ing suitable risk assessments of products; issuing “timely and accurate” health warnings to the public; conducting inspections of drug ingredients and manufacturing practices; and virtually all aspects of post-market surveillance, whether investigations of consumer complaints or tracking of adverse events.

Among the endemic structural flaws identified by Fraser were: inadequate assessment of the resources required to achieve objectives; shoddy or non-existent operational and financial plans; non-existent “performance measures with targets for expected results”; as well as violations of the Financial Administration Act, which require full cost recovery for the Drug Products and Medical Devices program services through user fees. For example, oversight of medical devices costs \$21.8 million but user fees account for only \$7.4 million.

Fraser urged 10 specific recommendations as part of a massive overhaul of Health Canada’s oversight of regulatory programs. In response, the department agreed to implement reforms by the end of fiscal year 2007/08. — Wayne Kondro, *CMAJ*

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Ottawa creates clearing house for cancer information

Cancer treatment inequities across the nation should eventually be mitigated by a new federal plan, funded to the tune of \$260 million over 5 years, to disseminate “best practices” information about prevention, detection and treatment, according to the chairman of the newly-minted, arm’s-length Canadian Partnership Against Cancer.

There’s often a lag on the order of 10 to 15 years between “what we know works and actually applying it” to cancer care, says Jeff Lozon, president and chief executive officer of St. Michael’s Hospital in Toronto. “If we can contribute [to reducing that lag time], we’ll have done a good job.”

Getting evidence-based information out to clinicians should invariably improve outcomes, Lozon added. “We want to get the right information to the right people at the right time, so that care can be delivered faster and, perhaps, more effectively. It’s lending national support to helping them do their jobs.”

The primary purpose of the agency will be to “serve as a clearing house for state-of-the-art information about preventing, diagnosing and treating cancer,” Prime Minister Stephen Harper said while unveiling the initiative in Montréal. “Its job is simply to make sure that the best cancer care practices

plementation of the CCSC, although there may be small research projects that will be required to achieve that.

Among the specific mechanisms promised by the CSCC’s designers were development of rigorous clinical practice guidelines; establishment of a suitable Human Resources model for the cancer workforce; development of national prevention strategies to reduce the incidence of skin cancer caused by the sun and cancers caused by environmental and occupational exposures; creation of an “integrated, responsive, patient-focused cancer care system” through the use of standards

The agency will “get the right information to the right people at the right time.” — Jeff Lozon, chair of the Canadian Partnership Against Cancer

in any single part of Canada are known and available to health care providers in every part of Canada.”

Essentially, the Partnership has been charged with implementing the Canadian Strategy for Cancer Control (CSCC), which has been under development by Health Canada, the Canadian Cancer Society and the Canadian Alliance of Provincial Cancer Agencies since 1999.

At the core of that strategy is a mechanism to provide some measure of national oversight of cancer prevention, research, diagnosis and treatment in the form of an “integrated risk management and knowledge transfer system to gather and move cancer knowledge quickly and easily across Canada to assist the provinces to better manage cancer locally.”

The Canadian Cancer Society’s Group Director of Cancer Control, Paul Latierre, says none of the monies will be spent on diagnosis, treatment, biomedical research or any form of direct care. Rather, all will be devoted to im-

and guidelines; establishment of a national plan for strategic investments in priority areas of research; and establishment of a national cancer data collection system.

Seven “action groups” have been struck to develop specific measures to achieve the CSCC’s objectives, Latierre says. They’re expected to report early next year with their initial recommendations.

The CSCC’s business plan notionally allocated \$40.3 million for administration, as well as specific pots of money for each of the 7 working groups, as follows: primary prevention (\$40.3 million), standards (\$12.3 million), clinical practice guidelines (\$13.8 million), rebalance focus (i.e., information for patients) (\$29.1 million), human resources (\$16.1 million), strategic research (\$6.9 million), surveillance (\$29.3 million), Surveillance (\$50.2 million) and knowledge platform, information technology and risk systems (\$7.9 million). — Wayne Kondro, *CMAJ*

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