

# Cancer Care Ontario

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Cancer Care Ontario (CCO) was established in April 1997 to integrate cancer services throughout the province. CCO assumed the operations of the Ontario Cancer Treatment and Research Foundation, which had been established under the *Cancer Act* to conduct a program of research, diagnosis and treatment of cancer, including:

- the establishment, maintenance and operation of research, diagnostic and treatment centres;
- the laboratory and clinical investigation of cancer problems;
- the adequate reporting of cases and the recording and compilation of data;
- the education of the public in the importance of early recognition and treatment; and
- the training of technical personnel.

CCO's primary task is "to ensure that people in Ontario continue to receive high-quality cancer treatment." CCO also aims to reduce the number of people affected by cancer in the future by increasing prevention and screening efforts. In addition, CCO advises the Ministry of Health on cancer issues.

CCO's operations include eight regional cancer centres, the Ontario Breast Screening Program and the Ontario Cancer Registry. Ministry statistics indicate that CCO provides approximately 75% of the radiation treatment in Ontario. The remaining 25% is provided by the Princess Margaret Hospital site of The Toronto Hospital.

To organize CCO's activities and to prevent unnecessary duplication of services and programs, regional cancer networks are being established to plan and coordinate all cancer services in their regions. This includes the work of voluntary and community-based groups, agencies, health professionals and institutions that provide cancer control services. The eight regional cancer centres and their respective host hospitals will act as the hubs for the regional cancer care delivery system.

During the 1998/99 fiscal year, CCO had expenditures totalling approximately \$209 million, of which \$173 million was funded by the Ministry of Health. The remaining \$36 million was generated from donations, bequests, investment income and other sources.

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## AUDIT OBJECTIVES AND SCOPE

The objectives of our audit of Cancer Care Ontario were to assess whether:

- adequate policies and procedures were in place to ensure individuals receive high-quality cancer services; and
- adequate procedures were in place for managing CCO's financial, human and physical resources.

Our audit was performed in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants, and accordingly included such tests and other procedures as we considered necessary in the circumstances. Prior to the commencement of the audit, we identified the audit criteria we would use to address our audit objectives. These were reviewed and accepted by senior management of CCO.

Our audit focused on both CCO's head office operations and the activities at a sample of regional cancer centres. The fieldwork for this audit was primarily conducted from February to September 1998. We reviewed and, where warranted, relied on work completed by CCO's internal auditor.

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## OVERALL AUDIT CONCLUSIONS

To help ensure that people in Ontario receive high-quality cancer care, the Ministry needs to clarify CCO's role and powers and the Ministry's expectations regarding CCO's administration through the establishment of a Memorandum of Understanding.

CCO needs to better ensure that individuals receive high-quality cancer services and that the provision of cancer care in Ontario operates as an integrated system. In particular, we noted that:

- Only 32% of patients requiring radiation therapy received it within the recommended four weeks from referral.
- A long-range plan that integrates radiation equipment and staffing requirements was needed to address the needs of patients.
- The Ontario Breast Screening Program had insufficient mechanisms to monitor whether screening centres were meeting required performance standards and to ensure that high-risk women were identified for screening.
- CCO lacked authority to collect certain medical information needed for planning, implementing and evaluating cancer detection and control.
- CCO's head office needed to better coordinate the reporting of quality assurance activities by regional cancer centres.

While CCO generally managed its resources adequately, improvements were still needed. We found that:

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- The approval and monitoring of research projects varied among regional cancer centres.
  - Potential conflicts of interest needed to be resolved prior to awarding contracts.
  - Controls over the acquisition and monitoring of services provided by smaller consulting firms were insufficient.
  - Cancer Care International was not managed with due regard for economy.

In making our recommendations, we were aware that CCO was in the process of implementing and developing a number of initiatives which are intended to improve the provision of cancer services, including: the development of clinical practice guidelines; the provision of more community-based radiation oncology consultations; and the development of new prevention programs. In addition, CCO has implemented activity-level reporting, which enables it to compare levels and costs of services among regional cancer centres.

## DETAILED AUDIT OBSERVATIONS

### ACCOUNTABILITY

Legislative authority for the Ontario Cancer Treatment and Research Foundation (OCTRF) was established in Part 1 of the *Cancer Act*, 1957. CCO operates under the same legislation.

With the increasing emphasis on cancer prevention and screening, CCO's role is significantly different from that of the OCTRF. Accordingly, revised legislation is needed to define CCO's objectives, responsibilities and powers as well as the relationship between CCO and the Ministry of Health. At the end of our audit, we were informed that meetings had been held between the Ministry and CCO to discuss revised legislation.

Management Board of Cabinet directives require that operational agencies, which included the OCTRF, must, at least once every five years, prepare a Memorandum of Understanding between the chairperson of the agency and the minister responsible. All memoranda must be approved by Management Board of Cabinet. Areas to be covered include:

- the roles of the minister and the agency head;
- the accountability relationship;
- financial and administrative arrangements;
- reporting requirements; and
- the extent to which specific Management Board directives apply to the agency.

Neither CCO nor OCTRF had a Memorandum of Understanding with the Ministry of Health. The Ministry and CCO have met to discuss establishing a Memorandum of Understanding but, at the time of our audit, had not reached an agreement.

### **Recommendation**

To clarify Cancer Care Ontario's (CCO's) role and responsibilities and the Ministry's expectations regarding CCO's administration, the Ministry should expedite:

- revisions to the *Cancer Act*; and
- the establishment of a Memorandum of Understanding with CCO.

### **Ministry Response**

*In February 1999, the Ministry and CCO initiated a series of meetings to develop a Memorandum of Understanding. These meetings resulted in a final draft Memorandum satisfactory to CCO. It is anticipated that the Memorandum will be finalized in the second quarter, 1999/2000.*

*After the Memorandum of Understanding with CCO is finalized, the Ministry will begin the process of revising the Cancer Act.*

## **TREATMENT**

### **RADIATION THERAPY**

Radiation treatment in Ontario is provided at CCO's eight regional cancer centres (RCCs) and at the Princess Margaret Hospital site of The Toronto Hospital. In the 1998/99 fiscal year, approximately 336,000 radiation treatments were provided at the eight RCCs (in the 1997/98 fiscal year, 320,000 treatments were provided). Radiation treatments represent about one third of CCO's total operating budget, with total expenditures of \$50.5 million in the 1998/99 fiscal year.

Timely access to care requires a sufficient number of oncologists at the cancer centers to provide consultations and prescribe treatments, and sufficient radiation machines and staff to operate these machines.

### **PATIENT WAITING TIMES FOR RADIATION TREATMENT**

Radiation oncologists provide consultations and prescribe treatment, radiation therapists deliver the treatment and physicists maintain radiation equipment. At the time of our audit, CCO did not have staffing standards in place for any of these positions. CCO's 1998 Strategic Plan for the Radiation Treatment Program included recommendations that a workload standard for radiation oncology be determined and that appropriate staffing standards for radiation therapists and medical physicists be reviewed and endorsed.

All three RCCs we visited prioritized patients into categories for timing of treatment. Patients needing emergency treatment received same-day radiation treatment. While there are few evidence-based studies on acceptable waiting times from surgery to radiation treatment, the Committee on Standards of the Canadian Association of Radiation Oncologists recommends that the time between patient referral and initiation of radiation treatment not exceed four weeks. At the end of our audit, we were advised that CCO's head office had set a target for

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the RCCs to achieve, by March 31, 2000, 50% of cases moving from referral to treatment within four weeks and 90% within eight weeks.

CCO prepares reports on the length of patient waiting times from the time of a patient's referral to the RCC to the beginning of treatment. In 1998, only 32% of patients were treated within four weeks. The percentages at individual RCCs ranged from 24% to 40%.

CCO senior management informed us that maximum desirable waiting times vary, depending on the type of cancer. However, the standard of four weeks was being used because they did not know whether exceeding four weeks would compromise care. The Canadian Association of Radiologists generally endorses breast irradiation "as soon as possible after surgery and not later than twelve weeks after."

To help reduce waiting times, CCO's 1998 Strategic Plan for the Radiation Treatment Program recommended that the daily operating hours for radiation equipment at RCCs be increased to 10 hours at small centers and 12 hours at large centers. This would make better use of available treatment equipment capacity. CCO estimated that, if implemented, the savings from extending hours rather than adding new equipment would be \$99 million between 1998 and 2006.

The Strategic Plan also recommended that either the proposed Peel or Durham cancer centre open in 2005 and the other in 2008. In addition, a new cancer centre was recommended for the London/Hamilton region by 2002. However, based on the recommendations of the Health Services Restructuring Commission, all three centres are planned to be opened by 2002.

In its 1998/99 operating plan, CCO advised the Ministry, "If treatment capacity is not expanded, waiting times for consultation and treatment will increase significantly and at a very early time." We were informed that CCO expected a shortage of radiation oncologists in Ontario within the next few years. Shortages of radiation therapists and physicists were also expected. Adding new centres and equipment and extending hours of operation will increase the need for trained staff. At the time of our audit, plans in place to address the anticipated shortage of qualified staff were limited to radiation therapists.

In December 1998, the Minister of Health established a Task Force on Human Resources for Radiation Services. The purpose of the Task Force was to identify immediate and long-term human resource requirements and to make recommendations on how to meet those requirements. A report was issued to the Minister in February 1999. The report stated that the delays in accessing radiation treatment services, "which can compromise quality of care, result from an insufficiency in the availability of those professionals involved in the delivery of radiation treatment." The report included a number of recommendations to address the need for additional professional staff based on staffing ratios determined by the Task Force.

Historically, each RCC has determined its own radiation therapy equipment requirements using factors such as the increasing incidence of cancer due to an aging population; increased referrals for treatment due to more community outreach programs; new and more complicated treatment techniques; and aging radiation equipment. Between 1990 and 1997, CCO invested \$118 million in radiation equipment.

In June 1998, CCO developed a model for the replacement and funding of radiotherapy equipment for Ontario. The model projects that each year six or seven radiation therapy machines will require replacement and that an additional three to five new radiation machines

will be required to address the increasing patient load. CCO estimated the cost to meet this need at \$22 million to \$30 million per year.

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## Recommendation

To ensure patients' access to radiation therapy is improved, Cancer Care Ontario (CCO), in conjunction with the Ministry, should develop and implement a long-range planning and funding process that integrates equipment and staffing requirements for radiation therapy.

## Agency Response

*The Minister has accepted the recommendations of the Task Force on Human Resources for Radiation Services and has stated that resources will be made available to implement these recommendations. Further, the acceptance by the Ministry of both workload standards and cost-per-case funding of radiation services will allow CCO to implement a long-range approach to the staffing and equipment needs of radiation facilities.*

*CCO has completed a comprehensive review of radiation treatment equipment requirements for each of its regional cancer centres over the next decade (including new centres in Durham, Peel and Kitchener). This review, which encompasses both replacement and new radiation treatment equipment, has been submitted to the Ministry.*

## RADIATION EQUIPMENT AVAILABILITY

Radiation treatment is primarily delivered by cobalt machines, which produce low-energy radiation, and linear accelerators, which produce low- to high-energy radiation. Linear accelerators deliver more uniformly intense radiation, but are more than three times as costly to operate as cobalt machines. At three RCCs, we reviewed the percentage of radiation treatments on cobalt machines for two of the most common cancers.

**Percentage of Radiation Treatments on Cobalt Machines  
During the 1997/98 Fiscal Year**

Disease Site	Centre 1	Centre 2	Centre 3
Breast	16%	34%	64%
Lung	11%	30%	49%

*Source: Cancer Care Ontario data*

Centre 1, which had the lowest percentage of cobalt-treated patients, had the capacity to use either cobalt machines or linear accelerators. On the other hand, Centre 3 was already using its linear accelerators for extended hours and was referring some patients to another RCC. CCO

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advised the Ministry that, due to the mix of treatment machines at Centre 3, some patients who would benefit from high-energy linear accelerator treatments were being treated on medium-energy machines. As well, some patients who would be better treated at medium energy were being treated with cobalt. CCO stated, “This distribution results in two types of hazards: jeopardization of cure rates and increased normal tissue toxicity.”

### **Recommendation**

**To help ensure the best outcomes for patients from radiation treatment, Cancer Care Ontario (CCO), in conjunction with the Ministry, should implement a plan that provides the most effective radiation treatment equipment for patients.**

### ***Agency Response***

***Providing the most effective radiation treatment equipment requires that the most effective equipment is purchased and upgraded as necessary. Although there is a very effective process for identifying and funding the most effective equipment at the time of initial purchase, there is not an easily accessible method for funding equipment upgrades. While upgrades do not always have easily demonstrable patient benefits, improvements in quality and accuracy can only have a positive impact on patient care. The need for a more rigorous system for evaluating and demonstrating these benefits will be addressed.***

### ***Ministry Response***

***The Ministry supports the intent of the recommendation. As CCO is the primary advisor to the Ministry on cancer issues, the Ministry will request that CCO submit both a business and an implementation plan for the ongoing replacement of radiation equipment. The plan will include the type of equipment needed, the site, the cost in Canadian dollars and the date required.***

## **CLINIC WAITING LISTS**

Patients referred to an RCC must initially be seen by an oncologist, who determines the appropriate treatment. Referred patients are generally assigned the first available appointment. However, if there is a long wait for an appointment, appropriate action is taken by RCC staff. For example:

- The definition of a long wait for an appointment varied from two weeks to one month at the RCCs we visited. At one RCC, program heads were notified weekly of all waits greater than two weeks.

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- One RCC used “managed” waiting lists for patients with certain types of cancer, whereby appointments were based on patient priorities. We were informed that waits for clinic appointments for these patients ranged from six to eight weeks. However, higher priority patients would be seen as soon as medically required.

In general, waiting times from patient referral to initial clinic appointment were not formally tracked at the RCCs we visited. One RCC did track the time patients waited for appointments if the patient was referred to a medical or radiation oncologist. At the time of our audit, waiting times for patients to see a medical oncologist at this RCC varied from one day for lung cancer to 16 days for melanoma. Waiting times to see a radiation oncologist ranged from two days for central nervous system cancer to 69 days for breast cancer.

In the 1997/98 fiscal year, the number of patients treated by radiation was approximately 10% greater than the number treated using chemotherapy. CCO’s head office has introduced a monthly retrospective report which compares the waiting times to see a radiation oncologist at all RCCs. However, there was no similar report for medical oncologists. RCC satellite clinics maintained their own waiting lists for appointments. We were informed that the waiting times to access satellite clinics were not included in the RCC data on waiting times.

### **Recommendation**

**To help ensure that all cancer patients receive care within the recommended timeframe, Cancer Care Ontario (CCO) should:**

- **establish standards for waiting times from patient referral to initial clinic appointment; and**
- **ensure that patient waiting times for all types of clinic appointments are tracked and appropriately followed up.**

### ***Agency Response***

***Standards for waiting times and a monthly retrospective report of waiting times to see a radiation oncologist are now in place at all regional cancer centres.***

***We now have in place a similar program for patients receiving systemic treatment that records the wait time from the date of the phone call or written request for consultation to the time of the actual consultation. This program is now available by centre for all disease sites combined and for selected specific disease sites and will be an indicator for our quality assurance program. To date, there is no national or provincial standard for systemic treatment wait times. CCO plans to address this issue.***

## **PRACTICE GUIDELINES**

Practice guidelines are developed to assist doctors in making decisions about the treatment of their patients. Following these guidelines better ensures consistency of treatment, improves health outcomes and reduces unnecessary costs to the health care system.



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In 1993, CCO's predecessor established a practice guidelines initiative for the development of clinical practice guidelines. Using an established framework, preliminary guidelines are developed and then sent to a sample of doctors for feedback. Finalized guidelines are published in the *Canadian Journal of Oncology* and are also available on CCO's website. At the time of our audit, 16 guidelines had been completed and another 49 were in various stages of development. In January 1998, a process was proposed for reviewing and updating guidelines.

Further research is required to determine the best strategies for disseminating the guidelines, for determining whether they are being followed and for evaluating their impact on patient quality of life and survival. CCO had entered into an agreement with the Institute for Clinical Evaluative Sciences to review the effect of the guidelines on surgical practice.

Where provincial guidelines are lacking, CCO recommends that RCCs develop their own interim policies and protocols. We found that these interim measures were not always consistent among RCCs. For example, at one RCC, breast cancer patients received 25 radiation treatments while at another RCC patients received 16 treatments. We understand that CCO has conducted clinical trials on the optimal number of treatments; however, the results will not be known for a number of years.

### **Recommendations**

**Cancer Care Ontario (CCO) should periodically assess the usage and effectiveness of its practice guidelines and take corrective action where warranted.**

**To reduce duplication of effort by regional cancer centres (RCCs) and to better ensure consistent patient treatment, CCO should consider having RCCs jointly develop interim practice guidelines.**

### ***Agency Response***

***Plans have been initiated to assess the impact of guidelines. A joint program between the Institute of Clinical Evaluative Sciences and the Program in Evidence-based Care, funded by the Ministry, has begun research into outcomes to link patterns of practice in Ontario with the release of guidelines. The joint program has adopted the principle that audits of medical records should be incorporated into the review of patterns of practice and consistency with guidelines.***

***With respect to "corrective action," it would be premature to conclude that discordance between clinical practice and guidelines is necessarily an issue of correction per se. The reasons for such differences need to be explored.***

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***We agree that confusion around variations in practice in Ontario would be usefully addressed by having the regions adopt a cooperative model in developing management policies or protocols that could be shared. CCO has already begun to address this problem through the Medical Oncology Professional Advisory Committee. The policies for colorectal cancer are now complete.***

### **DRUG FORMULARY**

Systemic therapy is the use of drugs, including chemotherapy, hormones and immunotherapy, in the treatment of cancer.

In 1995, CCO's Task Force To Review Systemic Therapy at Regional Cancer Centres reported that "a provincial formulary will provide the information required by physicians to assist them in selecting the least costly regimen from those of similar benefit." The report also stated that accurate costing for the delivery of drugs by treatment regimen should be implemented. The Task Force recommended that a provincial formulary of chemotherapy regimens, including resource utilization, be implemented.

In February 1998, the Systemic Therapy Advisory Committee stated that "comparisons should be able to determine which of several drugs is more cost effective to treat a particular stage of disease." The Committee identified the need for information on the costs of drugs and other resources required to treat each type of cancer. The factors to be included were hospital admissions, toxicity of drugs and probability of survival.

Internal correspondence at CCO indicated that a provincial formulary would standardize chemotherapy protocols and regimens across CCO, reduce duplication and overlap and identify the most cost-effective protocol for a given type and stage of cancer. One RCC we visited had its own formulary, and another had a list of drug regimens that had been tailored to that RCC.

At the time of our audit, we were informed that a provincial formulary listing all treatment regimens in use was being implemented. However, it did not include information on which drugs are more cost effective for treating particular stages of cancer, as recommended by the Systemic Therapy Advisory Committee.

#### **Recommendation**

**To encourage the use of equally effective but less costly treatment regimens, Cancer Care Ontario should identify the most cost-effective drug regimens for treating different types of cancer and make this information available to medical practitioners prescribing cancer treatment.**

### **Agency Response**

***The development of the provincial drug formulary is nearing completion. Costs of the various regimens will be included. In addition to drug costs, one also has to consider the costs associated with the administration of the drug and the frequency of administration. For example, an expensive drug given once every three or four weeks may be more cost effective than a protocol using a much cheaper drug which is administered five days each month. The Systemic Therapy Advisory Committee, with the help of a health economist, is addressing these issues.***

## **SCREENING PROGRAMS**

The purpose of screening is the early detection of cancer in people without any symptoms. For screening to be effective, a cancer must be found early, before it spreads. CCO supports four cancer screening programs: breast, cervical, colorectal and genetic. Currently, population-based screening programs are used for breast cancer, because tumors can be detected early, and cancer of the cervix, because precancerous changes can be detected. The Ontario Breast Screening and Cervical Screening programs are province-wide initiatives funded by the Ministry of Health and administered and operated by CCO.

Breast and cervical screening programs are considered cost effective because the costs of screening appropriate segments of the population and treating cancer in early stages are generally less than the health care costs associated with treating advanced cancers. Colorectal and genetic screening programs are currently in the preliminary stages of development.

### **ONTARIO BREAST SCREENING PROGRAM**

The Ontario Breast Screening Program (OBSP) was established in 1990 to reduce mortality from breast cancer through early detection. To accomplish this goal, the OBSP provides mammograms at nine CCO-operated screening centres, 29 affiliated sites and one mobile unit. The OBSP is operated under an agreement between CCO and the Ministry of Health. The OBSP's target population is women 50 to 69 years of age with no current symptoms of breast cancer. CCO estimated that in 1997 there were approximately one million women in the OBSP's target population.

The suggested screening period for the majority of women is once every two years, although some higher risk women are rescreened annually. During the 1998/99 fiscal year, the costs of providing these services totalled approximately \$14.7 million.

### **INFORMATION AND DATA COLLECTION**

The OBSP's goal is to screen 70% of the target population once every two years by 2001. However, the OBSP's ability to determine whether it is achieving its goal is limited because:

- Women in Ontario can be screened (obtain a mammogram) either at an OBSP facility or through a physician referral to a non-OBSP facility. The vast majority of mammograms performed in Ontario in 1997 were performed at non-OBSP facilities. The cost of these mammograms is covered by the Ontario Health Insurance Plan on a fee-for-service basis.

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Due to the confidentiality of medical records, the OBSP does not receive information on women who have had non-OBSP mammograms. Accordingly, for the target population, the OBSP cannot determine:

- the number of women who have had mammograms in the last two years at facilities outside the OBSP;
  - which women outside of the OBSP have not been rescreened in the last two years;
  - which women are high risk; and
  - which women have never been screened.
- CCO's head office does not regularly track the timeliness of rescreens. The OBSP distinguishes only between initial screens and rescreens, regardless of the length of time between them.

For 1997, the OBSP's provincial participation rate was estimated to be only 13% of the target population. However, without information on the number of screens performed on the OBSP's target population at non-OBSP facilities, CCO is not in a position to plan an effective strategy to meet changing needs across the province.

### **Recommendation**

**To assist Cancer Care Ontario (CCO) in developing a strategy to achieve coverage targets for the Ontario Breast Screening Program (OBSP), the Ministry should examine ways of making available the mammography information it maintains on the OBSP's target population.**

### ***Ministry Response***

***The Ministry is committed to working with CCO to develop and implement strategies to increase the participation of women in the age group 50 to 69. The Ministry invites CCO to submit a proposal regarding information that would assist it in enhancing the OBSP's acceptance by the target group of women.***

## **EFFECTIVENESS MEASURES**

By reaching a participation rate of 70% of the women in its target group, the OBSP expects to be able to reduce mortality from breast cancer by 30%. Randomized, controlled trials have shown that a screening program can have an impact on mortality 4 to 10 years after its introduction.

At the time of our audit, CCO was evaluating parts of its screening programs and comparing the results to those of other jurisdictions and to recognized standards. In December 1997, it issued the first in-depth report on the activities and accomplishments of the OBSP. The report covered the period from 1990 to 1997 and included statistical data such as referral rates. These results were compared to other screening programs and to recognized standards.

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Since mortality reduction is the key objective of this program, we considered whether the OBSP would be in a position to measure its effectiveness in this area. A screening program's success in detecting cancer at an early stage is one of the main factors in achieving a reduction in mortality. The evaluation of the stage at which cancers are detected is a common method for monitoring the effectiveness of screening programs. The OBSP's ability to measure its effect on mortality is limited because the information required for a proper evaluation is only partially available from the OBSP's database. For example, while cancer stage is defined by a number of specific characteristics, the OBSP did not have complete data for any of these characteristics. In its 1998 five-year review of the program, the OBSP recognized the need for more complete data.

In addition, it is difficult to measure the OBSP's effect on mortality since many other factors can lead to a reduction. Accordingly, CCO is considering the use of alternative indicators of the OBSP's effectiveness.

### **Recommendation**

**Cancer Care Ontario should enhance its data collection systems to enable it to assess the effectiveness of the Ontario Breast Screening Program (OBSP).**

### ***Agency Response***

***The recommendation is accepted. The OBSP will continue to work to improve its capacity to collect and analyze information relevant to the effectiveness of the program. The OBSP cannot measure its impact on mortality directly and must rely on measures of program quality and effectiveness.***

## **CANCERS MISSED AT SCREENING**

The earlier a cancer is detected, the greater the likelihood of a positive outcome for the patient. Detectable cancers that are missed by the screening process are a serious risk.

If breast cancer is discovered prior to a woman's next screen, a panel of three independent radiologists reviews the initial mammogram to determine whether an abnormality was missed. If a majority of the radiologists detect an abnormality on the mammogram, the result is classified as "missed at screening." CCO records indicated that 53 of the 231 screens reviewed by panels during the past six years were determined to be cancers that were missed at screening.

Where possible, the OBSP informed radiologists when women they had screened were diagnosed with cancer. However, neither the radiologist who initially misread the film nor the regional radiology coordinator was informed of the panel's conclusions.

The OBSP did not monitor the source of cancers missed at screening, either by site or responsible radiologist. At the time of our audit, the OBSP was not identifying and matching radiologists who worked at more than one facility. This information would assist the OBSP in

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identifying patterns of cancers missed at screening so that it could take corrective action to reduce the frequency of such occurrences.

### **Recommendation**

**To improve the effectiveness of the Ontario Breast Screening Program (OBSP), Cancer Care Ontario should:**

- **develop protocols for informing radiologists and radiology coordinators of the results of radiological panel reviews; and**
- **monitor cancers missed at screening by site and responsible radiologist and take appropriate follow-up or corrective action.**

### ***Agency Response***

***The recommendation is accepted. The OBSP has recently hired a new Radiologist-in-Chief to strengthen its capacity to monitor and improve radiological quality.***

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## **STANDARDS AND GUIDELINES**

Under the terms of its OBSP agreement with the Ministry of Health, CCO is responsible for developing provincial standards and guidelines for the OBSP.

Generally, breast-screening programs are evaluated using standard measures developed from the findings of other screening programs and from randomized, controlled trials. Standards include cancer detection rates, patient referral rates and expected characteristics, such as stage of detected cancers. Although most of this information was available on OBSP's database, CCO did not routinely use it to identify differences in regional performance or instances where regions had not met provincial goals. We also noted that the completeness of information from different regions varied because information is provided on a voluntary basis. For example, completeness for one type of information ranged from 63% in one region to 93% in another region.

In addition, more frequent OBSP screening of women at greater risk of developing breast cancer could ensure earlier detection and reduce the number of cancers that are detected by other, less timely means. CCO's head office reviewed regional practices of recalling women for rescreening after one year rather than the usual two-year period. For the 17 sites operating in 1996, CCO found that one-year recall rates ranged from 3% to 14% of women screened. Although CCO had not determined the reasons for these variances, explanations included the lack of consistent definitions of high-risk women.

## **Recommendation**

**To help ensure that breast screening centres are delivering services in a consistent and effective manner, Cancer Care Ontario (CCO) should:**

- **monitor the performance of screening centres and, where standards are not being met, investigate and take corrective action as necessary; and**
- **develop mechanisms to ensure that high-risk women are identified for screening.**

## **Agency Response**

***The recommendation is accepted. The Ontario Breast Screening Program is committed to strengthening its capacity for quality assurance and quality control at its screening sites. CCO will conduct a review of its guidelines for screening high-risk women in 1999.***

## **INTERVAL BREAST CANCERS**

In a 1998 study that reviewed screening results from 1990 to 1995, CCO generally concluded that the OBSP had achieved the standards suggested by other studies and programs. One measure used was the prevalence of interval cancers, which are cancers discovered between screenings. While the number of interval cancers expected to be identified is relatively small, it is a relevant indicator of quality assurance.

The study found that the rate of interval cancers diagnosed within one year of screening was 0.25 per 1,000 women screened. This rate is one of the lowest among the jurisdictions we reviewed, including two other Canadian provinces, where rates ranged from 0.25 to 1.2 per 1,000 women screened.

During our review of these rates, we noted the following:

- The OBSP attributed its low rate of interval cancers partially to the use of clinical breast exams during screening. In addition to two-view mammograms, all OBSP sites were required to provide clinical breast exams by a trained nurse. The study concluded that without the additional cancers detected by the clinical breast exams, the interval cancer results would have been 0.64 per 1,000 women screened.

While the majority of affiliated sites continue to have a nurse perform clinical breast exams, as of April 1998, it was no longer required by the OBSP. This may affect interval cancer rates in future years. However, CCO management believes that it will enable the OBSP to increase the number of affiliated centres and reduce the number of unnecessary referrals.

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- Our review of OBSP data indicated that CCO had data on some interval cancers that were not considered in the study of interval cancer rates for women who had been screened by the OBSP. At the time of our audit, CCO was in the process of analyzing the effect the additional data would have on the results of its study. However, we calculated that if those cancers had been included in the study, the rate for interval cancers detected would increase.

### Recommendation

**To help ensure that Ontario Breast Screening Program (OBSP) outcomes are reported as accurately as possible and that those outcomes remain within acceptable standards, Cancer Care Ontario (CCO) should:**

- ensure that all relevant CCO data are included when calculating OBSP interval cancer rates; and
- assess the impact of clinical breast exams on interval cancer rates.

### Agency Response

*The recommendation is accepted. The OBSP is working closely with the Ontario Cancer Registry to ensure that all interval cancers are included in its analyses. OBSP will monitor closely the impact on interval cancer rates of clinical breast examination as an adjunct to mammography.*

## CERVICAL SCREENING PROGRAM

The goal of the Cervical Screening Program is to reduce the mortality rate from cervical cancer by increasing early detection of pre-cancerous conditions. One objective is to decrease mortality from cervical cancer by increasing the proportion of women screened according to the guidelines of the Ontario Cervical Cancer Screening Group.

Cervical screening (Pap smear testing) was introduced in the 1960s and is primarily performed by physicians as part of a woman's checkup and is paid for on a fee-for-service basis by the Ontario Health Insurance Plan. The procedure can detect pre-cancerous conditions and can thereby reduce the incidence of, as well as mortality from, cervical cancer. For the 1998/99 fiscal year, the Ministry provided \$1.7 million for the development of a cervical screening database and program operating costs.

In 1993, the Ontario Cancer Treatment and Research Foundation, the Ministry of Health and representatives from organizations involved in cervical screening activities formed the Ontario Cervical Screening Collaborative Group to develop, circulate and evaluate policies and recommendations related to a cervical screening program.

The Collaborative Group's objective is to reduce the incidence of and mortality from cervical cancer by 50% between 1993 and 2005.

The Collaborative Group recognized that an organized cervical screening program was needed to achieve the desired reduction in cervical cancer. In 1997, it decided to develop a computerized cervical screening database to enable it to measure program effectiveness.



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In 1995, a non-profit corporation formed by six private laboratories developed a centralized database for information on cervical screens. To establish the database, the six participating laboratories contributed patient diagnostic data from the cervical screening tests they performed.

The initial purpose of the database was to provide physicians with access to women's cervical screening histories to help them:

- properly interpret Pap smears;
- make informed recommendations for the follow-up of abnormalities;
- ensure detected abnormalities have been appropriately followed up; and
- ensure the timely scheduling of women for subsequent tests.

In December 1997, CCO and the non-profit corporation entered into a partnership to maintain and operate the database. However, its effectiveness has been limited due to incomplete data. For the 1997 year, only approximately 50% of the estimated 1.5 million Pap smears taken in Ontario were registered on the database. This can be attributed to the following:

- Reporting information on Pap smears is voluntary.
- Some laboratories are either not computerized or have computerized data that is incompatible with the database.
- Tests are performed in hospital laboratories, which cannot release their results due to restrictions contained in the *Public Hospitals Act*.

If the database was fully implemented and included information on all women screened over a period of years, CCO would be better able:

- to develop an effective process to help ensure all women in the target population are screened;
- to monitor whether women are being rescreened on a timely basis;
- to develop a program to monitor the quality of screening tests, including follow-ups with physicians who have regularly performed unsatisfactory Pap smear tests;
- to institute a program to monitor physician adherence to the Collaborative Group's recommendations on appropriate follow-up procedures, including the treatment of abnormalities; and
- to develop procedures to monitor and evaluate the Cervical Screening Program.

CCO estimates that to achieve the Collaborative Group's goal of reducing the incidence of and mortality from cervical cancer by 50% by 2005, complete data on women screened in the province must be brought into the database by the year 2000. Experts have also stated that if the database is successfully implemented, including full target-population screening and rescreening, the rescreening of women with three consecutive annual negative Pap smear results could be increased from two to three years, thus reducing health care costs.

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### Recommendation

To enable Cancer Care Ontario (CCO) to develop a more effective cervical screening program and to be in a position to better monitor the achievement of objectives, the Ministry should:

- facilitate access to appropriate cervical screening information; and
- develop protocols to use data for statistical purposes while safeguarding the privacy of patient information, including information received from private laboratories.

### Ministry Response

*The Ministry is currently reviewing a draft agreement with CCO and its private sector partners to ensure that patient confidentiality is protected in the collection, use and disclosure of data for statistical purposes. At the request of CCO, the Ministry is reviewing options to facilitate the collection of cervical data from hospital laboratories. This review is expected to be completed in the second quarter of 1999/2000.*

## QUALITY ASSURANCE

CCO uses various methods to monitor how effectively it is achieving its mission and objectives. These include accreditation by the Canadian Council on Health Services Accreditation; performance reviews of the chief operating officers of the RCCs; and the tracking of treatment statistics. CCO's senior management visits the RCCs periodically to discuss operations and issues with RCC management.

In 1995, the Canadian Council on Health Services Accreditation reviewed the head office of the Ontario Cancer Treatment and Research Foundation (OCTRF). The Council reported that "while all cancer centres surveyed showed evidence of quality improvement programs, the reporting and coordination of these activities at the provincial level has not been adequately demonstrated." The report noted that CCO had plans in place to address this issue.

In May 1996, the OCTRF's board of directors approved terms of reference for a Quality Improvement and Ethics Committee. This Committee's assigned responsibilities included:

- ensuring the development and maintenance of an integrated program of quality improvement, utilization and risk management, including the identification of standardized quality indicators; and
- reviewing accreditation surveys and other external sources and ensuring that any deficiencies noted are adequately addressed.

We found that the quality improvement activities at the three RCCs we visited varied widely. For example, one RCC stated that having formal processes for a quality improvement program, as well as reviewing and improving activities, were key to that RCC's future. Another RCC had a variety of quality improvement projects underway. However, we found little indication of quality improvement activities being coordinated at the provincial level among RCCs. For example, while one RCC had developed a patient satisfaction

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questionnaire that was also used by another RCC, the third RCC had developed its own survey.

In May 1998, CCO held its first workshop for staff on developing provincial performance indicators applicable to all RCCs. CCO intends to implement one or two indicators in 1999, with others to follow.

### **Recommendation**

**To enable it to ensure the delivery of high-quality cancer care in Ontario and to identify and act on significant variances among regional cancer centers (RCCs), Cancer Care Ontario (CCO) should:**

- expedite the development of performance indicators and coordinate RCC quality improvement activities;
- ensure that all RCCs consistently report quality improvement activities; and
- take timely corrective action as necessary.

### **Agency Response**

*The development of performance indicators and the assessment of the extent to which RCCs achieve performance targets are very high priorities for CCO. The board's Quality of Care and Ethics Committee has responsibility for overseeing this process. At the management level, a quality working group has been established with responsibility for the elaboration of provincial quality indicators and for the ongoing assessment of the extent of RCC adherence to these indicators. This group will be assigned the staff support and access to information systems required to achieve its objective.*

## **CANCER PREVENTION**

Prevention means eliminating the causes of cancer. Primary prevention is the main focus of cancer control for cancers that have known, modifiable risk factors. Such cancers include lung cancer (risk factor: smoking) and skin cancer (risk factor: exposure to sunlight). The approved budget for primary prevention for the 1998/99 fiscal year is \$700,000.

CCO's three-year strategic plan stated: "It has increasingly been recognized that in order to make important gains in reducing cancer incidence, morbidity and mortality, an approach that places greater emphasis on prevention is critical." In that regard, CCO planned to develop a comprehensive and coordinated approach to cancer prevention that is accessible to all individuals in the province.

CCO's strategy included ensuring that new prevention initiatives are implemented; however, no formal protocols had been developed to evaluate and coordinate their implementation. For example, CCO did not have protocols that could be used:

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- to evaluate new breast cancer prevention drugs and coordinate their use in conjunction with the Ontario Breast Screening Program; or
- to ensure that the most recent findings on skin cancer are communicated through coordination with other prevention agencies, including public health units.

In its April 1998 *Cancer Report Card*, CCO stated that “preventing cancer by eliminating its causes is our best strategy to save lives and prevent suffering.” However, cancer causes such as high-fat, high-calorie diets, physical inactivity, unprotected sun exposure, workplace carcinogens and excessive alcohol consumption were not being effectively addressed in Ontario. Plans to deal with this included encouraging a strong public health system and developing strategies for promoting healthy eating, active living and sun safety.

To this end, CCO created the Ontario Network for Cancer Prevention (ONCP) to create a single focus for cancer prevention in Ontario. All organizations in Ontario active in cancer prevention are to be brought together to identify, prioritize and develop new prevention programs; to document and build on the demonstrated strengths of existing programs; and to implement and evaluate a comprehensive approach to cancer prevention in the province. The ONCP will plan and promote the development, implementation and evaluation of effective and cost effective programs in cancer prevention. At the time of our audit, ONCP activities had been limited to preliminary contacts with other organizations regarding tobacco use prevention.

We will follow up on CCO’s progress in this area in the near future.

## MANAGING RESOURCES

### MANAGING RESEARCH

Cancer research includes research in the areas of basic science, prevention and clinical trials. CCO’s Provincial Research Advisory Committee is responsible for the setting of research standards, the development of research policies and the coordination of research projects. Prior to its April 1998 meeting, the Committee had not met since 1996. Research expenditures for the 1998/99 fiscal year totalled \$5.9 million.

In 1998, CCO began providing each of the five larger RCCs with block grants for research funding. Those five RCCs determine how their research funds are to be allocated. At the time of our audit, CCO had no comprehensive list of all of the RCCs’ research projects. However, we were informed that a system to track all research projects is being implemented.

CCO’s three-year strategic plan, prepared in 1997, stated that critical success factors for cancer research include fostering the development of initiatives among the various cancer research groups in Ontario and successfully selecting the individuals, programs and initiatives to support. However, CCO did not generally coordinate its research with other organizations such as the Canadian Cancer Society and the Institute for Clinical Evaluative Sciences (ICES). For example, although ICES had developed breast cancer decision-aid materials for patients, one RCC separately developed its own materials for similar purposes.

One of the RCCs we visited did not have a research strategy but had held a planning session in March 1998 to discuss the future direction and focus of its research. As a result, that RCC developed a vision statement to help determine which research projects to fund in the future.

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In addition, external research reviews had been conducted at five of the eight RCCs, generally as part of a five-year review of each RCC's chief executive officer. These reviews focused on overall research operations rather than specific research projects. We were also informed that all RCCs we visited completed annual performance reviews of researchers.

Monitoring of individual research projects varied among the RCCs we visited. One RCC held regular review meetings to discuss research projects, another had weekly seminars presented by researchers and a third assessed researchers based on the amount of outside funding they received.

### **Recommendation**

**To help foster cost-effective initiatives among cancer research groups in Ontario and to generate appropriate information for selecting researchers, programs and initiatives to support, Cancer Care Ontario should:**

- **develop standard processes for approving, monitoring and evaluating research projects; and**
- **better coordinate the research efforts of the regional cancer centres and monitor the research activities of other organizations.**

### ***Agency Response***

***A database for research projects has now been developed, and data entry for 1998 is complete. Internet-based forms will be developed in 1999 to permit continuous updating of research information as well as wider accessibility.***

***The Research Advisory Committee (RAC) coordinates and monitors, at arms length, the development of province-wide research initiatives and the establishment of targeted research groups. RAC meetings have now been scheduled to occur bi-monthly. Two have taken place since November 1998, as well as two teleconference calls.***

***Four members of the newly constituted RAC serve on the National Cancer Institute of Canada Advisory Committee on Research, and many of CCO's scientists are members of peer review committees. RAC membership now includes representatives from other cancer research institutions in Ontario and Canada.***

***The requirement that CCO scientists obtain their ongoing operating funds from external agencies provides assurance of research quality and productivity. The RAC is examining the feasibility of creating several networks to improve the coordination of research in Ontario. The possibility of joint funding of specific research networks is being discussed with the National Cancer Institute of Canada. Funding for outcomes research provided to CCO has been used to formalize links with the Institute for Clinical Evaluative Sciences. The feasibility of linking the research groups at the RCCs via video-conferencing and increasing the number of CCO-sponsored workshops will be assessed.***

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### CANCER SURVEILLANCE SYSTEMS

The purpose of cancer surveillance is to collect information that can be used by cancer researchers for planning, implementing and evaluating cancer control strategies. Relevant areas of information range from cancer incidence and mortality to public behaviours and attitudes.

In its 1998/99 Operating Plan, CCO assigned responsibility for developing a cancer surveillance plan for Ontario to the Director of the Surveillance Unit of its Preventive Oncology Division. At the time of our audit, CCO was addressing the development of a surveillance plan with a number of initiatives, including identifying weaknesses in the current system, identifying and creating province-wide information sources and ensuring access to information collected.

However, CCO's plan lacked a clear mandate from the Ministry, and, in some cases, the authority to collect needed information. For example, the Ontario Cancer Registry (OCR), the primary surveillance information system available to CCO, was established as a voluntary registry to contain medical data on Ontario residents who have been diagnosed with or have died of cancer. The OCR enables CCO to monitor and analyze cancer trends in the province, to compare them with national and international trends, to identify causes and influences of the courses of cancers, and to estimate current and future resource needs. Between 1964 and 1994, over 896,000 cases of cancer were recorded in the OCR.

CCO's senior management has estimated that laboratories do not submit to the OCR approximately 20% of their reports relating to cancer because there is no legislative requirement to provide such information.

In 1996, CCO attempted to improve OCR's accuracy by requesting the Ministry of Health to provide personal medical information contained in its Ontario Health Insurance Plan databases. However, the Ministry determined that such information is personal and providing it to CCO would be contrary to the *Freedom of Information and Protection of Privacy Act*. As a result, the OCR has not received any hospital records for cancer patients since 1996.

In addition, despite the fact that OCR has been in use for over 30 years, we found that CCO had not established minimum data standards for information to be collected during the course of treatment and submitted to the OCR by RCCs. Further limiting the usefulness of the OCR was lack of information on identified cancer stages. This information could be requested from the RCCs, which could routinely collect such data in the course of treating cancer patients.

## **Recommendations**

**The Ministry should clearly define Cancer Care Ontario's (CCO's) mandate regarding cancer surveillance and should ensure that CCO has the authority it requires to meet that mandate.**

**To improve the usefulness of the Ontario Cancer Registry, CCO should further develop standards and guidelines for the type of data to be collected.**

### ***Ministry Response***

***The Ministry agrees with the recommendation and has worked with CCO to define its mandate within the draft Memorandum of Understanding.***

### ***Agency Response***

***The recommendation is accepted. Improving the quality and utility of the Ontario Cancer Registry is a priority for CCO. The Ontario Cancer Registry has adopted the relevant data and operational standards from the International Agency for Research on Cancer, the Canadian Cancer Registry and the North American Association of Comprehensive Cancer Registries. The Ontario Cancer Registry is particularly interested in improving the depth of information it collects about cancer cases, including cancer stage.***

## **FINANCIAL CONTROLS**

### ***POTENTIAL CONFLICTS OF INTEREST***

CCO had developed a conflict-of-interest policy that applies to employees and to non-employees appointed to committees. Any conflict of interest is to be reported to the employee's supervisor or to the appropriate committee chairman to determine the need for written disclosure. However, we have certain concerns regarding the effectiveness of this policy, as illustrated by the following examples:

- In 1997, a consulting firm was paid \$12,000 to evaluate CCO's financial system requirements and recommend a suitable replacement system. Based on the firm's recommendation, CCO purchased a new financial system for \$166,000. Some members of the selection committee questioned the consulting firm's independence, noting that it had a direct interest in the supplier of the system being recommended.

While the consulting firm provided verbal assurance to CCO that it did not have a financial interest in the supplier of the system, it had a group specializing in installing the system. CCO subsequently awarded a \$172,500 contract to the consulting firm to implement the new system. This contract was not tendered.

In April 1998, CCO tested the new system and found a number of technical problems. CCO concluded that the new system would not work without significant modifications. In

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the interim, CCO incurred systems development costs totalling approximately \$282,000 and continued to use its old financial system. At the end of the audit, CCO was negotiating with the system supplier and the consultant.

- In February 1998, CCO competitively hired a consultant as Acting Manager of Technical Engineering and Production Support until a full-time manager could be hired. The consultant's first assignment was the review of a request for proposal for a Year 2000 assessment and coding correction project.

In March 1998, CCO, rather than issue another request for proposal, used the rates bid on the Year 2000 project to select a consulting firm to create a project management office. A firm owned by the Acting Manager submitted a lower proposed price than the prior bids and was awarded a one-year contract at \$1,047 per day (\$22,000 per month). No other consultants were given an opportunity to bid on the assignment. CCO management agreed that the consultant selected likely had information that could have assisted in making the proposal, which was just \$3 per day lower than the lowest prior bid.

In June 1998, the same consulting firm was the lowest bidder on a request for proposal for additional information technology work. This \$113,000 contract placed the firm in the position of supervising its own work.

- We reviewed the process used to purchase radiation equipment at one RCC. Documentation indicated that two of the three vendors submitting proposals approached selection committee members with additional incentives not included in their original proposals. A vendor that had offered to provide \$250,000 in research funding was awarded the contract. We were informed that the research offer was brought to the attention of the other selection committee members after all vendor proposals had been evaluated for their technical merit, but before the final decision was reached.

The value of the research funding was considered in the cost comparison of the proposals, and the individual receiving the offer remained a member of the selection committee.

### **Recommendation**

**To help ensure that the right goods and services are purchased at the right prices and to avoid potential conflicts of interest, Cancer Care Ontario should:**

- **eliminate actual or potential conflicts prior to awarding contracts; and**
- **inform vendors that proposals should detail all incentives and benefits.**

### **Agency Response**

***We have noted your comments and will reinforce the conflict-of-interest policy. We have also issued updated policies.***



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## ADMINISTRATION OF CONSULTING CONTRACTS

When hiring consultants, competitive practices and contracts with fixed prices and measurable deliverables help ensure that the best qualified and most economical candidates are selected. We found that CCO's controls over the acquisition and monitoring of large consulting contracts were adequate. However, controls over services from smaller firms were insufficient. For example:

- While CCO's policies require at least three written quotations for all expenditures in excess of \$2,000, a number of consulting contracts in excess of \$2,000 were awarded with no evidence of a documented needs assessment or explanation for not using a competitive selection process. Written explanations are required where three quotations are not obtained.
- Written contracts outlining the expected deliverables and rates of remuneration were not always prepared for consulting arrangements. Some consultants were hired solely on a verbal understanding as to the expected deliverables and remuneration.
- Little or no documentation existed to indicate that the work of the consultants was formally monitored and evaluated. The length of contracts was often extended without evaluating the consultant's performance or explaining why the deliverables had not been met.

### **Recommendation**

**To better ensure that value for money is received from consultants, Cancer Care Ontario should:**

- **enforce compliance with its policy that written explanations be obtained where competitive acquisition policies are not followed;**
- **require that contracts contain measurable deliverables, rates, timeframes and termination clauses; and**
- **ensure written evaluations are prepared on the work performed by consultants.**

### **Agency Response**

***We have noted your comments and have enforced compliance of policies. A revised/new policy for consulting has been issued and we will request written evaluations wherever possible.***

## CANCER CARE INTERNATIONAL

Management Board of Cabinet directives state that prior Management Board approval is required to establish or incorporate all new agencies, including subsidiaries of existing agencies. In 1995, the Ontario Cancer Treatment and Research Foundation (OCTRF) created a subsidiary, Cancer Care International (CCI), to provide cancer consulting and training services to developing countries. While support was obtained in December 1994 from the

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then-Deputy Minister of Health, we found no evidence that Management Board approval had been obtained for the creation of CCI.

We were informed by CCO management that, in addition to providing assistance to other countries, CCI would provide OCTRF/CCO staff with an opportunity to broaden their knowledge and experiences. Revenues generated by CCI were to be used by the OCTRF/CCO for cancer research and other cancer programs in Ontario.

While CCI had obtained a number of contracts, it did not earn sufficient revenues to cover its operating and administrative costs. As at March 31, 1998, CCI reported an accumulated operating deficit of approximately \$538,000, mostly funded by a \$495,000 loan from CCO.

In June 1998, CCO's board of directors decided to limit its liability and authorized management to locate a potential purchaser of CCI. Under the proposed terms of sale, CCO would continue a strategic alliance with the new owner of CCI. In August 1998, CCI was sold to its vice-president for a percentage of certain future gross revenues. We were advised by CCO management that since CCI had only one ongoing contract, there were no other interested buyers. CCO was to provide secretarial support and office space at no cost to the purchaser for one year. The outstanding loan would be considered repaid after CCI paid CCO approximately \$150,000 it was to receive for services already rendered, thus resulting in CCO potentially writing off over \$300,000 in loans to CCI.

Although the *Cancer Act* does not address the establishment of a subsidiary company, Section 15 of the Act does permit CCO to dispose of any rights or interest it has acquired, subject to the approval of the Lieutenant Governor in Council. CCO notified the Ministry of Health in July 1998 that a sale was pending, but there was no record of a response or advice from the Ministry nor an Order in Council evidencing the approval of the Lieutenant Governor in Council.

We analyzed CCI's expenditures since inception and found that its accumulated deficit resulted primarily from the following:

- Unexpected circumstances resulted in CCO paying \$125,000 to an executive placement firm to recruit two new presidents during CCI's three-year history. In the second year of operation, a consultant received \$15,000 to evaluate CCI's executive compensation plan and to develop a bonus formula based on the projection that CCI would be a growing, profitable company.
- At the time that CCO decided to sell CCI, CCI had three executive staff members with combined annual salaries and benefits totalling approximately \$400,000 while annual gross revenues were less than \$500,000.
- In 1997, CCI spent \$140,000 for renovations to its office space. The original budget was \$100,000. The contractor suggested less costly alternatives to the hardwood flooring and the upgraded mahogany office furniture selected. These alternatives were not accepted.

We also reviewed CCI's expenditures and found that some travel and hospitality claims were approved and paid without appropriate supporting documentation. At our request, CCO staff subsequently obtained the required documentation to support the expenditures.

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## **Recommendation**

**In future:**

- **the Ministry and Cancer Care Ontario (CCO) should ensure that proper approvals are obtained for the creation of any subsidiaries and their disposition;**
- **start-up costs should be kept to a minimum; and**
- **expenses should be properly documented and supported.**

### ***Agency Response***

***We have noted your comments and will ensure that your recommendations will be followed in the future.***

### ***Ministry Response***

***The Ministry agrees with this recommendation and will explore ways to incorporate such requirements into revisions to Cancer Care Ontario's governing legislation.***