from home for care, involving challenges with childcare, need for a travel escort and unfamiliar surroundings

- Language barriers in interactions with care providers and lack of translation services
- Unattachment to a primary care provider
- Lack of access to health services, new treatments and clinical trials
- Lack of diverse representation of underserved groups and First Nations, Inuit, Métis and Urban Indigenous peoples across the health workforce
- Health care providers' biases, stereotypes and prejudice
- Historical racism in the health system and limited access to community-led, designed and culturally responsive care
- Distrust in the health system by First Nations, Inuit, Métis and Urban Indigenous peoples due to the Indian Act, colonialism, residential schools and intergenerational trauma

We have made progress in embedding a health equity approach in the work that we do. This is founded on the principles of Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework.

We will continue to build on strong relationships with First Nations, Inuit, Métis and Urban Indigenous leadership, organizations and communities as we build on progress made with the First Nations, Inuit, Métis and Urban Indigenous Cancer Strategy 2019 – 2023. and launch the next (fifth) iteration of this strategy.

We will also work with partners including the Black Health Alliance, health leaders, academics and community members to advance the Black Health Plan. We will plan and implement initiatives focused on improving outcomes for Black populations to ensure that Black communities across Ontario receive safe and equitable access to cancer prevention, education, screening and care. This will include working collaboratively to build upon the success of community-led screening models, such as the Afrocentric screening model developed by TAIBU Community Health Centre.

We will use health equity data to understand the distinct needs of underserved populations and respond with co-designed solutions that are evidence informed. We will follow the Indigenous Data Governance Matters process and principles, which provide direction, accountability and a standardized approach to appropriate use of First Nations, Inuit and Métis data at Ontario Health. In addition, we will continue to update tools such as Ontario Cancer Profiles to provide key cancer and sociodemographic statistics at the sub-regional and public health unit levels to support targeted cancer control strategies.

MELISSA G.

"I feel very strongly that more choices need to be available throughout the care continuum, and they need to be available to everyone. I had the same chemotherapy treatments at two different facilities (because I was travelling for a family event). At one facility, the time I spent in hospital was considerably less. I was really surprised by the differences in how the care was delivered. Resources and care just aren't the same across the province."

Melissa G. was diagnosed with triple negative breast cancer in 2013 when she was just 34. Her treatment included surgery, chemotherapy, radiation and brachytherapy, and she now has no evidence of the disease.

GOAL

Improve the Patient, Care Partner and Provider Experience

Strategic Objectives

- Implement a comprehensive model of care in hospital and community for patients and care partners to access psychosocial, symptom and side-effect management, throughout the care continuum
- Establish integrated survivorship services to improve the patient and care partner experience
- Implement the recommendations in the Palliative Care Health Services Delivery Framework for patients and their care partners in hospital and community settings
- Promote provider well-being through measurement and integration of best practices

A patient's clinical outcome is defined not only by excellence in clinical care; their views of their experience and quality of life are equally important. We have expanded opportunities for patients to report on their health and experience through Your Symptoms Matter and the re-designed Your Voice Matters. Going forward, we want to improve the utilization of these patient-reported experience and outcome tools. This information can support care decisions, identify patients who are likely to experience a higher burden of symptoms after diagnosis, and improve access to psychosocial and symptom management services outside the walls of the cancer centres and hospitals.

Increasingly, we are appreciating the vital role of care partners in providing a wide range of essential support and care (see, for example, our Oncology Caregiver Support Framework). We will continue this work to improve access to psychosocial oncology and supportive services, including mental health support, for both patients and care partners throughout the cancer continuum.

As we focus on creating a more connected cancer care system, we will need to provide additional support for and enhance collaboration with primary care providers and other health care organizations throughout the care continuum. We will create a streamlined post-treatment path to survivorship care, and back to specialist care if required, to address the needs of the growing number of cancer survivors.

We will create an integrated survivorship care continuum, with access to specialist care as needed, to address the needs of Ontario's current and future cancer survivors. Support will be provided to the survivors of childhood cancer as they transition from the pediatric to adult system, including a single point of contact to address their questions and meet their unique needs. Patients and care partners who would benefit from a palliative approach to care will be supported by health care providers with comprehensive, specialized training to ensure their care is informed by the latest evidence.

As we make it faster and easier for patients to transition through various supports in the cancer system, we must also improve access to urgent and after-hours care. For example, we will continue to offer CareChart Digital Health, an after-hours telephone service that provides symptom support for oncology patients receiving systemic and radiation therapy when their local treatment centre is closed, helping to avoid emergency department visits. We will monitor and strengthen this service.

We will work to reduce the administrative burden for providers (including primary care) to deliver care (e.g., related to ordering tests, making referrals, etc.). Patients Before Paperwork, a collaborative effort between the Government of Ontario and Ontario Health, is working to mobilize digital health tools to improve patient care, enhance health system coordination, strengthen health privacy and finally axe the fax from health care settings.

In 2019, we led a study on physician well-being in cancer care. We will build on this work through a Provider Well-Being Forum with clinicians and administrative leaders from the Regional Cancer Programs. This advisory forum will focus on improving well-being among cancer care providers and collaborate on content and tools that can be implemented at the local level to support health care providers. We recognize that improving provider health and well-being improves retention, protects these vital workers, and safeguards Ontarians and the health care system.

We will develop new care models (e.g., team-based care) that leverage technology and optimize health human resources to ensure care is provided in the right place at the right time by the right provider.

LESTER K.

"When you become a patient, you are entitled to care and cure. When cure runs out, you are still entitled to care. We need to do a better job of educating providers to humanize and provide person-centred care from the very beginning to the very end. That includes teaching about symptom management, palliative care and how to have difficult discussions."

Lester K. and his late wife, Carol, were each other's care partners when he had colon cancer six years ago and she had breast cancer three times over the course of 27 years. Per her wish, she died at home, in 2021.

GOAL

Achieve Seamless and Effective Integration of all Cancer Services

Strategic Objectives

- Leverage digital solutions to support coordination of care, access to comprehensive health information and system navigation for patients, their care partners and providers
- Establish integrated diagnostic services supported by navigation and access to information to improve timely diagnosis and patient outcomes
- Strengthen integrated community and home support models for patients and their care partners

Navigating our large and complex cancer system can be challenging for patients, care partners and health care providers. Patients will see many different care providers in many different settings as they transition through the different phases of the cancer continuum. In order to optimize connections to primary care, we will support and integrate our cancer system initiatives with Ontario Health's Primary Care Strategy.

Provincial digital health solutions, which are being led by Ontario Health, offer a new opportunity for the cancer system to be better integrated into the broader health care system. These innovations will help ensure timely information is accessible and shared among everyone, including patients and their entire health care team across various settings. This will also help care partners make timely and more informed clinical decisions when meeting with patients and reduce duplication of tests.

Making it faster and easier for patients and care partners to navigate the cancer care system can also help reduce stress for people undergoing testing for diagnosis, especially if it is a timely and efficient process and information and psychosocial supports are easily available for patients and care partners. In Ontario, there have been significant efforts to improve access to diagnostics and expedited follow-up after an abnormal screening test result, including lung diagnostic assessment programs, MRI and CT scans, and gastrointestinal endoscopy procedures. We will use evidence and experiences from within Ontario as well as other jurisdictions to continue expanding access to high-quality, timely and supportive diagnostic care, leading to faster and earlier cancer detection and better outcomes and quality of life.

Our work to strengthen integrated community and home care has begun with systemic treatment. To address growing demand for systemic treatment, and in recognition that patients and their care partners benefit from care closer to home, we developed evidence-based recommendations to optimize the delivery, quality, safety and consistency of systemic treatment in the home and community. These recommendations were developed by Ontario Health (Cancer Care Ontario), in collaboration with representatives from Ontario Health atHome (formerly Home and Community Care Support Services), service provider organizations, and Regional Cancer Programs as part of Phase 1 of the Systemic

Treatment in the Home and Community Initiative. As part of Phase 2, Ontario Health atHome, in collaboration with health system partners, will work towards implementation of the recommendations outlined in this report within the next five years. In an effort to further support the safe delivery of systemic treatment in the home and community, a patient education resource, *How to Safely Handle Cancer Medications and Body Fluids at Home*, was also developed. This resource is meant to support people receiving cancer medication at home, as well as their care partners.

TAUDE P.

"Some of my appointments were virtual, but for most I had to travel about an hour. I would like to see more integrated community and home support. My family health team has a diabetes clinic, a foot care clinic, a heart clinic. Why not a cancer clinic? We need local services where we can get care and information without having to make an appointment and travel to see an oncologist."

Taude P. was diagnosed with breast cancer in 2017. Her biopsy and lumpectomy were done in her home town, chemotherapy and radiation at her Regional Cancer Centre, and a subsequent oophorectomy at a third site.

GOAL

Improve Cancer Outcomes and Quality of Life for Ontarians

Strategic Objectives

- Advance system-level approaches to promote health and well-being, improve disease outcomes and reduce risk factors relevant for cancer and other chronic diseases
- Evolve the design and delivery of Ontario's organized cancer screening programs to improve access and increase participation
- Drive safe, high-quality care to improve outcomes, survival and quality of life through best practice adoption and continuous quality improvement
- Integrate data and new evidence, leveraging health services research, into practice and policy recommendations
- Implement a streamlined approach for timely adoption of innovation and technologies

Since the launch of the previous cancer plan, notable progress has been made towards improving clinical outcomes and quality of life for people across the province. From 2019 to 2024, enhancements to cancer screening programs include:

- Adding 26 new screening sites in the Ontario Breast Screening Program (OBSP)
- Adding two high risk OBSP sites and 19 new OBSP breast assessment sites
- Implementing fecal immunochemical testing (FIT) for colorectal cancer screening for people at average risk of the disease
- Increasing access to colorectal screening by making FIT kits available at nursing stations and health centres in 28 communities in Sioux Lookout and area
- Launching the Ontario Lung Screening Program
- Continuing to work towards implementing human papillomavirus (HPV) testing in the Ontario Cervical Screening Program

This progress is in addition to previously establishing and fostering tobacco-smoking cessation programs in the Regional Cancer Programs.

In 2020, we launched the Chronic Disease Prevention Strategy 2020 – 2023, which provided a guide for our work to prevent chronic disease (including cancer) and improve population health. In 2022, we released two reports on cancer and chronic disease prevention (one related to cancer prevention for people living with serious mental illness, and the other about the health burden of smoking and alcohol).

We will continue to build on this progress. With Ontarians living longer than ever before, chronic disease prevention and early detection via screening are critical to improving their quality of life and building a sustainable health care system, especially as cancer is one of the top four chronic diseases in the province[i]. Shifting focus from treatment to preventive care and screening can reduce the incidence of cancer and other chronic diseases, enable early detection and intervention, and decrease health care costs.[ii]

Despite the benefits, not all Ontarians receive or have access to recommended preventive care and screening services. Using patient navigation models that make it easier for people to connect to preventive care and screening is proven to increase access to care and reduced barriers and gaps across health services.[iii], [iv] We will work with primary care, Ontario Health Teams and community partners to increase access to preventive care and early detection of chronic diseases. This includes establishing a preventive care program to support underserved populations, including First Nations, Inuit, Métis and Urban Indigenous peoples, Black communities, and rural and remote communities.

In cancer screening, we will implement provider-collected and self-collected HPV testing in the Ontario Cervical Screening Program and expand access to the Ontario Lung Screening Program by adding new screening sites across the province. We have also expanded access to the Ontario Breast Screening Program to eligible people ages 40 to 49, giving one million more eligible Ontarians the option to connect to breast cancer screening. We will also work to provide more education to patients and providers on screening recommendations by developing decision-support tools and launching physician-linked invitation and recall letters for cervical screening.

We will continue to do more work to expand the reach of the commercial tobacco cessation programs. This will include providing better access to nicotine-replacement therapy for people with cancer, as quitting smoking after a cancer diagnosis significantly reduces cancer-specific mortality.

In conjunction with our goal to improve health equity, we will focus these initiatives on underserved and difficult-to-reach populations (e.g., rural, remote, northern and unhoused). To do so, we will utilize evidence-informed programs and technology, such as mobile preventive care coaches and a digital portal to access correspondence letters and virtual care.

Safety is paramount in high-quality cancer care. In recent years, new and updated evidence-based guidelines and engagement with communities of practice have led to improvements in patient care. This work has resulted in improved standardization of diagnosis and treatment approaches across the province and improved the safety and quality of cancer services.

New treatment options, including innovative immunotherapies such as CAR T-cell therapy, and the emerging field of gene therapies are now available. These therapies are potentially lifesaving to patients who had no other treatment options just a few years ago and are more cost effective for the system.

The implementation of funding for volumes tied to quality care delivery in cancer surgery, systemic treatment and most recently radiation treatment has improved patient access to evidence-informed treatments. This has also reduced regional variation within the province.

Working with our health care partners, we will continue to develop and implement clinical recommendations, guidelines, standards and accountability to ensure consistent, safe, high-quality care wherever it is provided, across the province and in all health care settings. We will explore and investigate the root causes of decreasing survival rates and increasing stage at diagnosis for bladder and prostate cancer, and we will monitor access to care and survival rates in complex malignant hematology. We will identify gaps in the quality and safety of systemic treatment delivered outside hospital. We will also provide Regional Cancer Programs and other health service providers with tools and education to minimize the potential for errors.

We will evolve and adapt as new evidence emerges, leading to improvements in equity, experience and cancer care. We continue to make great strides in increasing access to emerging diagnostics and care, as seen through funding for expanded and new cancer genetic tests and additional indications for PET scans and interventional oncology. However, there can still be a long lag between identification of emerging, effective diagnostics or treatments and implementation. To ensure access to the most effective and safe care, we will create better partnerships between clinical care and research by accelerating the innovation pathway. This means streamlining processes for identifying, evaluating, prioritizing and implementing innovation, including new health technologies, and removing barriers to their implementation. This could be particularly effective when assessing new genetic tests and combined targeted imaging and therapies (theranostics).

As a learning health system, we drive system improvement by working with clinical experts, health system researchers, and the Regional Cancer Programs to define and close the gap between the current and ideal states of care. We use evidence, national and international standards, and a robust performance review process to inform policy and care guidelines. We will continue to build on our important partnerships with health system researchers and other stakeholders to advance care that is world class.

While there is increasing interest in expediting the introduction of new drugs and technologies, these products may lack sufficient evidence of improved patient outcomes and value-for-money. Given robust pipelines of new drugs and other technologies, there is a pressing need to ensure that value-for-money is considered in the implementation of any new treatment and that adequate resources are in place to evaluate their real-world effectiveness.

JILL TINMOUTH

"Nearly half of Ontario's population is eligible for cancer screening. As screening touches so many people, it is important we get it right. That means improving access to screening, particularly for under-served and difficult-to-reach populations, ensuring an efficient and safe experience with screening and follow-up tests, improving access to preventive measures such as smoking cessation programs, and ensuring a seamless transition to treatment for those who are diagnosed with cancer. Ontario Cancer Plan 6 provides a roadmap to "getting it right" and guides important initiatives such as implementation of human papillomavirus testing in the Ontario Cervical Screening Program and the provincial expansion of the Ontario Lung Screening Program."

Dr. Jill Tinmouth is Provincial Medical Director, Cancer Control, Ontario Health (Cancer Care Ontario)

GOAL

Ensure Sustainable Cancer System Infrastructure and Workforce

Strategic Objectives

- Develop and implement comprehensive and scalable health human resource and infrastructure strategies
- Implement the ambulatory systemic treatment models of care recommendations to optimize service delivery for oncology providers and patients

There are now more people living with cancer in Ontario than ever before (see "Cancer in Ontario," below). In 2019, the prevalence of newly diagnosed people with cancer, as well as people who were previously diagnosed with cancer and who are still alive, was an estimated 845,188 people. This is projected to increase by about 50% to 1,265,216 in 2034.[v]

Behind these numbers are people who need cancer services, including increasingly complex, expensive and time-intensive treatments, follow-up and survivorship care. Further, approximately half of Ontario's population is eligible for participation in organized cancer screening. For Ontario's cancer system to be sustainable and available when needed, we need to make the best use of our human, infrastructure and financial resources. This requires proactive and long-range workforce and infrastructure capacity planning based on robust and timely data. This will enable better prediction of future need and allocation of resources.

We will continue to increase capacity for and access to complex malignant hematology services, PET (positron emission tomography) (see Figure 3: PET Scanning in Ontario) and radiation treatment with the most up-to-date treatment machines. Moving forward, we will continue to improve efficiency and maximize existing resources, including reducing duplication and inappropriate testing/imaging.

Figure 3: PET Scanning in Ontario

* Formerly Cancer Care Ontario

Figure 3: PET Scanning in Ontario

Positron emission tomography (PET) is a type of imaging that is the standard of care for detecting and evaluating many cancers, providing the information needed to make crucial decisions about a patient's clinical management. Ontario Health has a PET Capital Investment Strategy in place to ensure PET machines are strategically timed and placed to sustain and improve equitable access to high-quality PET scans for all Ontarians. This work has been critical to support patients as the use of PET scanning increases and evolves, based on the best available evidence for imaging and treatments.

We also need to be innovative in our approach to bolstering our health care workforce, guided by the priorities set out in Your Health: A Plan for Connected and Convenient Care. This includes introducing new educational seats and financial supports to expand the training of new doctors, nurses and allied health professionals, providing expedited and accessible opportunities for internationally educated health care providers to become licensed to practice in Ontario, and using new models of care to maximize scope of practice and team-based care. We will examine ways to use and integrate health professionals (e.g., nurse practitioners, occupational therapists, physiotherapists, speech language pathologist, pharmacists) and non-regulated and non-traditional providers (e.g., care partners and volunteers) to meet growing demand for care in various areas, including systemic treatment at more than 70 hospitals across the province.

To strengthen existing health system resources and overall system capacity, we will implement technology and automation tools to enable our health care providers to perform more effectively, efficiently and in a more integrated workflow both in the hospital system and with our primary care and community partners. We will also consider how to utilize care settings beyond the cancer centres, including the home, community, out-of-hospital premises and integrated community health service centres, and establish required processes to support high-quality care in these settings.

RAVI V.

"My father waited four months for the results of a biopsy of his jaw, and then was told he had to wait another six weeks to see a specialist. During this time, the cancer was growing and becoming harder (and more expensive) to treat. Ontario has so many resources, but are we using them effectively? Do specialists have too many patients or too much paperwork? We need to make sure they can spend most of their time seeing patients and make the best use of their skills."

Concerned about wait times for care, Ravi V. took his father to India for cancer treatment. Unfortunately, the cancer returned five years later, and his father died in 2020.

Cancer in Ontario

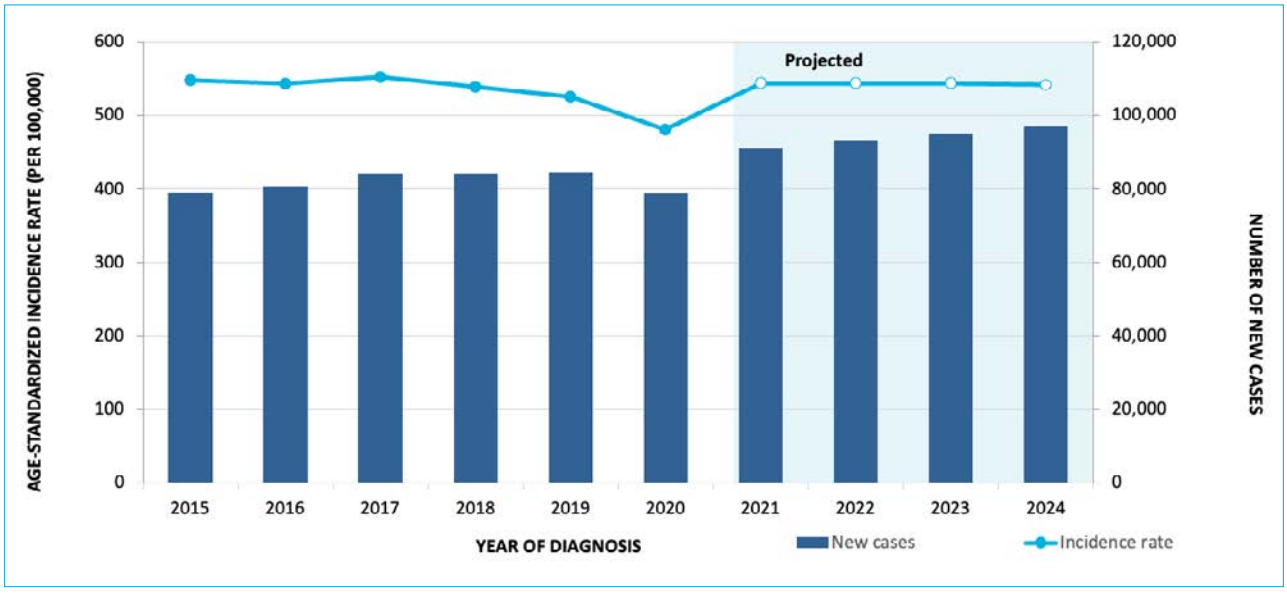
Why we need a Cancer Plan

Understanding current state and future cancer trends helps health planners, policy-makers and health care service providers anticipate the resources and costs needed to care for people newly diagnosed with cancer and provide ongoing care to people living with cancer.

Recent Ontario Cancer Surveillance Statistics

Nearly one out of every two people in Ontario is expected to develop cancer in their lifetime.

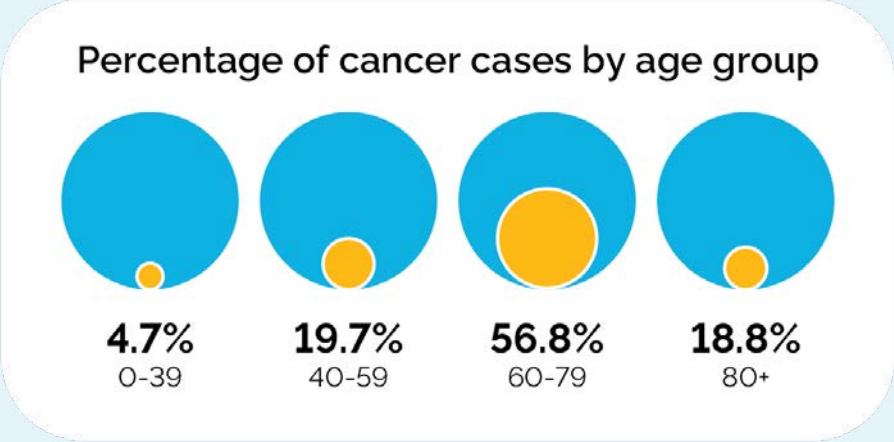
In 2024, about 266 new cancer cases are expected to be diagnosed every day.



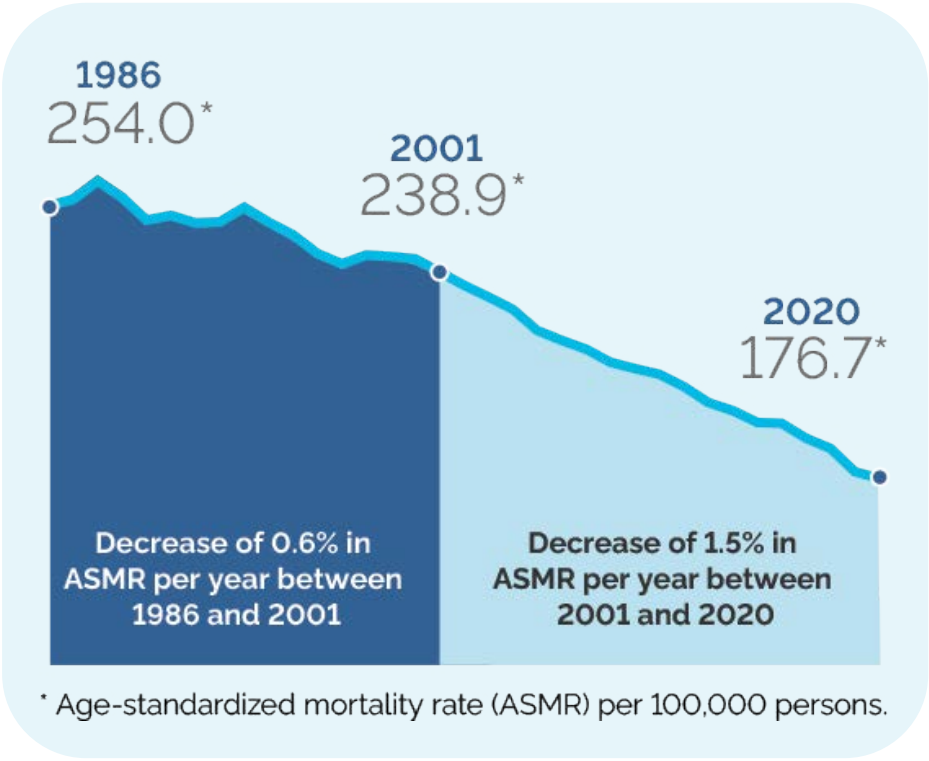
For data table, see Table 1 in Appendix.

In 2024, female breast, lung, prostate and colorectal cancers are expected to be responsible for almost half of all new cancer cases.

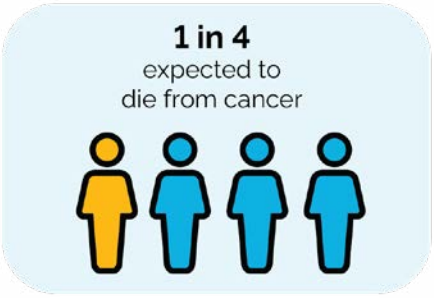
In 2024, the largest number of new cancer cases is expected to occur in people ages 60 to 79, with this age group accounting for more than half of all new cancers.



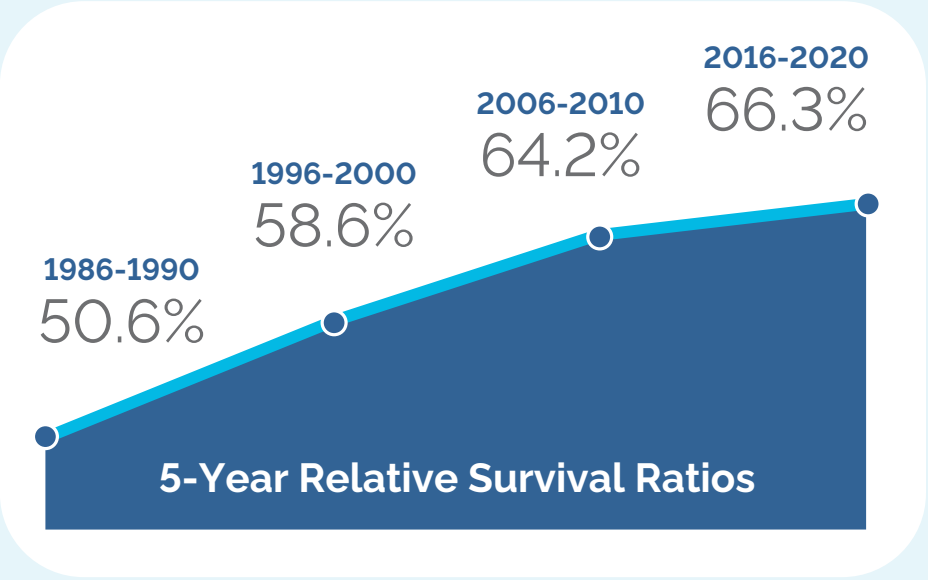
For data table, see Table 2 in Appendix.



Although approximately one in four people is expected to die of cancer, death rates for all cancers combined continue to decline over time.

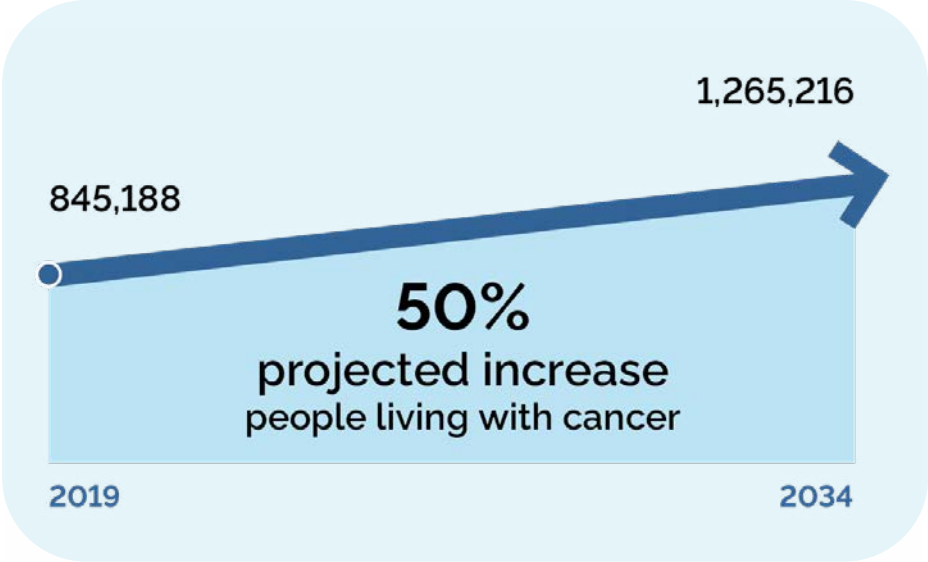


For data tables, see Tables 3a and 3b in Appendix.



For data table, see Table 4 in Appendix.

The five-year relative survival for all cancers combined continued to improve over time; however, there is a large variation in survival rates by cancer type.



For data table, see Table 5 in Appendix.

As more people are diagnosed with, survive and live longer with cancer, the health system, our patients and their care partners will face new challenges.

The Ontario Cancer Statistics report paints a detailed and comprehensive picture of who is at greatest risk of developing, dying from surviving and living with different cancers.

There is much that can be done to prevent new cancer cases and to detect it early, including implementing new prevention and screening programs in our health care system. Moreover, work led by public health, such as championing policies that ensure healthy environments and efforts to encourage healthy behaviours, are also critical to improving population health. Some groups of people face higher risks of getting cancer, greater challenges in accessing services and have poorer health outcomes than other groups. The risk of cancer and other chronic diseases is linked to numerous social determinants of health – that is, non-medical factors affecting our well-being, including but not limited to the conditions and exposures where we are born, grow, work, live and age. These factors may also influence participation in cancer screening, and health outcomes. For example:

- While there have been some improvements in recent years, First Nations, Inuit, Métis and Urban Indigenous people have more new cases of certain cancers than other people in Ontario, with generally poorer outcomes and higher death rates than other people in Ontario. [vi, vii, viii, ix, x, xi, xii]
- Women from low-income households or who are recent immigrants are less likely to have Pap tests compared to women who are from high-income households or Canadian born.
- Lower household income level may be a barrier to long-term smoking cessation. [xiii]
- Research has shown that women in Ontario from Latin America, the Caribbean and South Asia are less likely to have a screen-detected breast cancer, have longer wait times to breast cancer diagnosis, and have their breast cancer diagnosed at a later stage than long-term residents of Ontario.[xiv]

Ontario's Cancer System

How We Work Together

Regional Cancer Programs

We work in close partnership with Ontario's 14 Regional Cancer Programs, which are networks of hospitals and other health service providers involved in delivering cancer services at the local level. Each Regional Cancer Program is led by an Ontario Health (Cancer Care Ontario) Regional Vice President and has an administrative and clinical leadership model to support the local needs of patients and consistent with our overall provincial goals. The regional clinical leadership embedded within each Regional Cancer Program creates Communities of Practice through clinical champions and local thought leaders to ensure that change occurs at the clinical and, more importantly, the patient level. This model enables us to ensure that people across Ontario have access to high-quality cancer services as close to home as possible.

Ontario Health Regions

Ontario Health's operating model includes six Ontario Health Regions: Central, East, West, North East, North West and Toronto. These regions work closely with Health Service Providers to support planning, design and implementation of provincial strategies and programs, including the Ontario Cancer Plan. The Ontario Health Regions work in collaboration with the Regional Cancer Programs to identify and ensure opportunities for alignment and system advancement.

Clinical leadership

Clinical Leads, including physicians, nurses and other health care professionals, provide leadership and expert advice to help improve the cancer system. Over 2,500 health care professionals from across Ontario participate on expert panels and advisory committees, and as reviewers to support our work, including the development of clinical program standards and evidence-based guidelines. Their contributions ensure that the initiatives implemented are credible, evidence-based and feasible. They are critical to success at the local level through Communities of Practice and local leadership engagement.

Patient and family advisors

Patient and family advisors participated in the development of the Ontario Cancer Plan 6. Their experiences and advice helped create a cancer plan that better addresses the needs and values of the populations we serve.

Furthermore, as policies, programs and practices are developed to meet the goals of the Ontario Cancer Plan, ongoing input from patient and family advisors and people with lived experience will help shape decisions that affect patient care and services. We thank all of our patient and family advisors for sharing their lived experiences for the betterment of our cancer system.

The government and system partners

The Ministry of Health helps bring the Ontario Cancer Plan to life. The ministry reviews and assesses the plan and provides funding for its programs and projects. We advise the ministry about the cancer system performance and regularly report on the results of our work.

Many system partners help develop and inform programs, policies and projects that support the strategic objectives of the Ontario Cancer Plan. External partners include provincial agencies, researchers (including health services researchers), other health care organizations and health care professionals.

As Ontario's health system continues to evolve and mature, it is absolutely essential for success that we work in an integrated way with our system partners, including Ontario Health Teams and home and community services to advance the goals and strategic objectives of this plan. Ontario Health Teams provide a new way of organizing and delivering care that is more connected to patients in their local communities. Under Ontario Health Teams, health care providers (including hospitals, doctors, and home and community care providers) work as one coordinated team – no matter where they provide care.

NEIL JOHNSON

"Ontario Cancer Plan 6 gives clear direction for patients, health care organizations and those who work in the health system of the important work that is ahead of us. Each region has unique needs and circumstances, but this Ontario Cancer Plan unifies our regions and all who work in the cancer system on an improvement path that will benefit all Ontarians."

Neil Johnson is Regional Vice President, Hamilton Niagara Haldimand Brant Regional Cancer Program and Vice President Oncology, Hamilton Health Sciences Site Executive Lead, Juravinski Hospital.

Measuring Progress

Accountability and Measurement

We are accountable to the Ministry of Health, our partners and the people of Ontario for meeting the priorities outlined in this plan.

Annual business plans submitted to the ministry and detailed internal operating plans set out how initiatives and programs will be developed and put in place to support the plan's goals and strategic objectives.

There is a robust measurement plan and performance indicators to measure progress. We publicly report our progress in Ontario Health's annual report and cancer screening performance reports.

In addition, the Cancer Quality Council of Ontario monitors and publicly reports on the performance of the cancer system through the Cancer System Quality Index. This index tracks Ontario's progress towards improving the quality of cancer control, provides international comparisons and highlights opportunities to improve.

The Your Voice Matters (YVM) patient experience survey was re-designed in 2023 to ensure it captures feedback on the aspects of in-person and virtual care that matter most to patients and care partners (see Figure 4: Your Voice Matters (YVM) Progress (2016 - 2023). The survey results provide actionable insights to hospitals and support quality improvement efforts that enhance the cancer care experience at the local level and across Ontario. Building on the success of the previous version of the survey, we plan to expand implementation of Your Voice Matters to additional hospitals across the province. In collaboration with the Canadian Partnership Against Cancer, we have shared our approach of real-time measurement with other provinces and are contributing to national benchmarking efforts for the collection and analysis of patient-reported outcome and experience measures.

We use all of this information to adjust planning, respond to changes and improve quality and performance of the cancer system.

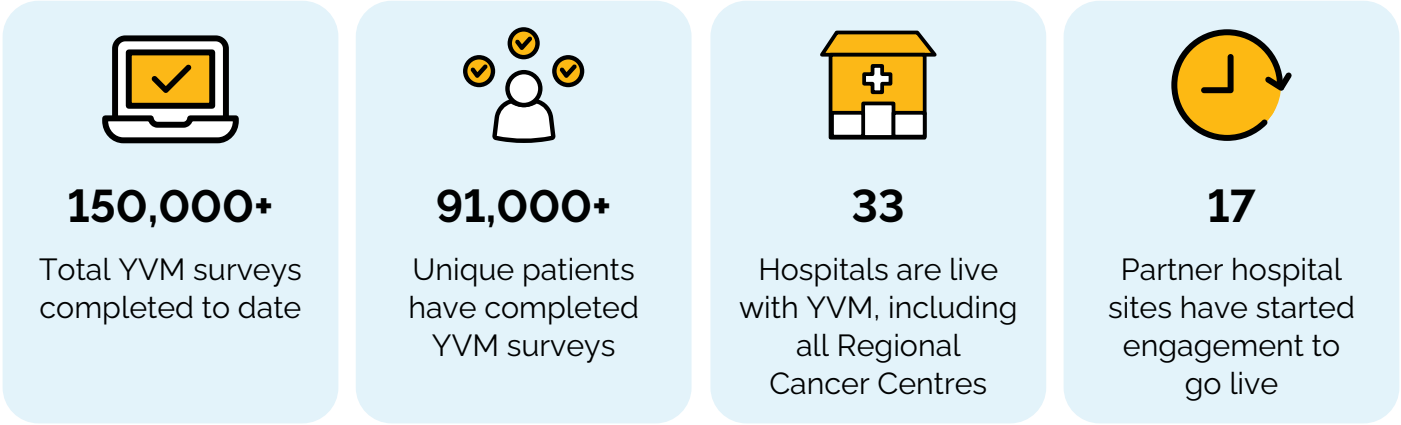


Figure 4: Your Voice Matters (YVM) Progress (2016-2023)

NATALIE AUBIN

"Ontario Cancer Plan 6 highlights important opportunities to improve integration within and across the health care system. By strengthening these connections, we will improve care coordination and outcomes for all Ontarians. The plan also focusses on provider well-being and health human resource strategies that will enable future cancer system improvements, innovation and sustainability. Recruitment and retention are especially important in the North, where we often experience greater health human resource challenges."

Dr. Natalie Aubin is Regional Vice-President, North East Regional Cancer Program and Vice-President, Social Accountability, Health Sciences North.

Appendix: Data Tables

For Tables 1 to 5 below, select data notes have been provided. For complete information on the analyses, visit the Ontario Cancer Statistics report.

Table 1: Projected incidence counts and age-standardized rates for all cancers combined, Ontario, 2015 to 2024

Year of Diagnosis	New Cases	Age-Standardized Incidence Rate (per 100,000)
2015	79,138	547
2016	80,636	544
2017	84,204	553
2018	84,244	539
2019	84,305	526
2020	78,772	481
2021	90,979	543
2022	93,173	544
2023	95,208	543
2024	97,193	542

Notes:

- Rates are standardized to the age distribution of the 2011 Canadian Standard population
- Because 2020 was an anomalous year that can bias the estimates, incidence data for 2020 have been excluded for calculating projected incidence counts and rates
- Cancer incidence in 2020 was lower than expected compared to previous years in Ontario. This decrease was seen in many jurisdictions and is due to an overall decrease in cancer cases diagnosed as a result of the COVID-19 pandemic.

Analysis by: Surveillance, Ontario Health (Cancer Care Ontario)
Data Source: Ontario Cancer Registry (December 2022), Ontario Health (Cancer Care Ontario)

Table 2: Expected proportion of new cancer cases for all cancers combined, by age group, Ontario, 2024

Age Group	Per Cent of New Cancer Cases (%)
Ages 0 to 39	4.7
Ages 40 to 59	19.7
Ages 60 to 79	56.8
Ages 80 and older	18.8

Analysis by: Surveillance, Ontario Health (Cancer Care Ontario)
Data Source: Ontario Cancer Registry (December 2022), Ontario Health (Cancer Care Ontario)

Table 3a: Age-standardized mortality rates for all cancers combined, Ontario, 1986 to 2020

Year	Age-standardized Mortality Rate (per 100,000)
1986	254.0
1987	255.8
1988	261.0
1989	256.3
1990	249.9
1991	251.2
1992	249.1
1993	249.4
1994	253.5
1995	249.3
1996	245.7
1997	240.4
1998	237.5
1999	240.0
2000	239.6

Year	Age-standardized Mortality Rate (per 100,000)
2001	238.9
2002	235.2
2003	231.4
2004	228.1
2005	224.6
2006	218.6
2007	215.8
2008	213.3
2009	209.6
2010	207.8
2011	206.2
2012	202.7
2013	198.2
2014	195.9
2015	192.6
2016	192.3
2017	188.1
2018	185.2
2019	178.6
2020	176.7

Table 3b: Average annual per cent change in age-standardized mortality rates, for all cancers combined, Ontario, 1986 to 2020

Time Period	Annual Per Cent Change (%)
1986 to 2001	-0.6
2001 to 2020	-1.5

Note: Rates are per 100,000 and standardized to the age distribution of the 2011 Canadian Standard population.

Analysis by: Surveillance, Ontario Health (Cancer Care Ontario)
Data Source: Ontario Cancer Registry (February 2022), Ontario Health (Cancer Care Ontario)

Table 4: Age-standardized five-year relative survival ratios, for all cancers combined, Ontario, from the 1986 – 1990 to the 2016 – 2020 period

Time Period	Relative Survival Ratio (RSR) (%)	95% Confidence Interval
1986 to 1990	50.6	50.4–50.9
1996 to 2000	58.6	58.4–58.8
2006 to 2010	64.2	64.0–64.4
2016 to 2020	66.3	66.1–66.6

Note: Relative survival ratios were age-standardized using the International Cancer Survival Standards.

Analysis by: Surveillance, Ontario Health (Cancer Care Ontario)
Data Source: Ontario Cancer Registry (December 2022), Ontario Health (Cancer Care Ontario)

Table 5: Projected prevalence counts for all cancers combined, Ontario, 2019 to 2034

Year	Prevalent Cases
2019	845,188
2034	1,265,216

Analysis by: Surveillance, Ontario Health (Cancer Care Ontario)
Data Source: Ontario Cancer Registry (December 2022), Ontario Health (Cancer Care Ontario)

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