

Better coordination of screening in Canada:

What is the best way forward?



Health Council of Canada
Conseil canadien de la santé

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About the Health Council of Canada

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Introduction

While screening is an important aspect of preventive health care, ways to improve it are not often top of mind for governments, health care providers, or the general public. Screening is the process of identifying apparently healthy people who may be at risk of a disease or condition. They can be offered information, further tests, and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.¹ Well-organized, evidence-based approaches to screening can pay off with better health and better care for Canadians, and better value for the health care system.

Screening may sound straightforward, but the reality—for health care providers, managers, and policy-makers—is quite complex. Screening is not simply a test. Rather, a screening test is part of a process that should ensure the right people get screened, are actively followed up, and are offered appropriate care and treatment.² Responsibility for screening in Canada is often unclear and confusing, shifting between public health and primary care sectors and between population and individual responsibilities. In addition, local contexts and capacities to implement screening programs vary widely. We screen for many conditions, but for what and for whom depends often on where you live. Why, for example, are newborns screened for cystic fibrosis and sickle-cell anemia in some provinces and territories, but not in others?^{3,4}

Media reports regularly highlight the evolving evidence and opinion that supports or opposes a particular type of screening process. Many respected experts and/or organizations will often offer conflicting recommendations about screening for particular diseases and conditions, while decisions to screen or not to screen need to balance legitimate perspectives on benefits and harms, quality and cost. Controversies about the benefits of prostate cancer screening are a recent example.⁵ A wide range of contributors provide guidance on prostate cancer screening, including Canadian and international health ministries, cancer agencies, health technology assessment organizations, cancer advocacy groups, and numerous professional associations and networks representing clinical areas such as urology, radiology, or general practice. Who do you listen to?

All of this makes for a challenging environment that has resulted in a patchwork of screening programs and services across the country and, in the background, a myriad of decision-making approaches and processes for screening. This is raising concerns about disparities in access and quality of care, and inefficient use of limited resources and expertise. It also raises questions about the factors that influence government decision-making in this critical area of health policy. When a new screening issue lands on a health minister's desk today, where does he or she turn for advice?

What we've done

As part of our mandate to report on a number of health policy issues that straddle screening (prevention, health promotion, public health, and primary health care), the Health Council of Canada undertook a scoping exercise to better understand screening issues, the types of screening activities that the provinces and territories carry out, the concerns that health ministries and experts in the field have about the current state of screening in Canada, and national and international examples of best practices for screening decision-making.⁶

We also sponsored a stakeholder dialogue at the McMaster Health Forum in October 2013. The dialogue engaged a group of health care leaders and screening experts about the issues and options for improving screening practices in Canada.^{7,8}

What we've learned

In our interviews with experts in Canada and around the world, we found a general consensus that the status quo for making screening decisions in Canada is less than optimal.^{6,7,8} Complexity, variation, and controversy have been persistent challenges for screening, but momentum is building to improve policy and delivery decisions that use our scarce resources more efficiently, effectively, and equitably.

For more information

These recent publications on screening in Canada provide more information on many of the issues discussed in this report:

- ▶ Health Council of Canada. (2013). *A Scoping Review of Screening in Canada*. Toronto, ON: Health Council of Canada.
- ▶ Wilson, M. G. & Lavis, J. N. (2013). *Evidence Brief: Supporting Optimal Screening Approaches in Canada*. Hamilton, ON: McMaster Health Forum.
- ▶ Wilson, M.G. & Lavis, J.N. (2013). *Dialogue Summary: Supporting Optimal Screening Approaches in Canada*. Hamilton, ON: McMaster Health Forum.

While the McMaster Health Forum dialogue was not intended to reach a consensus about how best to respond to these challenges, participants did agree that it is important to push forward and to continue seeking better approaches to making screening decisions. Many noted the need to more clearly set out the urgency around this topic and to map out a series of actions that will improve screening policy and practices in Canada.⁸

The goal of this report is to promote continued discussion among system stakeholders, with a focus on three questions:

- ▶ In looking at ways to develop a better approach to making screening decisions in Canada, what are the key issues that need to be considered and resolved?
- ▶ What existing organizations could play a key role in taking action towards a better approach to making screening decisions in Canada?
- ▶ Is there a role for a coordinating body (or bodies) to oversee and/or guide screening decision-making in Canada?

This report cannot fully answer these questions, although we do advance the argument that there are important reasons to support a coordinated approach to screening. First, we outline some of the complexities of screening in Canada and highlight coordinated approaches being taken abroad and, to some degree, in this country. We then outline four options that should be deliberated to improve decision-making on screening in Canada. Finally, we identify some key issues that need to be considered and some organizations that could take the lead. The Health Council hopes this report and related background documents will inspire governments, organizations, health care providers, and other stakeholders to continue to debate the questions and options raised and, ultimately, to take action to improve screening for all Canadians.

A complex environment

To appreciate the need for a more coordinated approach to screening, it's important to understand why screening is a particularly complex area of health policy. A number of challenges contribute to the current confusion, variation, duplication, and missed opportunities.

Lack of clarity on goals and responsibilities

Screening touches on many parts of the health system and, as a result, tends to belong to everyone and no one. It's often unclear where responsibility for screening lies. As a central component of disease prevention, screening straddles primary health care, specialty care, and public health. We screen for many diseases and conditions (e.g., genetic disorders, cancers, diabetes, dementia); for many target groups (e.g., asymptomatic/average-risk and higher-risk people across all age groups); and in many settings (e.g., primary care offices, hospitals, mobile screening units, laboratories, private clinics). And, as we've noted, screening is itself a complex process, not simply a test.^{2,9}

Screening suffers from a lack of clarity on what it is and is not. It is challenged by competing perspectives about how screening as a health service is best organized and delivered and how to achieve the desired health goals for individuals and populations. For example, organized screening programs (such as Ontario's Newborn Screening and Colon Cancer Check programs) are offered to whole populations and all patients are offered the same information and services.

Organized screening programs seek consistent, evidence-based standards and are typically monitored and evaluated for quality. Alternatively, opportunistic screening occurs when a primary health care or other provider offers a test to an individual patient being seen for an unrelated issue or when a patient seeks screening on their own. Although system accountability is more challenging outside of organized programs, opportunistic screening can be part of a systematic approach. In fact, many screening activities in Canada could be called "organized opportunistic," with primary or specialty care providers being the point of access to screening for their patients. But problems can arise when opportunistic screening is ad hoc, leading to variations in practice that are in conflict with the best evidence.

Underlining the tension between organized and opportunistic screening is the contrast between the need for a strengthened primary health care system—one that optimizes a holistic approach to caring for patients—and the highly structured but often siloed nature of organized screening programs, which should be connected to primary care but often are not.⁸

The lack of clarity on goals and responsibilities, and the tensions between organized and opportunistic screening, have an impact on both practice and policy. They affect where and how screening is delivered, whose voices are sought or given priority in decision-making and, ultimately, who takes on the responsibility for improving screening in Canada.

Complexities in decision-making and the nature of the evidence

Screening decisions are made at multiple levels. Governments, private insurers, and disease-specific agencies seek to make system-level decisions regarding the need for, and ability to implement, various screening options, whether they are organized, population-based programs or opportunistic screening models. At the delivery level, providers must make recommendations to patients on whether or not to screen for a variety of diseases and conditions. The decision whether to follow through with screening lies with individual patients, who must weigh advice from their health care providers, other sources of information, personal considerations and circumstances, and their ability to access screening services.

The complexity around screening decisions has been documented for decades and important guidance is available, dating back to 1968 when Wilson and Jungner were commissioned by the World Health Organization to develop principles for population-based screening decisions (see *Wilson and Jungner's principles of screening, 1968*).¹⁰ As a general guide for decision-making, these 10 principles have remained remarkably relevant and are still routinely cited as part of screening decision-making in Canada and abroad.^{2,6}

Over the years, however, a number of groups have attempted to modify or refine Wilson and Jungner's principles of screening, with more recent efforts highlighting the need for greater focus on operational and implementation issues for screening programs. For example, there has been increasing interest in how to assess the appropriate resource requirements for a screening program, how to integrate follow-up care into the screening process, and how to establish a sound approach to performance management, assessment, and monitoring.^{2,7,11}

Wilson and Jungner's principles of screening, 1968

1. The condition sought should be an important health problem.
2. The natural history of the condition, including the development from latent to declared disease, should be adequately understood.
3. There should be a recognizable latent or early symptomatic stage.
4. There should be a suitable test or examination.
5. The test should be acceptable to the population.
6. There should be an agreed policy on who to treat as patients.
7. There should be an accepted treatment for patients with recognized disease.
8. Facilities for diagnosis and treatment should be available.
9. The cost of case-finding (including diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole.
10. Case-finding should be a continuing process and not a "once and for all" project.

To adequately and appropriately address the principles of screening, a wide and varied evidence base must be considered. The nature of that evidence base presents challenges for decision-makers.

At the most basic level, high-quality studies, such as randomized controlled trials (RCT), are needed to establish evidence of effectiveness. For example, decision-makers need to be able to answer the question: Can early detection from screening reduce the negative outcomes of a disease or condition? These studies must be run over extended periods of time to provide the data necessary for assessing the longer-term outcomes of screening, such as the impact on five-year or 10-year survival rates. This makes the development of the scientific evidence base both expensive and protracted. It also makes the research results difficult to interpret and to apply to specific decisions.

With these long timelines, the resulting evidence often lags behind technological developments. Screening for colorectal cancer is a relevant example. Several RCTs conducted from the 1970s to the 1990s focused on the fecal occult blood test (FOBT), a laboratory test that has been widely adopted. Since then, not only has FOBT technology evolved, but at least half a dozen other types of competing screening tests have emerged, with several recent RCTs revealing potential advantages of a different test (flexible sigmoidoscopy, an endoscopic procedure) for population-based screening.¹² Even when high-quality evidence emerges, however, it can be extremely hard for screening programs to shift gears, given the significant financial and human resource investments required.

Intuitively, the potential to identify the early occurrence of disease makes sense, and lay people and health professionals alike are often disappointed by the reality that the benefits of detection for a few are offset by harm to many more (false positives, false negatives, overdiagnosis). This puts a greater onus on decision-makers to understand and apply the evidence appropriately.

Beyond the evidence for whether a particular type of screening process is effective, screening decisions need to consider a range of contextual factors that are more local in nature. These include the local health system's organization, structure, and resource capacities; commercial and other stakeholder interests; and prevailing values and beliefs. These factors all influence how evidence is identified, interpreted, and applied, and they can all play a role in screening decisions, interacting in complex ways.^{2,13} Different views—such as perspectives and expertise from health economic evaluation, bioethics, health information technology and systems, implementation science, and other disciplines—will also influence how the evidence is assembled and used.¹⁴ However, these varied influences are inconsistently incorporated into screening decisions. In part, this is because expertise in collecting and using such contextual and experiential evidence is not widely available. Further, approaches to engaging the public and patients vary widely, affecting our ability to understand and incorporate their values and preferences, improve transparency, and inform policy.^{15,16}

Sorting out these evidence and decision-making complexities is rarely simple.¹⁷ Inevitably, as with other health interventions, screening decisions involve trade-offs—between benefit and risk, and between economic cost and health outcomes. Today, the same trade-offs are being considered in many parts of Canada for a range of screening options, but often without the benefit of active coordination or collaboration among competing interests.

Variation across health systems

Where you live in Canada can have a very real impact on which screening tests are recommended and available. For example, eligibility for and access to colon cancer and breast cancer screening varies by and within each province and territory. Newborns are routinely screened across Canada, but the number of conditions for which they are screened varies widely, depending on location.^{3,4,18}

Some of this diversity and discordance may be understandable. Provincial/territorial responsibility for health care enables Canada's jurisdictions to decide whether, where, and how they will support screening. Population needs differ, as do provincial/territorial policy objectives and system constraints. But in speaking with stakeholders across the country, we heard concerns that the variations in screening programs among jurisdictions in Canada rarely reflect informed consideration of global and local evidence on screening.⁶ Some programs offer routine screening in the face of unclear evidence or divergent recommendations, while in other instances guidelines recommend routine screening but there are no formal programs.⁷ Uptake of screening programs also varies in ways that do not seem to be linked to population differences.⁷

In addition, Canada's provinces and territories display marked differences in the governance structures and processes that oversee and support screening, in resource availability and in their capacity to develop organized population-based programs, and in service delivery models (including remuneration for services). Access to care for disorders identified through screening also differs across jurisdictions.⁷

In this regard, screening is emblematic of the broader systemic challenges in Canadian health care—fragmentation, poor communication, and a lack of collaboration between governments and between sectors. The absence of a national or system-wide vision, coupled with the myriad decision-making approaches for screening, contributes to unnecessary duplication and waste, with many jurisdictions conducting their own reviews of the evidence and developing their own distinct processes and programs. The variation that results raises concerns for patient safety, accessibility, equity, program effectiveness, and accountability. With common needs for information and limited availability of expertise, a coordinated approach to support decision-making on screening across jurisdictions and across diseases and conditions would appear to make better sense.

A few examples of coordinated approaches to screening do exist in Canada, but these efforts are mostly limited to particular diseases or areas of screening. The Canadian Partnership Against Cancer reports on the performance of cancer screening programs, monitors evolving evidence, and provides a forum for sharing information on provincial/territorial cancer screening programs. The Canadian Task Force on Preventive Health Care conducts systematic reviews of the evidence for some screening processes.

Several provincial agencies also support coordinated approaches to screening within their jurisdictions. Newborn Screening Ontario, which coordinates screening of infants in the province, is supported by a cross-program governance structure with broad interdisciplinary representation.¹⁹ Cancer Care Ontario drives quality improvement in disease prevention and screening for cancer and chronic kidney disease, among other areas of responsibility, supporting and integrating several population-based, cancer screening programs.²⁰ The BC Cancer Agency provides a population-based cancer control program for residents of British Columbia and the Yukon that covers the spectrum of care, from prevention and screening to diagnosis, treatment, and rehabilitation.²¹

Moving forward

There is a clear consensus from our analysis and dialogue about screening in Canada that the status quo needs to be challenged. To move the issue forward, the Health Council of Canada encourages governments, health care providers, and other stakeholder groups and organizations to debate options for improving the currently fragmented approach to screening in Canada. This is an opportunity to build on the successes of the Canadian organizations that are taking a coordinated approach to some aspects of screening; it is also an opportunity to learn from countries that are moving towards nationally coordinated approaches because of the benefits in quality, safety, equity, and effectiveness. These include the UK (see *The United Kingdom's comprehensive, national model*), New Zealand,²² Australia,²³ and the Netherlands.²⁴ Discussions about Canada's screening efforts should explore ways to more efficiently and effectively identify and coordinate relevant evidence, interpret it, and support implementation of evidence-based recommendations on screening.

The question of whether and how to coordinate screening activities is neither new nor unique to Canada.^{6,18,25} In seeking answers to these persistent challenges, we can look to approaches abroad. Angela Raffle and Muir Gray, internationally recognized leaders in screening policy and program development, suggest that "national, rather than local, policy making has the best chance of fulfilling the requirements for valid scrutiny of evidence and resources, due process, transparency, fairness, [and] accountability..."²

The United Kingdom's comprehensive, national model

The UK National Screening Committee (NSC) provides advice on all aspects of screening to the ministers of health and the National Health Service (NHS) in the four UK countries (England, Scotland, Wales, and Northern Ireland). In England, where the NSC and all screening programs are now part of Public Health England, the NSC also oversees program implementation with mechanisms to monitor effectiveness and quality.

While the NSC makes UK-wide policies on what screening should or should not be offered, it is up to each jurisdiction to determine when and how to put those policies into practice. As a result, there may be some differences in what screening services are available in each jurisdiction.

The NSC works collaboratively with other programs (e.g., NHS Cancer Screening Programs) and agencies (e.g., the National Institute for Health and Care Excellence). Supported by dedicated funding, the NSC takes a comprehensive approach to assessing the evidence for screening programs. The committee's recommendations are grounded in evidence and based on internationally recognized criteria covering the condition, the test, the treatment options, and the effectiveness and acceptability of the screening program. According to the NSC's website, "Assessing programmes in this way is intended to ensure that they do more good than harm at a reasonable cost." (www.screening.nhs.uk)

Communication is also a key focus of the NSC; a portal called "a gateway to information on screening in the UK" provides information for the public and professionals, such as patient-centred materials and continuing professional development.

So what's the best way forward for Canada?

The provinces and territories have come together in the past to tackle common health challenges.²⁶ In October 2013, provincial and territorial health and wellness ministers announced they would form a short-term working group to explore areas of pan-Canadian cooperation to address the "considerable variation" in newborn screening practices across the country.²⁷ In addition, health ministers—through the Council of the Federation's Health Care Innovation Working Group—recently provided recommendations to improve consistency among clinical practice guidelines with the goal of improving quality of life and health outcomes.²⁶ Recognizing that work, the ministers acknowledged the need for collaborative efforts in other areas of health, such as quality improvement and controlling the costs of generic drugs.²⁶ Could the Council of the Federation play a role in championing a coordinated approach to screening more broadly?

A number of other national organizations are positioned to lead further discussion and/or support implementation of a coordinated approach. As seen in the three organizations we highlight (see *National organizations that could carry the discussions forward*, page 9), Canada has developed substantial expertise and leadership potential in this area.

Approaches to better coordinate screening

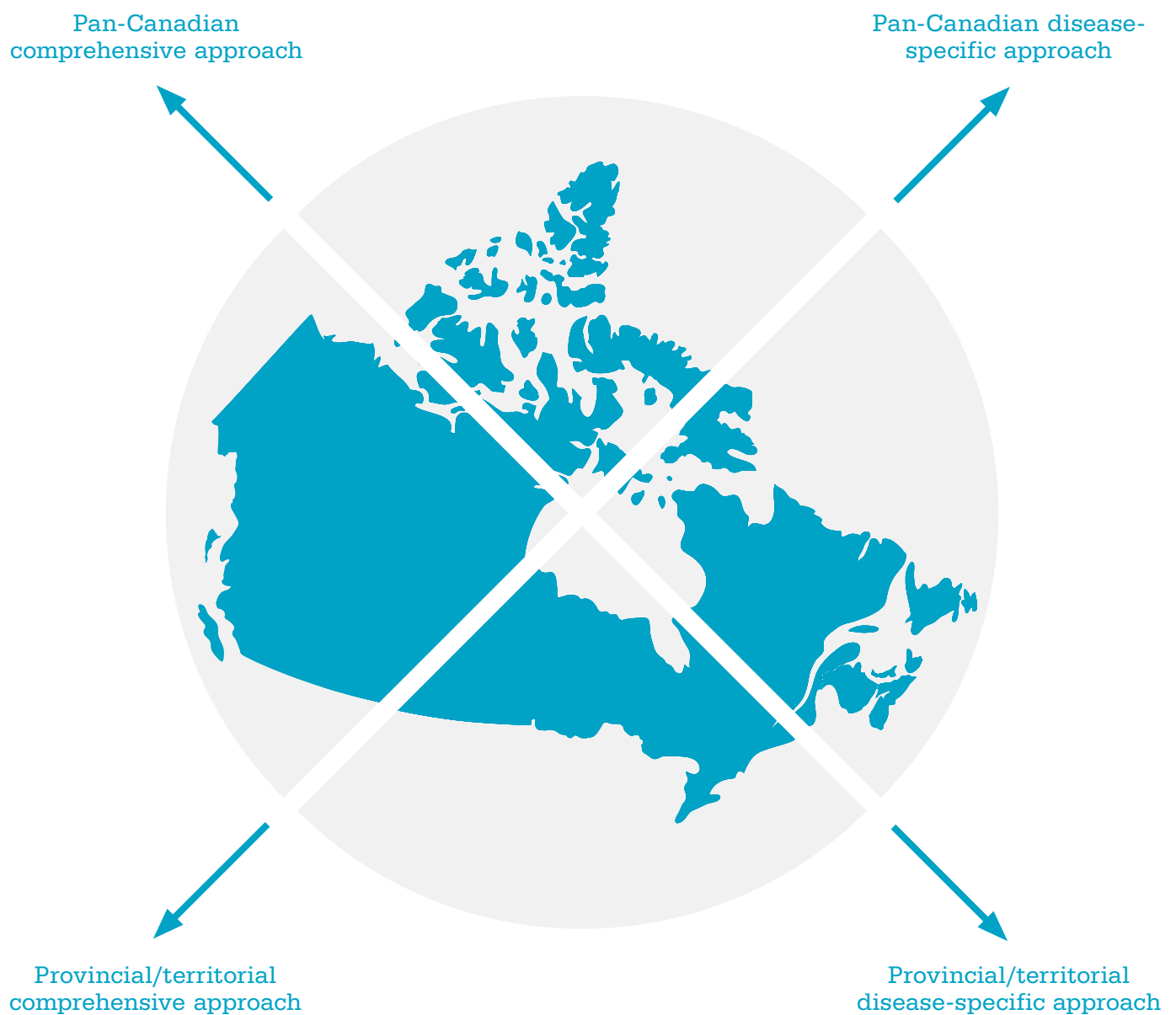
Should a coordinated approach to screening focus on all diseases and conditions or on specific ones? Should it be national in scope or be duplicated in each province and territory? Should coordination be accomplished through an organization with a dedicated mandate or through existing or new network arrangements? Should coordination of screening be guided by a patient-centred approach? Should coordination be limited to the synthesis of research evidence or should it also consider implementation issues that are dependent on context? Should leadership and governance structures of screening organizations include cross-program linkages and interdisciplinary expertise?

With their limited mandates and resources, existing agencies in Canada are currently unable to address many facets of screening. This section outlines four possible directions that could be taken. The Health Council of Canada recommends considering these options as a starting point for further discussion, with the goal of arriving at a more coordinated decision-making system for screening in Canada.

National organizations that could carry the discussions forward

- ▶ **Public Health Agency of Canada (PHAC)** has a broad mission to promote and protect the health of Canadians. Among its specific roles, PHAC is involved in the prevention and control of infectious and chronic diseases through surveillance activities and through the development of screening guidelines and recommendations. For example, PHAC supports the Canadian Task Force on Preventive Health Care to develop clinical practice guidelines that support primary care providers in delivering preventive health care (www.canadiantaskforce.ca). Importantly, PHAC's mandate also includes applying international research and development to Canada's public health programs, strengthening intergovernmental collaboration on public health, and facilitating national approaches to public health policy and planning. (www.phac-aspc.gc.ca)
- ▶ **Canadian Partnership Against Cancer (CPAC)** is an independent organization funded by the federal government to accelerate action on cancer control for all Canadians. CPAC's work spans the cancer control continuum, from prevention and screening to research and supportive care. CPAC provides an important coordinating function for sharing and spreading best practices in cancer screening among health ministries and cancer agencies from across the country. (www.partnershipagainstcancer.ca)
- ▶ **Canadian Agency for Drugs and Technologies in Health (CADTH)** is an independent agency that provides decision-makers with the evidence, analysis, advice, and recommendations about the effectiveness and efficiency of health technologies. Funded by the federal, provincial, and territorial governments, CADTH focuses on providing support for evidence-based decisions about which drugs, medical devices, procedures, and programs to adopt, implement, and fund, so that health systems can harness the benefits of technology while getting the best value from every health dollar. (www.cadth.ca)

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Pan-Canadian screening approaches

Comprehensive

This approach would give one organization a mandate to develop and oversee the implementation of a collective, national vision for screening policy and practice for the full spectrum of screening-related activities for all diseases, conditions, and populations across all provinces and territories. This approach would maximize economies of scale by drawing on the best expertise available across the country to support local decision-making. This could be accomplished by developing a new organization or by expanding the mandate of an existing organization, such as the Public Health Agency of Canada (PHAC), the Canadian Agency for Drugs and Technologies in Health (CADTH), or the Council of the Federation's Health Care Innovation Working Group. An example is the UK National Screening Committee, which was frequently mentioned in our expert interviews as a best-practice model for coordinating screening (see *The United Kingdom's comprehensive, national model*, page 7).

There is no parallel model in Canada for screening at present. However, Canada does have a pan-Canadian approach to reviewing evidence on immunization, through the National Advisory Committee on Immunization (which reports through PHAC). In addition, CADTH carries out some similar activities, particularly with the Common Drug Review, and could be positioned to expand that role to screening.

Disease- or condition-specific

Pan-Canadian screening organizations could be developed with mandates to guide the full spectrum of screening-related activities for specific diseases or conditions across the country. For example, individual organizations could each be responsible for one of the following areas: preconception/prenatal screening for genetic conditions; newborn/early childhood screening; human immunodeficiency virus screening; cancer screening; and screening for chronic diseases. These organizations would serve all provinces and territories and collaborate with one another, related organizations, and providers (specifically primary care). There could be an ongoing forum for national experts with both specialist and generalist perspectives to interact and collaborate. Cancer screening is a Canadian example where the Canadian Partnership Against Cancer coordinates evidence synthesis, monitors cancer screening performance, and shares implementation practices across the country. National, condition-specific screening agencies modelled on Newborn Screening Ontario, with its interdisciplinary, cross-program governance initiative, could also be developed.

Provincial- and territorial-based screening approaches

Comprehensive

This approach would involve one organization in a province or territory with a mandate to support and guide decision-making for screening for all diseases, conditions, and populations in that jurisdiction. These organizations could collaborate with sister organizations across provinces/territories and with other related organizations and providers. Although health ministries may have this responsibility by default, we are not aware of any dedicated provincial/territorial examples that fit this screening model in Canada.

Disease- or condition-specific

This approach would involve multiple organizations in each province and territory, with each organization providing the spectrum of screening-related guidance and practice for one specific area of screening (e.g., cancer). Several models of this approach exist in Canada. For example, Newborn Screening Ontario is a province-specific collaboration and coordination group for newborn screening activities, while the BC Cancer Agency and Cancer Care Ontario play a similar role for cancer screening in their respective jurisdictions.

Questions to consider

Any discussion about how to better coordinate screening in Canada will need to deliberate and resolve many questions. In addition to the questions about scope and purpose noted earlier, discussion will need to address **decision-making approaches** (e.g., Who needs to be involved? Who can provide expertise?); **performance measurement and evidence reporting** (e.g., How can we develop, implement, and monitor better metrics? Who will be responsible for data collection, evidence gathering, and performance reporting?); **collaboration and knowledge sharing** (e.g., How can new networks be formed or existing ones be built on to enable collaboration? What are the best ways to improve collaboration so that learnings and expertise can be shared efficiently?); and **feasibility** (e.g., How should resources be allocated? Where does screening fit relative to other investments in preventive services, including those outside of medicine, such as social investments for population health?).^{2,28,29}

Ideally, a coordinating organization or organizations would be appropriately resourced to conduct the range of tasks required for comprehensive support of screening activities—evidence synthesis, implementation support, setting and monitoring quality standards, sharing learnings, and fostering exchange within and between jurisdictions and sectors.

Coordination can yield many benefits, but realizing them requires organizing many disparate pieces—knowledge and understanding of screening principles, knowledge of the evidence (clinical, population, and implementation), a broad and accessible base of expertise, a range of stakeholders, and collective resources. Where does responsibility lie for initiating this process in Canada? Which issues are best attended to at the local level versus those more effectively managed at the provincial/territorial or national level?

Common goals, coordinated action

Countries that have adopted a nationally coordinated approach to screening are recognizing its value in improving quality, accountability, equity, and efficiency in screening policy and practice.⁶ Interest in a similar approach for Canada is building. The Health Council is not the first to make this call. Newborn screening stakeholders have come to similar conclusions,^{6,18} and many provinces have identified the need to coordinate genetic testing and related services.³⁰ The issues we have outlined have come to the forefront through a number of voices, and so the time has come for an informed, national-level debate about how to improve decision-making and coordination of screening in Canada.

The Health Council took up the issue of screening because we were concerned about the potential for waste, harm, and missed opportunities associated with suboptimal care in this area. Our research shows that best practices in screening are built upon the following features:

- ▶ strong leadership and a clear governance framework;
- ▶ pooling of expertise;
- ▶ a systematic, analytical approach to decision-making (through robust processes and principles, use of evidence, and engagement of stakeholders);
- ▶ performance measurement and reporting;
- ▶ cross-program learning and development; and
- ▶ support for local and regional implementation of policy to ensure consistent and coherent quality standards.⁶

Guided by these features, Canada should work towards a coordinated approach. The next time a screening issue lands on a health minister's desk, he or she should be able to turn for advice to an organization mandated to provide the highest-quality, coordinated decision-making support. Coordination can ensure that well-established principles are put into action in a transparent way; that evidence is paramount in decision-making; that voices, interests, and perspectives are balanced; that screening initiatives are grounded in a patient-centred approach that links primary health care with organized screening programs; and that a broader public conversation takes place to improve understanding of the complex nature of screening.

Conclusion

As the Health Council winds up its mandate, we urge others to continue this discussion. Our own scoping review and the evidence brief produced by the McMaster Health Forum have described the key issues. The Forum's summary of the stakeholder dialogue and this report suggest some possible solutions. Across a diversity of voices, we heard that the current screening environment is inequitable and ineffective, and that there is interest in tackling the common problems and working towards common goals. A number of existing organizations are well-positioned to take up this challenge and to build the partnerships necessary to map and implement the substantial change that is needed. We have identified several organizations with relevant missions, experience, and expertise. Now we have to ask: Which one will take a leadership role on this issue?

We recognize that developing a coordinated approach to screening in Canada is no small task. But we strongly believe that the various organizations now involved in screening, along with others who have valuable relevant expertise, have a responsibility to work together and set a new course. A more coordinated approach to the full spectrum of screening decision-making will result in better care for Canadians.

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