PANCREATIC CANCER POLICY BUILDERS

WHERE YOU LIVE Matters

Thirteen provinces and territories assessed across eight key healthcare pillars—from screening and drug coverage to clinical trial access.

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Where You Live Matters: How Canada Responds to Pancreatic Cancer

Thirteen provinces and territories assessed across eight key healthcare pillars—from screening and drug coverage to clinical trial access.

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Research by the 2025 Policy Builders of Tomorrow cohort.

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Foreword

About 6,500 Canadians are expected to die of pancreatic cancer in 2026, making it the third leading cause of cancer death in the country.

No province or territory has an organized screening program for it. None has a dedicated pancreatic cancer program. What changes from one place to the next is everything around that gap: whether a tumour can be tested close to home or must be sent away; whether surgery is down the road or in another province; what a patient pays for the drugs they take home; and whether anyone is funding the research that could change the outcome.

The differences are stark. Ontario runs a publicly funded biomarker testing program across the province. Prince Edward Island (PEI) has no in-province testing pathway at all. Of the 88 pancreatic cancer research grants in the register compiled for this report, six went to Atlantic Canada, totalling $273,000, and every one of them was in Nova Scotia.

This report grades each jurisdiction's system on eight measures. Six jurisdictions had enough evidence to be graded; seven did not, and the report says so plainly. The grades speak to policy and system design. They are not a judgment on patients, families, clinicians or hospitals.

Patients and families deserve to see how the system they depend on compares with the rest of the country. Those who plan and fund cancer care in each jurisdiction can answer one simple question: what is being done for pancreatic cancer here?

About this snapshot. *This report is built on research conducted in 2025 by the research team of the Pancreatic Cancer Policy Builders of Tomorrow program. Key figures were independently verified before publication (October 2026; see Section 1). The findings are a dated snapshot of the policies and programs in place in 2025. Policies change, and developments after the research period are noted where they affect a published statement.*

Executive summary

Across all 13 provinces and territories, the research team found the same gap: no organized pancreatic cancer screening program and no dedicated pancreatic cancer program. What varies is how well the general system around pancreatic cancer serves the people who develop it: testing, drug coverage, trials, surgery, travel support, navigation and research funding.

Key findings

- **Strategy.** *Some provincial cancer strategies, including Manitoba's and Saskatchewan's, do not highlight pancreatic cancer at all. Federally, there are no recommendations for population-based pancreatic cancer screening and no guidelines on adopting validated early detection tools (Section 2.1).*
- **Research funding.** *The register compiled for this research holds 88 pancreatic cancer grants from the Canadian Institutes of Health Research (CIHR), totalling $23,354,337. Six went to Atlantic institutions, all in Nova Scotia, totalling $273,000 (Section 4).*
- **Biomarker testing.** *Access is two-tier. Ontario operates the benchmark: a publicly funded, comprehensive provincial program. In Atlantic Canada, Nova Scotia and New Brunswick have partial in-province capacity, while Newfoundland and Labrador and PEI rely on send-out testing and out-of-province referral (Section 2.2).*
- **Drug costs.** *A 2021 report by 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 the Atlantic groupings, compared with 12% in Alberta (full wording and caveats in Section 4).*

- **Waits.** *PEI recorded the longest median wait in Canada, 77.4 weeks from GP referral to treatment across all specialties. Nova Scotia recorded 39.1 weeks (Fraser Institute, 2024). These are all-specialty medians, not pancreatic cancer waits. The researchers found no published pancreatic-specific wait times.*
- **Travel.** *In the 2025 research period, Atlantic pancreatic surgery was centralized in Halifax and St. John's, and trial access in the region was assessed as extremely limited. Patients routinely travel between provinces for care, and existing travel support is largely reimbursement-based, income-tested, or both. A later development at The Moncton Hospital is noted in Section 2.5.*

The grades. *Each jurisdiction was graded against an eight-category rubric (Section 1). Six received an overall grade. The other seven had fewer than five assessable categories and are published as "Insufficient data, not graded," with their assessed categories still shown.*

Jurisdiction	Overall grade	Mean	Categories assessed
Ontario	**A**	*3.6*	*7 of 8*
British Columbia	**B**	*2.5*	*6 of 8*
Nova Scotia	**C**	*2.1*	*8 of 8*
Newfoundland and Labrador	**C**	*1.6*	*8 of 8*
New Brunswick	**C**	*1.6*	*8 of 8*
Prince Edward Island	**D**	*1.1*	*7 of 8*
Quebec	*Insufficient data, not graded*	*2.3**	*4 of 8*
Alberta	*Insufficient data, not graded*	*2.7**	*3 of 8*
Manitoba	*Insufficient data, not graded*	*2.3**	*3 of 8*
Saskatchewan	*Insufficient data, not graded*	*2.3**	*3 of 8*
Nunavut	*Insufficient data, not graded*	*1.0**	*2 of 8*

Northwest Territories	*Insufficient data, not graded*	*1.0**	*1 of 8*
Yukon	*Insufficient data, not graded*	*0.0**	*1 of 8*

** Mean of assessed categories only, shown for transparency. No overall grade is published below the five-of-eight evidence threshold (Section 1).*

The grades assess provincial systems: policy, funding and service architecture. They are not a judgment on patients, families, individual clinicians or individual hospitals.

1. About the program

The program

Pancreatic Cancer Policy Builders of Tomorrow is an applied research initiative supported by The Heather Cutler Foundation, a pancreatic cancer charity based in Mount Pearl, Newfoundland and Labrador. The program brings together university students and emerging professionals to examine how Canada's health systems respond to pancreatic cancer. Its objectives are to assess pancreatic cancer care, research and policy structures at the national and provincial levels; to identify barriers to access, funding and participation in precision medicine; and to map the organizations, jurisdictions and gaps that shape care.

The 2025 research track ran in a fully online format. It brought together a cohort of eight Memorial University undergraduate students (see Authors and acknowledgements). Program staff led the work, and cross-sector mentors with backgrounds in health research, public policy, advocacy and health care administration gave structured, phase-based feedback throughout.

The researchers compiled structured inventories:

- *A cancer strategy database covering all 13 provinces and territories*
- *A biomarker testing policy database recording funded pathways, jurisdiction by jurisdiction*

- *Implementation, infrastructure and transport matrices*
- *Assessments of Atlantic representation in national bodies, workforce policy, and rural and Indigenous cancer care*
- *A register of federal pancreatic cancer research funding*

The work proceeded through 13 modules, from mapping the policy landscape, through the points where care is decided (trials, testing, drug approval), to document verification, timeline cross-referencing and a closing coverage review.

In addition to this desk research, the research team conducted outreach to local and provincial cancer leaders and academics.

The grading rubric

The grades in this report are an assessment layer applied to the research team's inventories. No research document assigned grades to provinces. The rubric scores each jurisdiction from 0 to 4 in eight categories:

1. *Strategy and pancreatic focus*
2. *Biomarker and genetic testing*
3. *Drug coverage and patient costs*
4. *Clinical trials access*
5. *Timely care: waits and surgical capacity*
6. *Travel and transport support*
7. *Workforce, navigation and support*
8. *Research funding and representation*

Each category is scored against published band definitions that describe observable conditions, such as whether a funded province-wide testing program is in effect, or whether pancreatic surgery is delivered in-province. Three rules govern the scoring:

- **Missing data is never scored as zero.** *Where the research holds no usable evidence for a category, the jurisdiction is marked "Not assessable" for it. Not-assessable categories are excluded from the average, and the gap is disclosed. A low score is given only on evidence, including evidence of absence, such as a jurisdiction hosting zero research grants.*

- **A minimum-evidence threshold applies.** *The overall grade is the equal-weight mean of the assessed categories, rounded to the nearest band (.5 rounds up) and mapped 4 = A, 3 = B, 2 = C, 1 = D, 0 = F. A jurisdiction needs at least five of eight categories assessable to receive an overall grade. Below that, it is published as "Insufficient data, not graded," with its assessed categories still shown.*
- **The mean is published beside the grade.** *Readers can see how close a jurisdiction sits to the band above or below. British Columbia's mean of exactly 2.5, for example, rounds up to a B.*

Two simplifications are declared rather than hidden. Category 5 rests primarily on where pancreatic surgery and systemic therapy are delivered, because numeric wait times exist in the research for only two provinces and are not pancreatic-specific. Category 8's representation evidence measures Atlantic representation only; for non-Atlantic jurisdictions, that category rests on hosted research funding and infrastructure.

Verification and the conflicts rule

Before publication, the key figures in this report were independently verified against primary sources (October 2026). One rule governed the process: nothing published may contradict itself. Every conflict found in the research was resolved in one of three ways: a correct value verified from an authoritative source; both values published with the discrepancy disclosed; or the item omitted and labelled "data not obtainable." Unobtainable data is stated as such and never filled in. The full text was also reviewed before publication. Section 6 lists what could not be verified and which judgment calls the scoring required.

2. National findings by theme

2.1 Strategy and pancreatic focus

Every jurisdiction records the same finding: no organized or population-based pancreatic cancer screening program and no dedicated pancreatic cancer program. Pancreatic cancer is managed within general oncology services everywhere. Some strategies do not highlight it: Manitoba's "does not explicitly highlight pancreatic

cancer," and Saskatchewan's does not feature it "as a distinct focus." Ontario's Cancer Plan 6 (2024–2028) comes closest to a pathway, referencing rare and complex cancers generally with referral pathways, but it contains no targeted pancreatic initiatives. The territories are thinnest: Yukon has no standalone cancer strategy equivalent to a provincial agency, and Nunavut has no standalone cancer agency. Care in both runs by referral south. Federally, there are no recommendations for population-based pancreatic screening and no guidelines on adopting validated early detection tools.

2.2 Biomarker and genetic testing

Testing access is the report's clearest two-tier finding.

Ontario. *This is the benchmark: its publicly funded Comprehensive Cancer Biomarker Testing Program rolled out from June 2021 and was implemented province-wide by 2021/22, with standardized public funding and coordination covering BRCA1/2 germline testing, tumour MSI/dMMR, NTRK and other pancreatic-relevant markers. (January 1, 2024 is the effective date from which the program's currently listed indications are funded, not its launch.)*

Other provinces. *British Columbia's Cancer Genetics & Genomics Laboratory holds a provincial mandate for molecular diagnostics for all cancer patients. Alberta Precision Laboratories' Cancer Genomics Program provides next-generation sequencing (NGS) covering BRCA, MSI and other relevant markers. CancerCare Manitoba's Molecular Diagnostics Expansion is in effect. Quebec's INESSS/RQDM process (the Réseau québécois de diagnostic moléculaire) adds genomic tests to its Répertoire and supports NGS repatriation.*

Atlantic Canada. *Nova Scotia has in-province sequencing at the QEII Health Sciences Centre, and New Brunswick's Horizon Health runs a pan-cancer panel that explicitly lists pancreas, but neither has a comprehensive, funded, province-wide program. Newfoundland and Labrador's laboratory formulary funds BRCA1/2 and hereditary colorectal panels under an entry dated 2019, the oldest in the inventory; broader profiling requires send-out testing. PEI has no in-province pathway at all.*

Gaps. *The biomarker database contains no entries for the three territories. A pan-Canadian evidence paper ("Toward Timely and Equitable Advanced Biomarker Testing in*

Canada," 2025) recorded that 65% of comprehensively tested patients faced challenges accessing testing.

2.3 Drug coverage and patient costs

The research's only comparative drug-cost figure is a 2021 PMPRB estimate, based on 2019 spending, showing that private plans and cash account for a much larger share of selected take-home oncology spending in the Atlantic groupings than in Alberta. Section 4 gives the figures and their caveats.

The Atlantic provinces have no income-based drug program equivalent to Ontario's Trillium Drug Program, which caps out-of-pocket costs relative to household income. Ontario also runs an Exceptional Access Program, which decides case-by-case requests in three days to six weeks with backdating, and a New Drug Funding Program, under which patients pay $0 for covered in-hospital IV drugs. Province-by-province cost figures within Atlantic Canada were not obtainable (Sections 4 and 6).

2.4 Clinical trials access

The research's verdict on Atlantic Canada is direct: "Pancreatic cancer trials access in Atlantic Canada is extremely limited." Nationally, enrolment is concentrated. About 7% of Canadian cancer patients enrol in trials; Toronto's Princess Margaret Cancer Centre reports 21%, while smaller regions report 3–4%. One research document recorded Montreal at 34% of trial activity and Nova Scotia at 2.6% (figures as recorded).

Decentralized models are the main counterweight:

- The CRAFT pilot runs in British Columbia, Ontario, and Newfoundland and Labrador, with a satellite research site in Grand Falls–Windsor.
- Horizon Health Network has implemented decentralized trials on a digital platform.
- The Atlantic Clinical Cancer Research Unit (Nova Scotia Health) in Halifax was reported with 45–55 trials in start-up and 20–25 active.
- The Toronto-based COMPASS pancreatic sequencing program expanded one site to Halifax.

2.5 Timely care: waits and surgical capacity

*Numeric wait times exist in the research for two provinces only, from a single source (the Fraser Institute's **Waiting Your Turn**, 2024 edition), and they measure all specialties, not pancreatic cancer. PEI's median wait from GP referral to treatment was 77.4 weeks (Fraser Institute, 2024), the longest in Canada; the Fraser Institute cautions that PEI's smaller survey sample warrants care in interpretation. Nova Scotia's was 39.1 weeks (Fraser Institute, 2024).*

During the research period, Atlantic pancreatic surgery was centralized in Halifax and St. John's, and PEI's Whipple-eligible cases were typically performed in Halifax. Since the research was completed, The Moncton Hospital has performed Atlantic Canada's first robotic Whipple procedure (announced September 2026), which adds a third surgical city in the region. The report's grades score the research period and do not capture this change. Nova Scotia's public wait-time dashboard includes pancreas surgery for pancreatic cancer, one of the few places in the country where a pancreatic surgical wait is published at all.

2.6 Travel and transport support

Because specialized care is centralized, travel support is a core part of treatment access in Atlantic Canada.

- **Newfoundland and Labrador.** *The Medical Transportation Assistance Program (MTAP) cost-shares airfare, mileage, accommodations and meals for eligible out-of-area care. Research assessors rated it 3 of 5, citing an up-front payment burden documented as capable of delaying treatment starts for rural and Labrador patients.*
- **Nova Scotia.** *The Boarding, Transportation and Ostomy Program funds travel over 50 km one-way but is income-tested at a $35,000 gross family income threshold, documented as excluding many rural residents.*
- **Prince Edward Island.** *The Maritime Bus Subsidy (100% or 50%, by income) and the Hope Air partnership were each rated 4 of 5.*
- **Charitable lodging.** *Daffodil Place (St. John's) and The Lodge That Gives (Halifax) were each rated 5 of 5, the highest ratings in the research.*

- **Federal.** *The Non-Insured Health Benefits program provides medical transportation for eligible First Nations and Inuit patients.*

Outside Atlantic Canada, the only patient-cost support the research could score was British Columbia's donor-funded Patient Relief Fund. Ontario's provincial travel support was not documented and is marked not assessable.

2.7 Workforce, navigation and support

Across 10 federal and provincial workforce policies, three gaps recur: no oncology or diagnostic workforce targets; weak retention mechanisms beyond initial bonuses or debt forgiveness; and overreliance on locums and pilot programs. The Atlantic Locum & Recruitment Program was rated "Not adequate: only short-term fix."

Navigation is a documented regional strength in places, including Nova Scotia's province-wide Cancer Patient Navigation Program, oncology nurses serving as navigators in Labrador-Grenfell, and Indigenous Patient Navigators at Horizon Health (see the profiles in Section 3). Ontario's "Your Symptoms Matter" patient-reported outcomes program has operated province-wide since 2017.

Across 26 Indigenous cancer care policies, navigation infrastructure exists in all four Atlantic provinces. However, cultural-safety standards are not consistently mandated, traditional healing is often facilitated informally rather than encoded in policy, and Indigenous self-determination in cancer care is "partially supported but rarely codified."

2.8 Research funding and national representation

The CIHR register compiled for this research contains 270 grant records totalling $102,717,028 (competitions from September 2008 to November 2024). Records are concentrated at the University of British Columbia (46), the University of Toronto (40), University Health Network (30) and McGill University (21). Of the 270 records, 88 are flagged as pancreatic cancer research; the Atlantic share is set out in Section 4.

The research also assessed Atlantic Canada's representation on national health bodies. The results, including the gap the research rated most significant, are in Section 4.

3. Jurisdiction profiles

Scores are out of 4 per category. Categories marked "Not assessable" are excluded from the mean and never scored as zero (Section 1). Surgical locations are stated as of the 2025 research period (see Section 2.5 for a later development). In the tables, NL, NS, NB and PEI stand for Newfoundland and Labrador, Nova Scotia, New Brunswick and Prince Edward Island.

Newfoundland and Labrador: Overall C (mean 1.6, 8 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*Care runs through the NL Health Services Provincial Cancer Care Program, with budget lines for travel support (MTAP), telehealth and oncology investment. No dedicated pancreatic program.*
2	*Biomarker and genetic testing*	*1*	*The laboratory formulary funds BRCA1/2 and hereditary colorectal panels (entry dated 2019, the oldest in the inventory). Broader profiling requires send-out testing or interprovincial arrangements.*
3	*Drug coverage and patient costs*	*1*	*No income-based drug program equivalent to Ontario's Trillium. Scored on the Atlantic regional PMPRB figure (Section 4); no NL-specific figure was obtainable.*
4	*Clinical trials access*	*2*	*Teleoncology operates across all regions. NL is a CRAFT pilot province, with a satellite research site in Grand Falls–Windsor. Pancreatic trial access is nonetheless "extremely limited."*

5	Timely care: waits and surgical capacity	2	Pancreatic and hepatopancreatobiliary (HPB) surgery is provided in-province at a single centre (Health Sciences Centre / Bliss Murphy, St. John's). No NL-specific wait figure was obtainable.
6	Travel and transport support	2	MTAP cost-shares airfare, mileage, accommodations and meals (referral required); rated 3 of 5 by research assessors, citing the up-front payment burden. Daffodil Place lodging rated 5 of 5.
7	Workforce, navigation and support	2	Oncology nurses serve as navigators in Labrador-Grenfell. The Rural Physician Incentive is "partially adequate" for recruitment; retention is weak and allied health is excluded.
8	Research funding and representation	1	No CIHR pancreatic grant hosted in NL (0 of 88). NL participates in the Atlantic Cancer Consortium, holds a seat on the Management and Executive Committee of the Canadian Cancer Clinical Trials Network (3CTN), and has a voting member on the National Advisory Committee on Immunization (NACI) from the Department of Health and Community Services.

Care is centred on the Dr. H. Bliss Murphy Cancer Centre in St. John's. Within MTAP, Air Daffodil provides three flights a year for rural Labrador patients. The province also sits within a larger federal funding context: the Canada–Newfoundland and Labrador Working Together Agreement (signed March 25, 2024) provides approximately $256 million over three years for family health services, health workers and backlogs, mental health, and health data. This is general health funding, not a cancer allocation.

Nova Scotia: Overall C (mean 2.1, 8 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*Care runs through the Nova Scotia Health Cancer Care Program within the Action for Health plan (2022), including about $3 million to implement the lung screening program launched January 2024. No pancreatic-specific program.*
2	*Biomarker and genetic testing*	*2*	*In-province NGS operates at the QEII Health Sciences Centre (Illumina NextSeq 2000). Germline testing for the Maritimes runs through the Maritime Medical Genetics Service. No comprehensive funded province-wide program.*
3	*Drug coverage and patient costs*	*1*	*Scored on the Atlantic regional PMPRB figure (Section 4). One NS-specific datum: rural NS patients spend around 4% of income before coverage.*
4	*Clinical trials access*	*2*	*Hosts the Atlantic Clinical Cancer Research Unit (Nova Scotia Health), reported with 45–55 trials in start-up and 20–25 active; COMPASS expanded a site to Halifax. Regional pancreatic trial access remains "extremely limited."*
5	*Timely care: waits and surgical capacity*	*2*	*Pancreatic surgery is centralized in-province at a single centre (Halifax). Median wait from GP referral to treatment: 39.1 weeks (Fraser Institute, 2024).*

6	*Travel and transport support*	*2*	*The Boarding, Transportation and Ostomy Program funds travel over 50 km one-way but is income-tested at a $35,000 gross family income threshold, documented as excluding many rural residents. The Lodge That Gives rated 5 of 5.*
7	*Workforce, navigation and support*	*3*	*The Cancer Patient Navigation Program (province-wide, oncology-certified navigators, since the early 2000s) is an Atlantic strength. The Nursing Strategy is "Adequate" for supply but has no oncology specialization track.*
8	*Research funding and representation*	*3*	*All six Atlantic CIHR pancreatic grants are NS-hosted, totalling $273,000 (Dalhousie ×5; Nova Scotia Health Authority ×1). A Dalhousie member chairs the 3CTN Management and Executive Committee.*

Nova Scotia is the region's research and treatment hub. Its higher grade reflects that concentration, not a pancreatic program, which it does not have.

New Brunswick: Overall C (mean 1.6, 8 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*The New Brunswick Cancer Network coordinates services under the Department of Health; the 2024–25 budget includes $2.9 million for screening and oncology drug funding. No pancreatic-specific program.*
2	*Biomarker and genetic testing*	*2*	*Horizon Health's Molecular Oncology Pan Cancer Solid Tumor Panel explicitly lists pancreas and is available in-province (January 2025). Germline referrals go to the IWK or in-province clinics. No comprehensive funded program.*
3	*Drug coverage and patient costs*	*1*	*Scored on the Atlantic regional PMPRB figure (Section 4). No NB-specific figure was obtainable.*
4	*Clinical trials access*	*2*	*Horizon has implemented decentralized trials with a digital platform, and NB collaborates formally with Nova Scotia for specialized services and shared trials. Regional pancreatic access remains "extremely limited."*

5	*Timely care: waits and surgical capacity*	*1*	*No in-province pancreatic surgery in the research period (centralized in Halifax and St. John's; see Section 2.5). Systemic and radiation therapy are delivered in Saint John and Moncton. No NB wait figure was obtainable; the research states only that NB "also has very long wait times."*
6	*Travel and transport support*	*2*	*New Brunswick Medical Transportation covers out-of-province care and is rated "Moderate": "limited coverage scope, basic travel assistance only." Lodging is available at Mgr. Henri-Cormier, Moncton.*
7	*Workforce, navigation and support*	*2*	*The Health Human Resource Plan is "Partially adequate: broad scope," with weak cancer and diagnostic focus and weak retention. Navigation is characterized as robust, and Horizon reached 12 Indigenous Patient Navigators in 2025.*
8	*Research funding and representation*	*1*	*No CIHR pancreatic grant hosted in NB (0 of 88). NB participates in the Atlantic Cancer Consortium.*

Prince Edward Island: Overall D (mean 1.1, 7 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*The PEI Cancer Action Plan 2023–2028 (launched February 28, 2023) sets five priorities and four enablers, with about $2 million identified across screening, referrals and consortium integration. No PEI-specific pancreatic programs.*
2	*Biomarker and genetic testing*	*0*	*No in-province testing pathway. Access runs solely under the out-of-province access policy, with germline testing via the Maritime Medical Genetics Service in Halifax.*
3	*Drug coverage and patient costs*	*1*	*Scored on the Atlantic regional PMPRB figure (PEI and NL combined; Section 4). The implementation research flags take-home drug coverage disparities: patients "don't have full coverage for all types of medication."*
4	*Clinical trials access*	*1*	*No local trial infrastructure documented. Access is by cross-provincial referral, recorded as functional, with navigation support via Health PEI.*

5	*Timely care: waits and surgical capacity*	*1*	*No in-province pancreatic surgery in the research period; Whipple-eligible cases are typically performed in Halifax, while systemic therapy is delivered in Charlottetown and Summerside. PEI also carries the longest documented wait: 77.4 weeks, median GP referral to treatment, all specialties (Fraser Institute, 2024). The score rests on surgical location under this category's declared simplification (Section 6).*
6	*Travel and transport support*	*2*	*The Maritime Bus Subsidy (income-based, 100% or 50%) and the Hope Air partnership were each rated 4 of 5, and a hotel subsidy exists. Constraints include approval 10 days before travel and a single carrier's schedules.*
7	*Workforce, navigation and support*	*Not assessable*	*Not obtainable: PEI-specific workforce and navigation policy is not covered; PEI appears only inside regional workforce analyses.*
8	*Research funding and representation*	*1*	*No CIHR pancreatic grant hosted in PEI (0 of 88). PEI participates in the Atlantic Cancer Consortium, whose patient advisory committee holds equal representation from all four provinces.*

Ontario: Overall A (mean 3.6, 7 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*3*	*Cancer Plan 6 (2024–2028) sets five goals (equity; patient experience; system integration; workforce sustainability; research, innovation and data) through 14 Regional Cancer Programs, and references rare and complex cancers with referral pathways. No targeted pancreatic initiatives.*
2	*Biomarker and genetic testing*	*4*	*The Comprehensive Cancer Biomarker Testing Program provides standardized province-wide public (OHIP) funding and coordination (BRCA1/2, MSI/ dMMR, NTRK and other pancreatic-relevant markers). It rolled out from June 2021 and was implemented province-wide by 2021/22; January 1, 2024 is the effective date for its currently listed indications (Section 2.2). It is the benchmark program in this report.*

3	*Drug coverage and patient costs*	*4*	*All three protective mechanisms in the research: Trillium (since 1995) caps out-of-pocket costs relative to income; the Exceptional Access Program (since 2016) decides in three days to six weeks with backdating; the New Drug Funding Program leaves patients at $0 for covered in-hospital IV drugs. Ontario's own private-pay share is not in the research; the score rests on program architecture.*
4	*Clinical trials access*	*4*	*The national concentration point: Princess Margaret reports 21% enrolment against about 7% nationally, and the Toronto-based COMPASS pancreatic sequencing program operates from Ontario (with one Halifax site). Also a CRAFT pilot province.*
5	*Timely care: waits and surgical capacity*	*3*	*Care is delivered within a multi-centre tertiary and regional system (14 Regional Cancer Programs). No Ontario wait figure, overall or pancreatic-specific, was obtainable.*
6	*Travel and transport support*	*Not assessable*	*Not obtainable: no Ontario provincial travel-support program is documented in the research.*

7	Workforce, navigation and support	3	Workforce Sustainability is a named Plan 6 goal, and the "Your Symptoms Matter" patient- reported outcomes program has run province-wide since 2017. No Ontario workforce adequacy rating was obtainable.
8	Research funding and representation	4	Ontario institutions dominate the register: the University of Toronto (40 records) and University Health Network (30) lead the 270-record CIHR register, and its largest pancreatic-related grant ($2,778,938, Sinai Health) is Ontario-hosted. The representation research measures Atlantic representation only; the score rests on hosted funding and infrastructure.

Ontario's A comes from the aggregation rule, not from any single category: it scores 3 or 4 on every assessable category, and its one unassessed category is excluded rather than zeroed. It is the strongest system in Canada on this evidence, and it still has no dedicated pancreatic program.

British Columbia: Overall B (mean 2.5, 6 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*The 10-Year Cancer Action Plan (2023–2033) carries an initial $440 million investment (2023) through six regional cancer centres, with reported first-year hiring of over 70 oncologists and 30 radiation therapists. No pancreatic-specific provisions documented.*
2	*Biomarker and genetic testing*	*3*	*The Cancer Genetics & Genomics Laboratory holds a provincial mandate for molecular diagnostics for all BC cancer patients, recorded "In effect." No Ontario-type standardized funding-and-coordination program is described.*
3	*Drug coverage and patient costs*	*Not assessable*	*Not obtainable: BC's drug coverage architecture and patient costs are not covered in the research. (The relief fund below is scored under Category 6.)*
4	*Clinical trials access*	*2*	*A CRAFT pilot province, listed among provinces with trial sites. No BC enrolment rate or pancreatic-specific trial program is documented.*

5	Timely care: waits and surgical capacity	Not assessable	Not obtainable: the research does not state where pancreatic surgery for BC patients is delivered and has no BC wait figure.
6	Travel and transport support	1	The only documented support is charitable: the BC Cancer Foundation's donor-funded Patient Relief Fund (established about 2019). No BC provincial travel program is documented.
7	Workforce, navigation and support	3	A province-wide integrated outcomes platform (OaSIS/ COSI). The plan's first year filled over 325 FTE positions, including oncologists and radiation therapists, and established eight Indigenous patient navigator positions. No retention mechanisms documented.
8	Research funding and representation	4	UBC holds the largest institutional share of the CIHR register (46 of 270 records), and BC hosts a major pancreatic-flagged grant at Simon Fraser University ($994,500). The representation research measures Atlantic representation only; the score rests on hosted funding and infrastructure.

Jurisdictions not graded

The seven jurisdictions below did not reach the five-of-eight evidence threshold (Section 1). Their assessed categories are shown, and the mean given in each heading is the mean

of those assessed categories only. All other categories are "Not assessable" because the research held no usable evidence for them.

Quebec: Insufficient data, not graded (mean 2.3, 4 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*The **Plan d'action en cancérologie 2024–2026** sets eight strategic axes with orientations to 2030 and published screening targets. No pancreatic-specific provisions documented.*
2	*Biomarker and genetic testing*	*2*	*An INESSS/RQDM process exists to add genomic tests to the Répertoire, and the RQDM supports NGS repatriation ("Ongoing"). No comprehensive funded province-wide program documented.*
4	*Clinical trials access*	*3*	*Montreal is recorded at 34% of trial activity in the research's concentration figures, and Quebec is listed among provinces with trial sites. No Quebec enrolment rate is documented.*
8	*Research funding and representation*	*2*	*McGill accounts for 21 of the 270 records in the CIHR register, one of four concentration institutions. Institution-level counts within the 88 pancreatic-flagged records are not published beyond the largest grants; the score rests on register presence.*

***Not assessable:** Categories 3, 5, 6 and 7 (not covered in the research). For Category 3, Quebec's drug-review structure sits outside pCODR, and this separate system is noted as limiting pan-Canadian coherence.*

Alberta: Insufficient data, not graded (mean 2.7, 3 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*The Cancer Strategic Clinical Network Plan 2024–2027 and **Changing Our Future: Alberta's Cancer Plan to 2030** set three strategic directions through CancerControl Alberta. No pancreatic-specific provisions documented.*
2	*Biomarker and genetic testing*	*3*	*Alberta Precision Laboratories' Cancer Genomics Program provides NGS testing covering BRCA, MSI and other pancreatic-relevant markers ("Operational").*
3	*Drug coverage and patient costs*	*3*	*The research's measured low private-pay share: 12% of take-home oncology spending privately paid, versus up to 59% in the Atlantic groupings, which implies 88% public funding (PMPRB, 2021; 2019 data). Exceptional-access timelines are not documented.*

Not assessable: *Categories 4, 5, 6, 7 and 8. Alberta is listed among provinces with trial sites, but no enrolment rate, site detail or pancreatic-trial evidence is in the research. Alberta's institution-level register presence is not published; the Tomorrow Project (a cohort of about 55,000, since 2000) is research infrastructure, not pancreatic research funding.*

Manitoba: Insufficient data, not graded (mean 2.3, 3 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*CancerCare Manitoba's Strategic Framework 2024–2029 governs care from Winnipeg plus 11 regional oncology clinics; it "does not explicitly highlight pancreatic cancer."*
2	*Biomarker and genetic testing*	*3*	*The Molecular Diagnostics Expansion is recorded "In effect" (November 2024). Its marker-level scope is not detailed in the research.*
7	*Workforce, navigation and support*	*2*	*The Aboriginal Cancer Care Program provides Indigenous Patient Navigators with traditional-healing integration, and the Community Oncology Program of shared-care clinics is rated "High" as a decentralized care model. No Manitoba workforce-policy adequacy rating exists in the research.*

Not assessable: *Categories 3, 4, 5, 6 and 8. Coordinated travel support for northern and remote communities is documented as existing, but its terms (funding, lodging, prepayment, eligibility) are not in the research, so no band can be placed honestly. The Community Oncology Program concerns treatment delivery, not trials. Manitoba's register presence cannot be determined from the published counts.*

Saskatchewan: Insufficient data, not graded (mean 2.3, 3 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*2*	*The Saskatchewan Cancer Agency Strategic Plan 2024–2028 is in operation, with population screening including mobile units and telehealth links. "Pancreatic cancer is not highlighted as a distinct focus."*
2	*Biomarker and genetic testing*	*2*	*A funding approval framework for molecular biomarker testing is "Established" (July 2024). No operating program is documented.*
8	*Research funding and representation*	*3*	*One major pancreatic-flagged grant: the University of Saskatchewan's MUC-16 radioimmunoconjugate program (ovarian and pancreatic), $979,200.*

Not assessable: *Categories 3, 4, 5, 6 and 7 (not covered in the research beyond telehealth links for supportive care).*

Yukon: Insufficient data, not graded (mean 0.0, 1 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*0*	*"No standalone territorial cancer strategy equivalent to provincial cancer agencies"; care runs by referral to BC and Ontario.*

Not assessable: *Categories 2 through 8. The biomarker database has no entries for Yukon, and register counts are published only for the concentration institutions and Atlantic provinces.*

Northwest Territories: Insufficient data, not graded (mean 1.0, 1 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*1*	*Territorial screening, referral and community-based supports, with reliance on southern tertiary centres: services in operation without a consolidated strategy or agency-equivalent structure.*

Not assessable: *Categories 2 through 8. The biomarker database has no entries for the Northwest Territories, and register counts are published only for the concentration institutions and Atlantic provinces.*

Nunavut: Insufficient data, not graded (mean 1.0, 2 of 8 categories)

#	Category	Score	Reason
1	*Strategy and pancreatic focus*	*0*	*"No standalone cancer agency"; care runs by referral pathways to southern tertiary centres.*
6	*Travel and transport support*	*2*	*Patient travel support programs "are significant line items," a funded territorial program of significant budget scale. Its terms (lodging, prepayment, eligibility) are not in the research.*

Not assessable: *Categories 2, 3, 4, 5, 7 and 8. The biomarker database has no entries for Nunavut.*

The territories are published as "Insufficient data, not graded" because the research itself was thin there: strategy posture only, with no biomarker records. That is a finding about the evidence base, and it reflects the reality the grades describe: territorial patients are served entirely through referral to provincial systems.

4. Atlantic Canada: regional findings

Research funding

Of the 88 pancreatic cancer grants in the CIHR register compiled for this research, totalling $23,354,337, six went to Atlantic institutions, totalling $273,000, or about 1.2% of the funding. All six were in Nova Scotia: five at Dalhousie University (including a $98,000 NK-cell precision immunotherapy project, a $105,000 doctoral award in pancreatic neuroendocrine tumour immunotherapy, and three

17,500 awards) and one at the Nova Scotia Health Authority (***17,500, on quality of*** *care for pancreatic cancer patients in Nova Scotia). Newfoundland and Labrador, New Brunswick and PEI hosted none.*

The Atlantic Cancer Consortium

The region's flagship research collaboration is the Atlantic Cancer Consortium, a four-province consortium operating within the Marathon of Hope Cancer Centres Network. Its funding is a single two-year pilot budget of $3.6 million (launched January 2021), which includes the Terry Fox Research Institute's $1.5 million contribution; partners provided the approximately $2.1 million balance in matching cash and in-kind support. The consortium's demonstration projects target lung and colorectal cancer, and the research found that it does not currently address pancreatic cancer-specific programs in a coordinated manner. The collaboration infrastructure itself, including its Patient Advisory Committee, was assessed as proven and extensible to pancreatic cancer.

Representation in national bodies

Atlantic Canada's presence in national decision-making is mixed, and in places stronger than the research first recorded.

- **Canadian Cancer Clinical Trials Network (3CTN).** *The Management and Executive Committee is chaired by Dr. Ravi Ramjeesingh of Dalhousie University and includes Dr. John Thoms of Newfoundland and Labrador. The only 3CTN*

leadership roles with no Atlantic representation are the Scientific Director and Executive Director positions.

- **Canadian Partnership Against Cancer.** *The board, as listed in October 2026, comprises 17 directors and two designated non-voting observers.*
- **National Advisory Committee on Immunization (NACI).** *Three of its 16 voting members are Atlantic-based: Dr. Melissa Andrew (Dalhousie University, Halifax) and Dr. Tasha Ramsey (Nova Scotia Health, Halifax) for Nova Scotia, and Miranda O'Driscoll (Newfoundland and Labrador Department of Health and Community Services, St. John's) for Newfoundland and Labrador. New Brunswick and PEI have none (Public Health Agency of Canada roster checked October 23, 2026).*
- **Atlantic Cancer Consortium Patient Advisory Committee.** *The strongest Atlantic presence the research found: approximately four of 12 public members, drawn equally from all four provinces.*
- **National initiatives overall.** *Across 29 national initiatives assessed against the region's 6.8% population share, 15 sit above parity, 4 near parity and 10 are under-represented. The median number of Atlantic seats per initiative is one.*

The gap the research rated most significant is not a seat count but transparency. The membership of the pCODR Expert Review Committee at Canada's Drug Agency, which recommends which cancer drugs public plans should fund, is not publicly disclosed, so Atlantic representation on the body that recommends cancer drug funding cannot be assessed at all.

The cost of take-home drugs

A 2021 PMPRB report 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. The PMPRB figure covers 47 selected take-home oncology medicines (oral and subcutaneous), and "private plans and cash" combines private insurance with cash payments; it is not an out-of-pocket percentage. A separate source estimated average take-home cancer drug costs at $6,000 per month (CanCertainty Coalition, as cited in MacPhail & Snow, 2022). That estimate is drawn from a budget proposal and is not a measured average of what patients paid.

Because the PMPRB publishes the Atlantic figures only as regional groupings (New Brunswick; Nova Scotia; PEI and Newfoundland and Labrador combined), no province-level cost figure exists for any Atlantic province, and this report does not invent one. The four Atlantic Category 3 grades rest on the regional figure, as stated in each profile.

Travel and the rural burden

Atlantic Canada is Canada's most aged region, and much of its population is rural. The research records rural broadband access at 37%, against 84% urban; more than 600 rural emergency department closures nationally in 2022–2023; and 62 First Nations communities across the four provinces.

During the research period, pancreatic surgery was available in two cities (a later change is noted in Section 2.5) and specialized diagnostics were limited outside them, so travel is not an add-on to treatment: it is a stage of it. Patients routinely receive services in a province different from their residence. The friction documented across the programs in Section 2.6 is consistent: reimbursement rather than prepayment; income thresholds that exclude many rural residents; referral conditions; and ferry schedules that conflict with treatment appointments.

5. Recommendations from the research team

The recommendations below are the research team's own, drawn from their research documents. They are not findings of this report and not institutional positions.

- **Biomarker testing.** *Set a turnaround-time target of 10 working days or fewer for biomarker results, and build an Atlantic coverage baseline using Quebec's INESSS/RQDM processes as a template.*
- **Drug coverage.** *Adopt take-home cancer drug coverage standards that close the gap with Alberta-level public funding (88%), treating take-home drug coverage and the fragmentation of provincial laboratory formulary systems as critical priorities.*
- **Federal transfers.** *Move the Canada Health Transfer toward age-adjusted allocation, which the reform strategy projected could yield more than $200*

million annually in additional funding for Atlantic health services. This is a projection, not an observed figure.

- **Travel support.** *Raise Nova Scotia's travel-assistance income threshold from $35,000 to $50,000 in gross family income, and 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.*
- **Collaboration.** *Extend tri-provincial collaboration models to include Newfoundland and Labrador, particularly for high-burden, low-survival cancers. Integrate the Atlantic Clinical Trials Network with the consortium's patient advisory structures, which the researchers ranked the most impactful collaboration gap. Present the Atlantic Cancer Consortium and ACCESS Atlantic as national exemplars of regional collaboration.*
- **Workforce.** *Add oncology- and diagnostic-specific workforce targets to national and provincial policies, and build retention mechanisms that go beyond initial bonuses and debt forgiveness.*
- **Indigenous cancer care.** *Place Indigenous patient navigators in each province within 18 months; mandate explicit cultural-safety standards consistently; and move Indigenous self-determination in cancer planning from partial support toward codified decision rights.*
- **Transparency.** *Publish the membership composition of the pCODR Expert Review Committee, the gap the research rated most significant (Section 4).*

6. Data gaps and limitations

This report publishes what the research could support and states plainly what it could not.

Figures that could not be verified, and were not published

- *A claim in the research that Ontario's biomarker program was "operational since July 2025" could not be verified from any primary source and is not published. The verified record is the 2021 rollout described in Section 2.2.*

- *A claim that an Atlantic trials unit had "capacity spanning 30 to 50 clinical trials" could not be verified for any body and is dropped. The trial counts reported in Section 2.4 belong to the Atlantic Clinical Cancer Research Unit (Nova Scotia Health).*
- *Nova Scotia's wait time appears in the underlying research as 56.7 weeks. That was Nova Scotia's figure in the 2023 edition of **Waiting Your Turn**; the 2024 figure, 39.1 weeks, is the one published here.*
- *One representation analysis stated in its narrative that 22 of 29 national initiatives were under-represented, a claim irreconcilable with its own data table. This report publishes the table only: 15 above parity, 4 near parity, 10 under-represented.*

Coverage gaps in the research

- *The territories have strategy posture only. The biomarker database has no entries for Yukon, the Northwest Territories or Nunavut, and the narrative strategy synthesis covers the 10 provinces only.*
- *Numeric wait times exist only for PEI and Nova Scotia, from a single source, and measure all specialties. Pancreatic-specific wait times are not quantified anywhere in the research.*
- *Drug coverage detail is deep only for Ontario's programs. Atlantic drug costs rest on one regional figure from 2019 spending data, the most current the PMPRB publishes in that form, but dated.*
- *PEI's workforce policy is not covered at the province level. Workforce evidence generally is policy-level, not headcounts.*
- *The CIHR register ends with November 2024 competitions, so the funding picture is the most dated element of the report.*
- *One working draft in the research was undated and partly incomplete (its New Brunswick section was empty) and was treated as draft material throughout.*

Judgment calls disclosed by the scoring pass

- **Category 5 (timely care).** *The rubric's declared simplification, in which surgical location is the primary anchor, was applied to PEI. PEI's wait of 77.4 weeks, the*

longest in Canada, is stated in its profile, but PEI scores 1, not 2, because it has no in-province pancreatic surgery.

- **Category 4 (trials).** *Band 3's test, "multiple active trial sites," cannot be enumerated from the research for any province. Quebec's score of 3 rests on hub and concentration evidence (Montreal at 34% of recorded trial activity). Nova Scotia was held at 2, despite hosting the Atlantic research unit and the COMPASS Halifax site, because the research's own verdict is that pancreatic trial access in Atlantic Canada is "extremely limited."*
- **Category 6 (travel).** *Programs mentioned in the research without documented terms were not treated uniformly, because the evidence differed. Manitoba's bare mention of coordinated travel support was marked not assessable, while Nunavut's travel programs, documented as significant budget line items, scored 2.*

Standing limitations

Further limits apply. Figures that appeared only in the program's briefing materials were illustrative examples rather than findings, and were excluded from the evidence base. The representation research measures Atlantic representation only, which is why Category 8 rests on different evidence for Atlantic and non-Atlantic jurisdictions. The report records conditions during the 2025 research period and is not a live measure of current conditions.

Authors and acknowledgements

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The grades and the scoring layer were applied for this report to the research team's inventories. Responsibility for the published findings rests with The Heather Cutler Foundation. Listing a researcher here does not imply individual endorsement of the grades or recommendations.

References

The report's evidence base is the Pancreatic Cancer Policy Builders of Tomorrow research inventories (2025): the provincial cancer strategy database; the biomarker policy database; the provincial implementation, infrastructure and transport matrices; the workforce, rural-access and Indigenous cancer care assessments; the national representation database and analyses; and the CIHR funding register compiled by the researchers. References are grouped by the part of the evidence base they support and listed alphabetically within each group. Entries marked n.d. have no stated publication date.

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