How Canada responds to pancreatic cancer

A provincial and territorial report card — thirteen places, graded on the public evidence.

A	B	C	C	C	D
ONTARIO	BRITISH COLUMBIA	NOVA SCOTIA	NEWFOUNDLAND & LABRADOR	NEW BRUNSWICK	PEI

Six places graded. Seven not graded: not enough evidence.

Research: seven Memorial University undergraduate students, June–August 2025, in the Policy Builders of Tomorrow program.

Grades, verification and editorial responsibility: The Heather Cutler Foundation.

Evidence assessed to August 2025. A historical assessment, not a directory of services.

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Start here

0 of 13

No province or territory in Canada has a pancreatic cancer program of its own. None has an organized screening program for it either. Everywhere, pancreatic cancer is treated inside general cancer services. The researchers recorded the same finding in all **13 of 13** provinces and territories reviewed.

This report looks at how each place's system is set up. Seven Memorial University students collected the facts in the summer of 2025. The Heather Cutler Foundation, a registered Canadian pancreatic cancer charity based in Mount Pearl, Newfoundland and Labrador, checked key figures and gave the grades. The grades are fixed to the evidence available in August 2025.

Five things to know

1. **Pancreatic cancer research money barely reaches Atlantic Canada.** Of 88 grants flagged as pancreatic cancer research, worth $23,354,337, Atlantic institutions hold 6, worth $273,000. All six are in Nova Scotia.
2. **Take-home cancer drug costs look different from region to region.** A 2021 report estimated that private plans and cash paid 59% of 2019 spending on selected take-home cancer medicines in the Atlantic groupings it measured. In Alberta the figure was 12%. This is not the share patients pay themselves.
3. **Testing depends on where you live.** Biomarker testing looks at a tumour or a person's genes for clues that can guide treatment. Ontario has a funded, province-wide comprehensive program. Prince Edward Island has no in-province biomarker testing pathway.
4. **Clinical trials are hard to reach in Atlantic Canada.** The researchers called access "extremely limited." A clinical trial is a research study that tests a treatment with patients.
5. **Some answers do not exist yet.** The researchers found no published wait times for pancreatic cancer specifically. The three territories had too little public evidence to grade.

What the grades are not. They are not a rating of any patient, family, nurse, doctor or hospital. They are not an official government rating or a medical ranking. They describe written-down policies and programs.

A snapshot, not a service directory. This is a historical assessment of what was documented from June to August 2025. Programs, rules and hospitals may have changed since. Please do not use this report to look for services today.

The report card

Each grade is the mean of up to eight category scores, each from 0 to 4. A grade is shown as a letter, a mean to one decimal, and the number of categories that could be assessed — so you can see how close a grade sits to the one above or below.

A

Ontario

mean 3.6 · 7 of 8 categories assessed

B

British Columbia

mean 2.5 · 6 of 8 categories assessed

C

Nova Scotia

mean 2.1 · 8 of 8 categories assessed

C

Newfoundland and Labrador

mean 1.6 · 8 of 8 categories assessed

C

New Brunswick

mean 1.6 · 8 of 8 categories assessed

D

Prince Edward Island

mean 1.1 · 7 of 8 categories assessed

Not graded — insufficient data. Fewer than 5 of 8 categories had usable evidence. This is not a low grade, and missing evidence is never scored as zero.

- **Quebec** — 4 of 8 assessable
- **Alberta** — 3 of 8 assessable
- **Manitoba** — 3 of 8 assessable
- **Saskatchewan** — 3 of 8 assessable
- **Nunavut** — 2 of 8 assessable
- **Northwest Territories** — 1 of 8 assessable
- **Yukon** — 1 of 8 assessable

A place needs at least 5 of 8 categories with usable evidence to receive a grade. The drug-coverage scores for Nova Scotia, Newfoundland and Labrador, New Brunswick and Prince Edward Island rest on one regional estimate of 2019 spending, not on a province-level figure. Grades are fixed to evidence assessed to August 2025.

Category by category

Scores run from 0 to 4. A 4 is the strongest documented state. A 0 means the research documented an absence. A dash means not assessable: the research found no usable evidence, so the category is left out of the mean and never counted as zero.

JURISDICTION	STRATEGY	TESTING	DRUG COSTS	TRIALS	TIMELY CARE	TRAVEL	WORKFORCE	RESEARCH	OVERALL
Ontario	3	4	4	4	3	–	3	4	A · 3.6 7 of 8
British Columbia	2	3	–	2	–	1	3	4	B · 2.5 6 of 8
Nova Scotia	2	2	1	2	2	2	3	3	C · 2.1 8 of 8
Newfoundland and Labrador	2	1	1	2	2	2	2	1	C · 1.6 8 of 8
New Brunswick	2	2	1	2	1	2	2	1	C · 1.6 8 of 8
Prince Edward Island	2	0	1	1	1	2	–	1	D · 1.1 7 of 8
Quebec	2	2	–	3	–	–	–	2	Not graded 4 of 8 · 2.3*
Alberta	2	3	3	–	–	–	–	–	Not graded 3 of 8 · 2.7*
Manitoba	2	3	–	–	–	–	2	–	Not graded 3 of 8 · 2.3*
Saskatchewan	2	2	–	–	–	–	–	3	Not graded 3 of 8 · 2.3*
Nunavut	0	–	–	–	–	2	–	–	Not graded 2 of 8 · 1.0*
Northwest Territories	1	–	–	–	–	–	–	–	Not graded 1 of 8 · 1.0*
Yukon	0	–	–	–	–	–	–	–	Not graded 1 of 8 · 0.0*

4 Strongest documented 3 2 1 0 Documented absence – Not assessable

*Mean of assessed categories only, shown for transparency. Full category names: Strategy and pancreatic focus; Biomarker and genetic testing; Drug coverage and patient costs; Clinical trials access; Timely care (waits and surgical capacity); Travel and transport support; Workforce, navigation and patient support; Research funding and national representation.

How the grades work

What is graded. Written-down policies and programs: the plans, funding and services a province or territory has documented. Not people.

Who did what. The students built fact files on all 13 places from public information. They gave no grades. The Foundation reviewed their work, checked key figures against original sources, applied a published rubric (version 1), and is responsible for what is published here.

- The overall grade is the equal-weight mean of the categories that could be assessed.
- The mean is rounded to the nearest whole number (exactly .5 rounds up). Then 4 = A, 3 = B, 2 = C, 1 = D, 0 = F.
- At least 5 of the 8 categories must be assessed. Below that, a place is published as "Insufficient data — not graded."
- Not assessable is never counted as zero. A zero is a documented absence, such as no in-province biomarker testing pathway.

Two simplifications, stated openly. Timely care rests mainly on where pancreatic surgery and drug treatment are delivered, because wait numbers exist for only two provinces and are not specific to pancreatic cancer. Research and national representation rests on research funding and facilities for places outside Atlantic Canada, because the representation evidence covers Atlantic Canada only.

Three judgment calls, disclosed

- **Prince Edward Island, timely care.** Scored 1 because it has no in-province pancreatic surgery. Read literally, one scoring clause about waits would give it 2, and its mean would be 1.3. Its letter, D, is the same either way. Its 77.4-week figure is an all-specialty median, not a pancreatic cancer wait, and was not the basis for the score.
- **Clinical trials, Quebec and Nova Scotia.** No site-level count of trials exists in the research for any province. Quebec's 3 rests on evidence that trials are concentrated in Montreal. Nova Scotia stayed at 2 because the researchers' own verdict is that pancreatic trial access in Atlantic Canada is extremely limited.
- **Travel, Manitoba and Nunavut.** Nunavut's travel programs are documented as significant budget line items, so it scored 2. Manitoba's bare mention of coordinated travel support, with no terms, was marked not assessable. Under one uniform rule, Nunavut's travel score would also be not assessable. Nunavut is not graded either way.

The full scoring bands follow on the next page, exactly as applied. Every category score in this report is the highest band whose conditions the evidence fully meets.

What the scores mean

The scoring bands for all eight categories, as applied. A jurisdiction takes the highest band whose conditions it fully meets on the evidence. Two evidence notes are part of the method: Atlantic drug-coverage scores under band 1 rest on the regional PMPRB figure (page 3 states this wherever those grades appear); and Category 8 rests on hosted funding and infrastructure outside Atlantic Canada, because the representation inventories measure Atlantic Canada only.

Category		Band definition
1 · Strategy & pancreatic focus	**4**	A current provincial cancer strategy that includes a dedicated pancreatic cancer program or funded pancreatic-specific initiatives, with published targets.
	3	A current strategy with explicit provisions or referral pathways for rare and complex cancers, named goals, implemented through regional programs.
	2	A current strategy or cancer program in operation; pancreatic cancer addressed only within general oncology; some program funding lines identified.
	1	A strategy exists but funding is not identifiable in plan documents, or the strategy is dated or fragmented with no consolidated program.
	0	No provincial cancer strategy or agency-equivalent structure.
2 · Biomarker & genetic testing	**4**	A funded, province-wide comprehensive biomarker testing program: standardized public funding and coordination, a broad pancreatic-relevant panel, in effect.
	3	A provincial genomics or molecular diagnostics program operational for all cancer patients or covering key markers (e.g. BRCA, MSI), or a funded expansion in effect.
	2	In-province panel capacity for at least some solid tumours including pancreas, without a comprehensive funded program; or a funding-approval framework established but no operating program yet.
	1	A narrow funded test menu only; broader testing available only by send-out or interprovincial arrangement.
	0	No funded in-province testing pathway; access solely under an out-of-province referral policy.
3 · Drug coverage & patient costs	**4**	Income-based catastrophic coverage capping out-of-pocket drug costs, plus a transparent case-by-case access route with published timelines, plus funded in-hospital drug coverage at $0 patient cost for covered drugs.
	3	Broad public take-home drug coverage with cost-sharing; an exceptional-access route exists; measured private-pay share moderate where known.
	2	Public coverage exists but is fragmented, with documented gaps for take-home drugs and no income-based protection.
	1	No income-based protection and a high measured private-pay share, or documented full-cost exposure for common agents.
	0	No public coverage pathway for take-home cancer drugs documented.
4 · Clinical trials access	**4**	The province hosts major trial infrastructure with documented high enrolment (e.g. a centre reporting ~20% enrolment) and disease-specific programs (e.g. pancreatic sequencing and trial programs) in-province.
	3	Multiple active trial sites in-province, with some pancreatic trials accessible without leaving the province.
	2	Decentralized, satellite, or telehealth trial mechanisms — or formal pilot participation — exist, but disease-specific access remains extremely limited and most patients must travel.

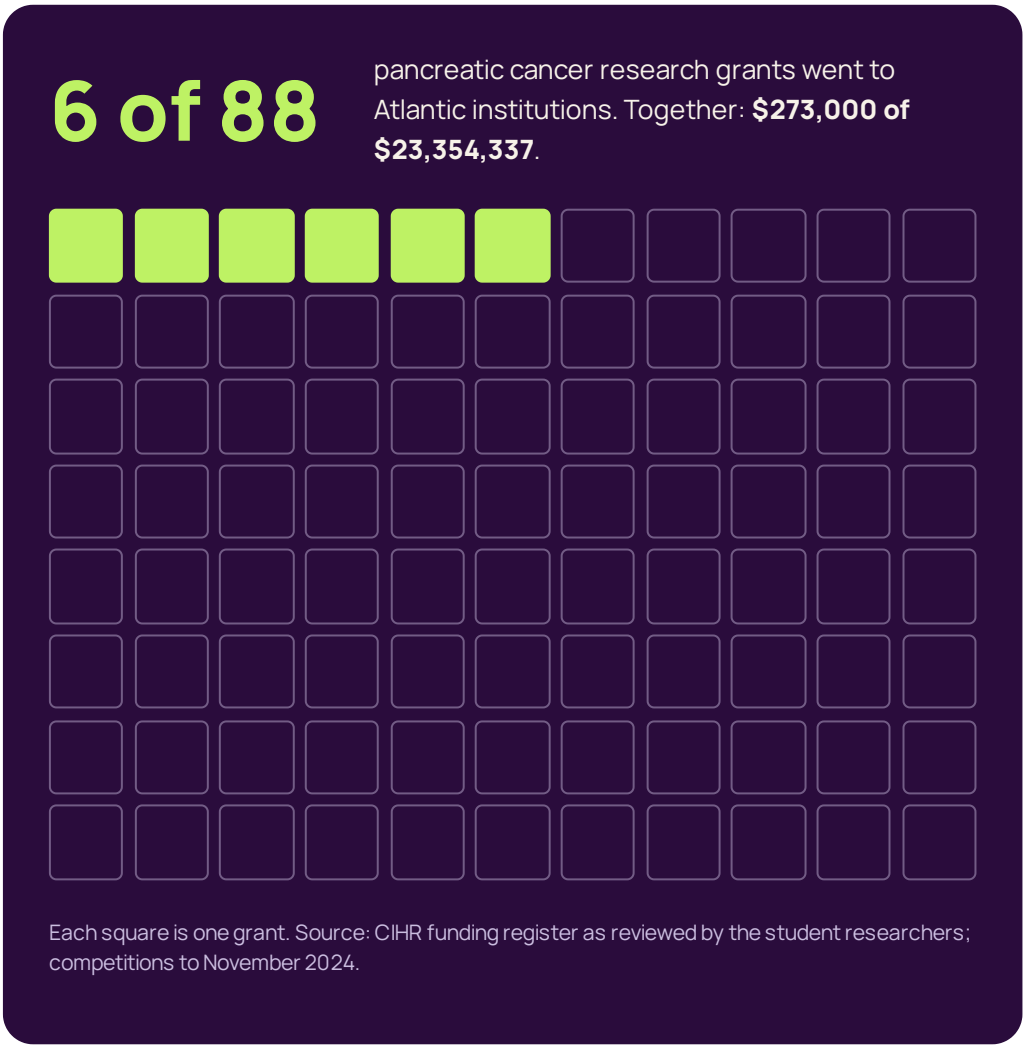
	1	Access by out-of-province referral only; no local trial infrastructure documented.
	0	No documented route to trial access.
5 · Timely care — waits & surgery	**4**	Pancreatic surgery available in-province at more than one centre, and documented wait performance better than the worst-in-country figures in the inventories.
	3	Pancreatic surgery and systemic therapy delivered in-province within a multi-centre tertiary and regional cancer system; numeric waits not available, or not pancreatic-specific.
	2	Pancreatic surgery in-province at a single centre, or documented longest-in-country waits, or both.
	1	No in-province pancreatic surgery — surgery by out-of-province referral; systemic therapy available in-province.
	0	No documented in-province surgical or systemic capacity; care accessed entirely by referral out.
6 · Travel & transport support	**4**	Funded province-wide support covering transport and lodging (and meals), prepaid or direct-billed or equivalent, with no documented up-front burden or restrictive income threshold.
	3	Funded transport and lodging programs with broad eligibility; cost-sharing minor; no documented systemic barrier.
	2	Documented transport and/or lodging programs, but reimbursement-based or cost-shared with a documented up-front burden, referral conditions, or an income threshold that excludes many patients.
	1	Support mainly charitable or third-party, or narrowly scoped to a single mode or route, or a provincial program that is nominal.
	0	No documented travel or lodging support of any kind.
7 · Workforce, navigation & support	**4**	A province-wide oncology navigation program with certified navigators, plus a workforce strategy carrying oncology-specific targets and retention mechanisms.
	3	Province-wide navigation or mature patient-support infrastructure, plus a workforce plan with named initiatives; oncology-specific targets partial or unevidenced.
	2	Navigation available in part of the province or through specific programs; workforce policies present but rated only partially adequate, or with documented retention weakness.
	1	Navigation or workforce measures limited to pilots or single programs, or rated not adequate.
	0	No documented navigation program or workforce measure.
8 · Research funding & representation	**4**	The province hosts a leading share of national pancreatic research funding, including major multi-year grants, plus research infrastructure based in-province.
	3	The province hosts multiple pancreatic-cancer grants, or one major grant, or a node of a national research network.
	2	The province hosts at least one pancreatic-flagged research grant or a dedicated pancreatic research program.
	1	No hosted pancreatic research funding, but documented participation in regional or national research collaboration.
	0	No hosted pancreatic funding and no documented participation.

What we found

Nothing is built for pancreatic cancer

The students' review of cancer plans found the same thing in every province and territory: no organized screening program for pancreatic cancer and no dedicated provincial pancreatic program. They also found no federal recommendation to screen the general population for it. Some plans do not name the disease at all. Manitoba's strategy "does not explicitly highlight pancreatic cancer." Saskatchewan's does not treat it as a distinct focus. Ontario's Cancer Plan 6 (2024–2028) reaches rare and complex cancers through referral pathways, not by name.

Research money barely reaches Atlantic Canada

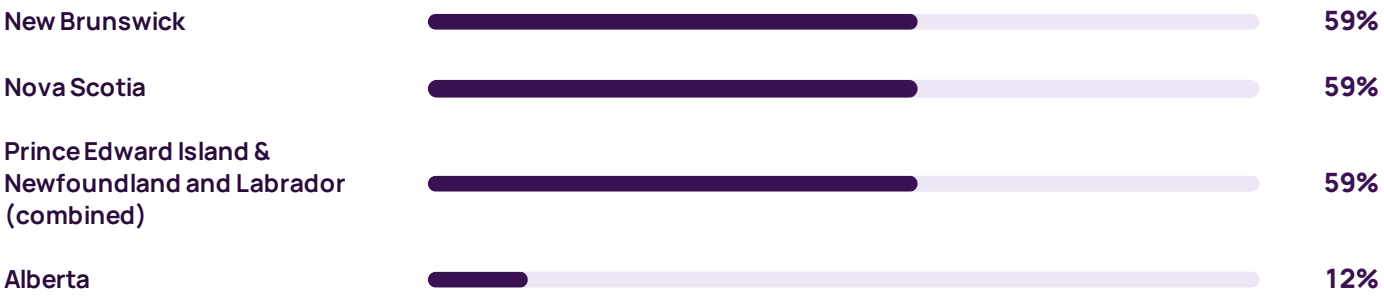


The students reviewed a register of 270 grants from the Canadian Institutes of Health Research (CIHR), worth $102,717,028 in total. Of those, 88 were flagged as pancreatic cancer research, worth $23,354,337. Atlantic institutions hold 6 of the 88: five at Dalhousie University and one at the Nova Scotia Health Authority. Newfoundland and Labrador, New Brunswick and Prince Edward Island have none. A recount confirmed these numbers. The full register is concentrated at four institutions: the University of British Columbia (46 records), the University of Toronto (40), University Health Network (30) and McGill (21).

Take-home cancer drugs

Some cancer drugs are pills or injections taken at home instead of in hospital. Who pays for them differs across the country. Here is the verified finding.

A 2021 report from the Patented Medicine Prices Review Board (PMPRB) estimated that private plans and cash payments accounted for **59%** of 2019 spending on selected take-home oncology medicines in New Brunswick, Nova Scotia, and the combined PEI–Newfoundland and Labrador market, compared with **12%** in Alberta. ("Oncology" means cancer care.)



Source: PMPRB, *Alignment Among Public Formularies in Canada, Part 2: Oncology Medicines* (May 2021), Figure 3.3(b); 2019 spending, 47 selected take-home oncology medicines (oral and injections under the skin).

What this number is, and is not

- It is a share of spending, not a share of patients.
- "Private plans" means insurance outside the public system. "Cash" means people paying directly. The two are combined.
- It is **not** the share patients pay out of their own pockets.
- It is reported for regions, not for any single province. No province-level cost figure exists in the research.
- It uses 2019 data, the most recent the PMPRB publishes in this form.

A separate estimate. Average take-home cancer drug costs were estimated at $6,000 per month. That estimate comes from the CanCertainty Coalition, as cited in MacPhail and Snow (*Current Oncology*, 2022). It is a different source measuring something different. Please do not read it alongside the PMPRB figure.

What Ontario does differently. The researchers found three pieces. The Trillium Drug Program caps drug costs relative to income. The Exceptional Access Program is a case-by-case route to drugs not otherwise covered; decisions take 3 days to 6 weeks, and approved coverage can reach back to the date of the clinical decision. Covered in-hospital intravenous (IV) drugs typically cost patients $0 under the New Drug Funding Program. The researchers' comparison found that Atlantic provinces lack an equivalent income-based program.

Testing, and clinical trials

Biomarker and genetic testing

Access comes in two tiers, even inside Atlantic Canada. Ontario is the benchmark: its publicly funded comprehensive biomarker testing program was announced on May 4, 2021, rolled out from June 2021, and was in place province-wide by 2021/22. British Columbia's genomics laboratory is mandated to provide molecular testing for all cancer patients in the province. Alberta's cancer genomics program is operating, and Manitoba's molecular diagnostics expansion is in effect. Saskatchewan has a framework for funding approvals but no documented operating program. Quebec has a provincial process for adding genomic tests.

In Atlantic Canada, Prince Edward Island and Newfoundland and Labrador rely heavily on sending patients out of province. Nova Scotia and New Brunswick have partial in-province testing. The researchers' database of testing policies has 22 records. None is for a territory.

Clinical trials

The researchers' verdict: **"Pancreatic cancer trials access in Atlantic Canada is extremely limited."** About 7% of all Canadian cancer patients take part in trials. Princess Margaret Hospital reports 21%. Smaller regions report 3–4%. The researchers' mapping expresses the concentration as Toronto 40% and Montreal 34% of recorded trial activity, against 2.6% for Nova Scotia (figures as written in the research).

Some newer models try to bring trials closer to home. A pilot of decentralized trials (trials run at more sites, not only big hospitals) covers British Columbia, Ontario, and Newfoundland and Labrador. New Brunswick's Horizon Health Network has set up decentralized trials. COMPASS, a program that sequences pancreatic tumours, is based in Toronto, with one expansion to Halifax. The Atlantic Cancer Consortium links the four Atlantic provinces. It began in January 2021 with one $3.6 million two-year pilot budget. That total includes $1.5 million from the Terry Fox Research Institute; partners provided the roughly $2.1 million balance in matching cash or in-kind support. Its demonstration projects focus on lung and colorectal cancer, not pancreatic cancer.

Surgery and waits

Where surgery happens

In the 2025 research period, pancreatic surgery in Atlantic Canada was centralized in Halifax and St. John's. The Whipple procedure, a major operation on the pancreas, was done in-province at the QEII in Halifax and the Health Sciences Centre in St. John's. New Brunswick and Prince Edward Island patients were referred out.

Waits

Only two provinces have numbers. Both are Fraser Institute medians from GP referral to treatment, all 12 specialties combined (*Waiting Your Turn*, 2024 edition).

These are not pancreatic cancer wait times. They average across all kinds of care. The researchers found pancreatic-specific wait times published nowhere. Nova Scotia does run a public wait-time dashboard that includes pancreas surgery for pancreatic cancer.

Travel, staffing and representation

Travel

In Atlantic Canada, travel is part of treatment. The researchers found three problems: up-front payment, income limits that shut people out, and help limited to one way of travelling. They rated 19 supports from 1 to 5. The best rated were Daffodil Place lodging in St. John's and The Lodge That Gives in Halifax (5 of 5 each), and Prince Edward Island's Maritime Bus Subsidy and Hope Air partnership (4 of 5 each).

Staffing, navigation and Indigenous cancer care

The researchers assessed 10 workforce policies. Three gaps came up again and again: no targets for cancer and diagnostic staff, few ways to keep staff beyond first-year bonuses or debt forgiveness, and heavy reliance on locums (temporary replacement doctors) and pilot projects. Keeping staff is flagged as a particular weakness in Newfoundland and Labrador and New Brunswick.

Navigation is the documented strength. A navigator is a nurse or staff member who guides a patient through care. Nova Scotia's Cancer Patient Navigation Program has run province-wide since the early 2000s. Manitoba's Community Oncology Program, with about 16 shared-care community sites, is the national example.

The researchers looked at 26 policies on Indigenous cancer care. Indigenous patient navigators exist in all four Atlantic provinces. Horizon Health in New Brunswick hired 10 new ones in 2025, for 12 across all its zones. The gaps: cultural-safety standards are not consistently required, and Indigenous self-determination in cancer care is, in the researchers' words, "partially supported but rarely codified."

Who has a seat at national tables

The researchers counted Atlantic Canada's presence on 29 national health and cancer bodies. Their table shows 15 above parity, 4 near parity and 10 under-represented. On average, Atlantic Canada holds about 4–5% of seats, against 6.8% of the population. The typical body has one Atlantic seat. Some percentages are the researchers' estimates. One body stands out: the Atlantic Cancer Consortium's Patient Advisory Committee has about 4 of 12 public members from Atlantic Canada (about 33%). The researchers also flagged that the membership of the committee that advises on cancer drug funding recommendations (the pCODR Expert Review Committee) is not publicly disclosed.

Ontario

Mean 3.6 of 4 · based on 7 of 8 categories

A

STRATEGY	TESTING	DRUG COSTS	TRIALS	TIMELY CARE	TRAVEL	WORKFORCE	RESEARCH
	4	4	4		–		4

Strongest areas

- **Testing.** The comprehensive biomarker testing program was announced on May 4, 2021, began in stages from June 2021, and was in place province-wide by 2021/22. It covers BRCA1/2 (inherited gene changes), the tumour markers MSI/dMMR and NTRK, and others relevant to pancreatic cancer.
- **Drug coverage.** The most developed in the research: an income-based cap, a case-by-case route to uncovered drugs, and typically $0 for covered in-hospital IV drugs.
- **Trials.** Princess Margaret Hospital reports 21% of patients in trials. COMPASS, which sequences pancreatic tumours, is based in Toronto.
- **Research.** Ontario has the largest concentration in the register: the University of Toronto (40 records) and University Health Network (30) together hold 70 of its 270.

Main gaps

- Ontario Cancer Plan 6 (2024–2028) has five goals and runs through 14 regional cancer programs. It has no pancreatic-specific initiatives and no targeted screening for pancreatic cancer.
- **Travel could not be assessed.** The files document no Ontario provincial travel program like the Atlantic ones, and the grading did not guess that one exists.
- No Ontario wait figure was found. Ontario's own private-pay share of drug spending is not covered in the research.
- **Navigation and staffing:** patients report their own symptoms through "Your Symptoms Matter" (active by 2017), and a telemedicine hub-and-spoke model operates. Targets specific to cancer staffing are not evidenced.

British Columbia

Mean 2.5 of 4 · based on 6 of 8 categories

B

2 STRATEGY · TESTING · – DRUG COSTS · 2 TRIALS · – TIMELY CARE · 1 TRAVEL · WORKFORCE · 4 RESEARCH

Strongest areas

- **Research.** The University of British Columbia holds 46 of the register's 270 records. BC also hosts research facilities of national scope.
- **Staffing.** In the first year of the 10-Year Cancer Action Plan, over 70 oncologists and more than 30 radiation therapists were hired across six regional cancer centres, and eight Indigenous patient navigator positions were created. More than 325 full-time-equivalent positions were filled.
- **Testing.** The provincial genetics and genomics laboratory is mandated to provide molecular testing for all cancer patients in BC.

Main gaps

- The plan (2023–2033, with an initial $440 million announced in 2023) addresses pancreatic cancer only within general cancer care.
- BC is a pilot province for decentralized trials, but no pancreatic-specific trial access is documented.
- The only travel help documented is a donor-funded charitable fund, the BC Cancer Foundation Patient Relief Fund. No provincial travel program is documented.
- Drug coverage and timely care could not be assessed.

Dated note: BC's mean of 2.5 sits exactly on the line between bands and rounds up to a B.

Nova Scotia

Mean 2.1 of 4 · based on 8 of 8 categories

C

STRATEGY	TESTING	DRUG COSTS	TRIALS	TIMELY CARE	TRAVEL	WORKFORCE	RESEARCH
2	2	1	2	2	2		

Strongest areas

- **Navigation.** The Cancer Patient Navigation Program has run province-wide since the early 2000s, with oncology-certified navigators. The researchers called it an Atlantic Canada strength.
- **Research.** All six Atlantic pancreatic cancer grants are here: five at Dalhousie University and one at the Nova Scotia Health Authority, totalling $273,000.
- **Testing capacity.** Tumour sequencing equipment is operating at the QEII Health Sciences Centre. Inherited-gene (germline) testing for Nova Scotia, New Brunswick and PEI runs through the Maritime Medical Genetics Service at IWK Health.
- **Trials.** The Atlantic Clinical Cancer Research Unit (Nova Scotia Health) is based here, and COMPASS has a Halifax site.

Main gaps

- The province's cancer program addresses pancreatic cancer only within general cancer care.
- The drug-cost score of 1 rests on the regional PMPRB estimate described in this report, with no income-based protection documented.
- Pancreatic trial access is still extremely limited.
- The Boarding, Transportation and Ostomy Program helps with travel over 50 km one way, but its income limit of $35,000 gross family income is documented as shutting out many rural residents.
- Pancreatic surgery is done at one centre, in Halifax. The Fraser Institute's 2024 median wait from GP referral to treatment is 39.1 weeks across all specialties. It is not a pancreatic cancer wait time.

Dated note: Since this research was completed, The Moncton Hospital completed Atlantic Canada's first robotic Whipple procedure (announced September 2026).

Newfoundland and Labrador

Mean 1.6 of 4 · based on 8 of 8 categories

C

2	1	1	2	2	2	2	1
STRATEGY	TESTING	DRUG COSTS	TRIALS	TIMELY CARE	TRAVEL	WORKFORCE	RESEARCH

Strongest areas

- **Travel and lodging.** The Medical Transportation Assistance Program shares the cost of eligible out-of-area travel. Air Daffodil provides three flights every year for rural Labrador. Daffodil Place lodging in St. John's is rated 5 of 5 by the researchers.
- **Trials.** The province is a pilot site for decentralized trials, with a satellite research site at Grand Falls–Windsor linked by telehealth to St. John's.
- **Navigation.** Labrador-Grenfell Health employs specially trained oncology nurses as patient navigators.

Main gaps

- **Testing.** Funded testing is a narrow menu: a 2019 laboratory entry for BRCA1/2 and hereditary colorectal panels. Broader testing is generally sent out.
- **Research.** Newfoundland and Labrador holds none of the 88 pancreatic cancer CIHR grants.
- **Drug costs.** The score rests on the regional PMPRB estimate.
- **Travel.** The program repays costs after the fact, which creates an up-front burden. The researchers wrote that rural and Labrador patients travelling to St. John's for surgery or radiation therapy "face cash-flow stress that may delay starts."
- **Surgery.** Pancreatic and HPB surgery (operations on the liver, pancreas and bile ducts) is done at a single centre in St. John's. No provincial wait figure was found.
- **Staffing.** Workforce policies are rated only partially adequate, with weak retention.

New Brunswick

Mean 1.6 of 4 · based on 8 of 8 categories

C

2	2	1	2	1	2	2	1
STRATEGY	TESTING	DRUG COSTS	TRIALS	TIMELY CARE	TRAVEL	WORKFORCE	RESEARCH

Strongest areas

- **Testing.** Horizon Health's pan-cancer tumour panel explicitly lists pancreas and is available in-province (record dated January 2025).
- **Trials.** Horizon has set up decentralized trials and works formally with Nova Scotia on specialized services and shared trials.
- **Navigation.** Horizon hired 10 new Indigenous Patient Navigators in 2025, for 12 across all zones.
- **Treatment.** Drug treatment and radiation therapy are delivered in Saint John and Moncton.

Main gaps

- **Surgery.** In the 2025 research period, New Brunswick had no in-province pancreatic surgery. That is why timely care scored 1. No New Brunswick wait figure was found, though the researchers' analysis describes long waits for treatment.
- **Research.** The province holds none of the 88 pancreatic cancer CIHR grants.
- **Travel.** Medical transportation support is rated moderate, with limited coverage and basic travel help only.
- **Staffing.** The workforce plan is rated partially adequate, with weak focus on cancer and diagnostics.
- **Drug costs.** The score rests on the regional PMPRB estimate.

Dated note: Since this research was completed, The Moncton Hospital completed Atlantic Canada's first robotic Whipple procedure (announced September 2026).

Prince Edward Island

Mean 1.1 of 4 · based on 7 of 8 categories

D

2	0	1	1	1	2	–	1
STRATEGY	TESTING	DRUG COSTS	TRIALS	TIMELY CARE	TRAVEL	WORKFORCE	RESEARCH

Strongest areas

- **Travel.** PEI's travel help is comparatively strong. The Maritime Bus Subsidy is income-based (100% or 50%) and requires an application 10 days before travel. The Hope Air partnership provides free flights, bridge or ferry passes, and gas cards for eligible low-income patients. The researchers rated each 4 of 5.
- **Plan.** The Cancer Action Plan 2023–2028, launched February 28, 2023, sets five priorities and four enablers. Funding is part of Health PEI budgets, not listed as separate program lines.

Main gaps

- **Testing.** Scored 0, because the research documented an absence: there is no in-province biomarker testing pathway. Access runs through an out-of-province policy.
- **Trials.** No decentralized or satellite trial mechanism is documented.
- **Surgery.** There is no in-province pancreatic surgery. Whipple-eligible cases are typically done in Halifax. The Fraser Institute's 2024 median wait from GP referral to treatment is 77.4 weeks across all specialties, the longest in Canada. It is not a pancreatic cancer wait time.
- **Drug coverage.** The researchers flag take-home drug coverage gaps: patients do not have full coverage for all medications.
- **Research.** PEI holds none of the 88 pancreatic cancer CIHR grants.
- **Staffing.** Could not be assessed: the research does not cover PEI-specific workforce policy.

Places we could not grade

Seven places did not reach 5 of 8 assessable categories. No overall grade is published for them. The category scores are shown for transparency only.

Quebec (4 of 8 assessable · mean of assessed 2.3*)

Quebec has a current plan, the Plan d'action en cancérologie 2024–2026, with eight strategic axes. It covers pancreatic cancer only within general cancer care. A provincial process adds genomic tests to the province's list, and Montreal accounts for 34% of recorded trial activity. The CIHR register shows at least one pancreatic grant in Quebec, a $36,000 award at the Institut de recherche de l'Hôpital Maisonneuve-Rosemont. Quebec sits outside the national cancer drug review process (pCODR). Drug coverage, timely care, travel and staffing could not be assessed.

Alberta (3 of 8 assessable · mean of assessed 2.7*)

Alberta has a cancer plan to 2030 and a strategic clinical network plan. Its cancer genomics program is operating and covers BRCA, MSI and other markers related to pancreatic cancer. Alberta is the comparison point in the drug-cost finding: private plans and cash paid 12% of 2019 spending on selected take-home oncology medicines, the lowest share measured in the research. Trials, waits, travel, staffing and research could not be assessed. Alberta runs a long-term research study of about 55,000 people (the Tomorrow Project), but no Alberta-hosted pancreatic cancer CIHR grant is recorded, and the grading did not guess what that meant.

Manitoba (3 of 8 assessable · mean of assessed 2.3*)

CancerCare Manitoba's 2024–2029 framework works through Winnipeg and 11 regional clinics but does not explicitly highlight pancreatic cancer. A molecular diagnostics expansion is in effect. An Aboriginal Cancer Care Program employs Indigenous Patient Navigators. Coordinated travel support for northern and remote communities is mentioned, but with no terms given. Drug coverage, trials, timely care and research were not covered.

Saskatchewan (3 of 8 assessable · mean of assessed 2.3*)

The Saskatchewan Cancer Agency's 2024–2028 plan does not highlight pancreatic cancer as a distinct focus. A framework for funding molecular biomarker tests was established in July 2024, but no operating program is documented. The University of Saskatchewan holds one large pancreatic grant, $979,200, for a radioimmunoconjugate (a targeted treatment) program. Five categories could not be assessed, including drug coverage, trials and travel.

Nunavut (2 of 8 assessable · mean of assessed 1.0*)

The files record no standalone cancer agency. Care runs by referral to southern tertiary (specialist) centres. Patient travel programs are significant budget line items, but their rules are not in the research. Testing could not be assessed because the research database has no entries for any territory.

Northwest Territories (1 of 8 assessable · mean of assessed 1.0*)

The files record screening, referral and community supports, with reliance on southern specialist centres and no consolidated cancer strategy. Seven categories could not be assessed.

Yukon (1 of 8 assessable · mean of assessed 0.0*)

The files record no standalone territorial cancer strategy equivalent to a provincial cancer agency. Care runs by referral to British Columbia and Ontario. Seven categories could not be assessed.

What the thin evidence tells us. In all three territories, pancreatic cancer is managed through referral and no screening program exists. Beyond that, the public record is sparse. The testing database has no territorial entries, and the strategy review covered only the ten provinces. Thin evidence does not mean nothing is happening. It means a patient, family member or advocate searching public sources would find very little to go on. That is a finding in itself.

What the student researchers recommend

These recommendations are the student researchers' own. They are not positions of The Heather Cutler Foundation. The Foundation publishes them to make them visible and to support public discussion.

1. **Biomarker testing.** Set a target of ten working days or fewer for biomarker test results. Build an Atlantic coverage baseline, using Quebec's provincial process for adding genomic tests as a template.

2. **Drug coverage.** Adopt take-home cancer drug coverage standards that close the gap with Alberta's public funding. Treat take-home drug coverage, and the patchwork of provincial laboratory formulary systems, as critical priorities.

3. **Federal transfers.** Move the Canada Health Transfer toward age-adjusted allocation. The researchers' reform strategy projected this could bring more than $200 million a year in additional funding for Atlantic health services. That is a projection, not an observed figure.

4. **Travel support.** Raise Nova Scotia's travel-assistance income limit from $35,000 to $50,000 in gross family income. Work toward the researchers' targets: travel distance under 200 km for 90% of patients within three years, and 80% rural broadband coverage within three years.

5. **Collaboration.** Extend three-province collaboration models to include Newfoundland and Labrador, especially for high-burden, low-survival cancers like pancreatic cancer. Connect the Atlantic Clinical Trials Network with the consortium's patient advisory groups, which the researchers ranked as the most impactful collaboration gap. Present the Atlantic Cancer Consortium and ACCESS Atlantic as national examples of regional collaboration.

6. **Staffing.** Add cancer- and diagnostic-specific staffing targets to national and provincial policies. Build ways to keep staff that go beyond first-year bonuses and debt forgiveness.

7. **Indigenous cancer care.** Place Indigenous patient navigators in each province within eighteen months. Require clear cultural-safety standards everywhere. Move Indigenous self-determination in cancer planning from partial support toward written-in decision rights.

8. **Transparency.** Publish who sits on the pCODR Expert Review Committee, the gap the researchers' advocacy analysis rated most significant. (pCODR is the national cancer drug review process.)

What this report cannot tell you

This report states what the research could support and what it could not. In several cases the limit is itself a finding. Where public information is too thin to assess a category, that thinness is what patients and advocates face.

Figures we left out

Several figures in the researchers' working papers could not be verified against original sources, or conflicted with one another. They are not used here. They include a launch date for Ontario's testing program, trial-capacity counts for an Atlantic trials unit, a Nova Scotia wait time from an earlier edition of the Fraser Institute report, a representation count that did not match the researchers' own table, a Nova Scotia lung-screening budget, and a Newfoundland and Labrador home-care funding figure.

Gaps in the research

- **Territories.** Only each territory's overall approach to cancer strategy is documented. The testing database has no entries for Yukon, the Northwest Territories or Nunavut, and the strategy review covers only the ten provinces.
- **Wait times.** Numbers exist only for Prince Edward Island and Nova Scotia, from one source, and they combine all specialties. Pancreatic-specific wait times are not measured anywhere in the research.
- **Drug coverage.** Province-level detail is deep only for Ontario. Atlantic drug costs rest on one regional figure from 2019 spending, the most recent the PMPRB publishes in that form, but dated. Several Atlantic drug-program details in the researchers' notes are leads that still need checking and are not published here.
- **Staffing.** PEI-specific workforce policy is not covered. Workforce evidence overall is about policies, not head counts.
- **Age of the evidence.** The CIHR register ends with November 2024 competitions, so research funding is the oldest part. Research data overall are current to mid- to late 2025.
- **Draft material.** One working draft was undated and incomplete. Its New Brunswick section was empty. It was treated as draft material throughout. Several other major source documents are undated.

Other limits

- The research is student work, in places unedited. Figures that appear only in the program's assignment briefs are worked examples, not findings, and were left out.
- The representation research measures Atlantic Canada only. That is why Category 8 rests on different evidence for Atlantic and non-Atlantic places.
- Atlantic drug-cost grades rest on a regional figure because no province-level figure exists. The basis is stated wherever the grades appear.
- Surgical locations are stated as of the 2025 research period.
- This is a one-off snapshot of the 2025 research period, not a live measurement. No re-grade is planned at this time.
- Errors may remain. Corrections are welcomed at support@heathercutler.ca.

What the next edition needs

Wait times for pancreatic cancer specifically; province-level take-home drug costs and coverage data; public biomarker-testing turnaround times and who is eligible; clinical-trial availability reported by cancer type; clear travel-support rules and up-front cost expectations; published information on navigation and staffing capacity; and a documented schedule for updating policies and programs.

Update since the research period. In September 2026, The Moncton Hospital completed Atlantic Canada's first robotic Whipple procedure, according to a Horizon Health Network release published September 21, 2026. This update does not change the August 2025 grades.

How we did it

The method in brief. The students built fact files for all 13 places. The Foundation applied its grading rubric (version 1). Each of eight categories is scored 0–4 or marked not assessable. Within a category, 4 is the strongest documented state, 3 or 2 is a partial program or capacity, 1 is narrow or nominal provision, and 0 is a documented absence. The overall grade is the equal-weight mean of assessed categories, rounded to the nearest whole number (.5 rounds up) and turned into a letter from A to F. At least five of eight categories must be assessable.

Five principles guided the grading: grades assess systems, not people; every category score traces to a specific record; figures found only in assignment briefs are not data; conflicts between sources are noted, not quietly resolved; and the same definitions apply to every place. Where the students' documents disagreed, the Foundation's checked figure was used.

Sources used to check figures

- Patented Medicine Prices Review Board, *Alignment Among Public Formularies in Canada, Part 2: Oncology Medicines* (May 2021), Figure 3.3(b), 2019 spending data.
- Fraser Institute, *Waiting Your Turn: Wait Times for Health Care in Canada* (2024 edition; 2023 edition for the Nova Scotia comparison).
- Ontario Health / Cancer Care Ontario, Comprehensive Cancer Biomarker Testing Program; University Health Network implementation notice (2021); Ontario Health Annual Report 2021/22.
- Terry Fox Research Institute, Atlantic Cancer Consortium pilot project record.
- Canadian Institutes of Health Research, funding data (competitions to November 2024).
- Horizon Health Network, news release on the first robotic Whipple procedure at The Moncton Hospital (September 21, 2026).
- MacPhail and Snow, *Current Oncology* (2022), citing a CanCertainty Coalition budget proposal.

Words used in this report

Biomarker testing	tests that look at a tumour or a person's genes for clues that can guide treatment.
BRCA1/2; germline	genes whose changes can be inherited; germline testing looks for inherited changes.
MSI/dMMR and NTRK	tumour markers the researchers identified as relevant to pancreatic cancer.
Clinical trial	a research study that tests a treatment with patients.
Decentralized trial	a trial run at more sites, closer to patients, not only at big hospitals.
Median	the middle value. Half of people wait less, and half wait more.
Navigator	a nurse or staff member who guides a patient through care.
Oncology	cancer care.
Private plans	insurance outside the public system.

Take-home cancer drugs	pills or injections taken at home instead of in hospital.
Tertiary centre	a large hospital that provides specialist care.
Whipple procedure	a major operation on the pancreas.
HPB surgery	operations on the liver, pancreas and bile ducts.
CIHR · PMPRB · pCODR	Canadian Institutes of Health Research · Patented Medicine Prices Review Board · the national cancer drug review process.

Credits

Research: Arafa Hossain, Charlotte Campbell, Grace Fitzgerald, Rayah Vokey, Seriman Doumbia, Chaturrvi Maruthireddy and Kimia Rezaeinejad — Policy Builders of Tomorrow, Memorial University. **Grades, verification and editorial responsibility:** The Heather Cutler Foundation.

Credit to any person or institution does not imply endorsement by any university, hospital, charity or agency. The research was an educational program. The Heather Cutler Foundation verified key figures, but errors may remain, and corrections are welcomed.

The Heather Cutler Foundation

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