2008 REPORT CARD ON CANCER IN CANADA

MEDIA BRIEFING

February 10, 2009
Welcome
Dr. Jim Gowing, Chair, CACC

Are you ready?
Canadians take comfort in the belief that our public healthcare system will be there in our time of need, but...long before the current economic woes, governments began to retreat from payment of cancer drugs. More and more of us have to rely on private insurance plans to cover the cost of expensive, potentially life-saving treatments. The trend has taken hold of half the country and will increase, as newer drugs come in oral form and appear on the market in waves. While a pill is more convenient for the patient than infusion at a clinic, the cost for those “take at home” treatments are increasingly borne by private insurers or, in the absence of insurance, at great expense to the patient.

Can employers and citizens absorb the offloading by our governments? The answer is, it depends. Your eligibility for private insurance, the type of plan you have and how your insurer feels about paying for clinical infusions will directly impact your finances after a cancer diagnosis.

Canadians might wonder if this is fair. Where did medicare go? The rules are set out in the Canada Health Act, but lacking a definition of “medically necessary”, the provinces seem free to offload “out-patient” drug costs as they choose.

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The Cancer Advocacy Coalition of Canada is a full-time registered, non-profit cancer group dedicated exclusively to advocacy. The CACC is not a charity and operates on unrestricted grants from sponsors based on guidelines that ensure the organization’s autonomy. The CACC publishes Canada’s only independent evaluation of cancer system performance, the annual Report Card on Cancer in Canada. The Board of Directors is comprised of unpaid volunteer oncologists, health sector executives and patient advocates from across the country.
HPV Vaccination Programs in Canada
Are We Hitting the Mark?

Rosemary Colucci, Health Advocacy Consultant
Dr. William Hryniuk, Medical Oncologist & Past-Chair, CACC
Colleen Savage, President, CACC
Background

- The Human Papillomavirus (HPV) transmitted through sexual activity found to cause cervical cancer, some other rare cancers and genital warts
- HPV vaccine is potentially a major advance in cancer control
- Discovery that the human papillomavirus virus caused cancer led to the award of the Nobel prize
- Approximately 1400 cases per year and 400 deaths
Background

- In 2007, the Federal government allocated $300 million to provinces and territories for a national vaccination program against HPV to reduce the risk of cervical cancer.
- The 2007 National Advisory Committee on Immunization (NACI) recommends vaccine for females aged 9-26 years.
- Since 2007, each province and the Yukon Territory introduced a program targeting various cohorts of females between 9 and 17.
What We Did

- Compared the HPV vaccination programs between the provinces and territory for females aged 9-17
- Calculated the percentage of females aged 9-17 (in 2007) covered by each provincial program (eligibility in the program)
- Compared the eligibility with the incidence of cervical cancer in each province and territory
What We Found

- Despite the equal allocation of funding across the provinces and territories, programs vary widely.
- Quebec offers the most comprehensive vaccination program with 100% of females aged 9-17 eligible:
  - Grade 4 and 9
  - Any girl under the age of 18
- Ontario vaccination program includes grade 8 girls (i.e., 66% of females aged 9-17 eligible)
- No relationship found between the program being offered and the estimated incidence of cervical cancer.
## Eligibility, Incidence of Cervical Cancer and Actual Rate of Vaccination

<table>
<thead>
<tr>
<th>Region</th>
<th>% Females 9-17 Eligible*</th>
<th>Estimated annual incidence of cervical cancer/100,000**</th>
<th>Actual Rate of Vaccination (%)</th>
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<td>84-Gr4, 87-Gr9</td>
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<td>66</td>
<td>7</td>
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<tr>
<td>MB</td>
<td>32</td>
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</tbody>
</table>

*Based on 2006 Statistics Canada Data, **Canadian Cancer Society, Canadian Cancer Stats, 2008
What We Found (cont.)

- More research needed:
  - Males are being vaccinated in other countries
  - Other HPV-related diseases
  - Cost-effectiveness
    - Preliminary literature review indicates that the vaccine is cost-effective
What It Means

- Equal funding across the provinces and territories resulted in different program

- Differences among the provinces may eventually result in differences in effective control of cervical cancer and other HPV-related diseases, notwithstanding consistent federal funding to all provinces

  - Will not be well-known for several years

- CACC supports CPAC leadership in bringing together all stakeholders to help improve cervical cancer control

  - Implementation Steering Committee to identify key priorities and integrate vaccination + screening efforts
The Use of Electronic Health Records in the Provision of Cancer Services: a Sample of Community Clinics Across Canada

Dr. William Hryniuk, Medical Oncologist & Past-Chair, CACC
Dr. Norm Archer, Professor Emeritus, DeGroote School of Business, McMaster University
Dr. David Saltman, Chair & Professor Oncology, Memorial University of Newfoundland, Faculty of Medicine
Rosemary Colucci, Health Advocacy Consultant
Daniel Gillespie, Research Assistant, CACC
Introduction

- Properly configured and integrated Electronic Health Records (EHRs) can facilitate safe, effective and economic cancer treatment and care.
- Clinics in smaller communities should have linkages through EHRs to their tertiary (regional) Cancer Centers to ensure patients get the same level of treatment and care as those living in larger centers.
Essential Features of the EHR at the Community Level

EHRs should be:

- Emanating and supported from the regional center
- Internet-based
- Secure
- Accessible to key community clinic personnel
- Interactive (allow data entry from community clinic personnel)
- Containing 9 essential elements
Nine Essential Elements of the EHR

- General medical information (doctor’s notes)
- Reports
- Pathology
  - Lab and X-ray
- Treatments received
- Treatment protocols
- Direct order entry or pre-printed orders
- Checkpoints to ensure chemotherapy orders are appropriate
- Nursing notes
- All medications taken
What We Did

- We surveyed 11 smaller communities ranging in size from 8,300 to 71,000 and covering 220,000 people in eight provinces to:
  - Assess their capabilities for delivering cancer treatment
  - Determine if they had EHRs linking them to their regional cancer center
- We also studied barriers to introduction of EHRs
What We Found

Capabilities of Community Clinics

- The 11 sampled community clinics almost all had extensive capabilities for delivering cancer treatment and care (except for radiation therapy).

- There was no relationship between size of the community and capability for delivering cancer care and treatment.
What We Found

EHR Linkages to the Regional Cancer Center

- Of the 11 sampled communities:
  - 4 had no linkage
  - 4 had a suboptimal linkage (did not allow data entry from the community and did not allow access to the EHR for other caregivers)
  - 3 had adequately configured linkage and even then access could be limited only to doctors in the clinic
- Of the 8 provinces, in only 3 was the EHR linkage adequately configured
What We Found (cont.)

- No EHR at the community level covered all 9 essential elements
- Two covered 7 elements
- The rest of covered 5 or fewer elements
Lack of linkage and comprehensiveness raises the possibility of:

- Reduced adherence to guideline-based treatment
- Greater potential for chemotherapy errors
- Reduced efficiencies (increased test duplication)
- Lack of ability to detect drug-drug interactions
- Increased waiting for results of tests and notes
- Less effective emergency care
What We Also Found

Barriers to Introduction of Oncology EHRs:

- Parochialism
- “Lack of Funding”
- Privacy and Security Regulations
- Concerns regarding “integrity” of the system
- Resistance to change of health professionals
- Incompatibility of different systems
- Lack of a national strategy to develop an integrated EHR in oncology
What It Means (cont.)

We concluded there was a need for:

- Community caregivers (clinic personnel, surgeons, ER physicians, family doctors, etc) to be given access to EHRs already in existence

- A national strategy to:
  - Develop standard specs for an oncology EHR
  - Increase EHRs linkages of community clinics to their regional centers
  - Use of SNOMED CT to accommodate differences in terminology

- Development of this strategy to be facilitated by the Canadian Partnership Against Cancer (CPAC) in collaboration with Canada Health Infoway

- Need for EHRs to be oncology-specific as the first step
We were concerned that, given the barriers previously enumerated, an oncology EHR might not be developed and linked to most Canadian community cancer clinics in our lifetime.

We therefore suggest that to break the logjam created by the barriers, patients should be given continuing access to their own EHR in conjunction with access to information enabling them to make best use of it.
What It Means (cont.)

- Patients could then, in the comfort of their own homes:
  - Understand the implications of their disease and its management
  - Become more aware of delays in referrals and tests
  - Look up the implications of these delays
  - Be better prepared to become active participants in their own care during visits to their oncologists
What It Means (cont.)

- This could break down existing silos in cancer management and lead to:
  - Higher quality of treatment and care
  - Reduced distress due to lack of information
  - Reduced waiting times
  - Improved safety
  - Reduced repetitions of tests and x-rays
  - Reduced cost of systems protecting confidentiality of paper records
If patients can access their financial records anywhere in the world, why not their electronic health record?
The Cost of Cancer Drugs in Canada
Part 2: Who is Bearing the Cost?

Dr. Kong Khoo, Medical Oncologist & Vice-Chair, CACC
Rosemary Colucci, Health Advocacy Consultant
Dr. William Hryniuk, Medical Oncologist & Past-Chair, CACC
Robert Kamino, Vice President, Consulting Services, Brogan Inc.
Tania Redina, Economist, Brogan Inc.
Colleen Savage, President & CEO, CACC
Background

- Variable access to new cancer drugs depending on where you live
- Increased reliance on private insurance to obtain cancer drugs, particularly in the Eastern provinces
- More comprehensive study to look at Take Home Cancer Drugs (THCD) by province from 2002 to 2007
What We Did

- Brogan Inc. database for public (Pharmacare) and private insurance plans identified 43 THCD
  - Excludes analysis of out-of-pocket costs and intravenous drugs
- Merged with provincial data from BC, AB, SK and NL
- Analysis for:
  - Costs per incident cancer case by province
  - Rate of increase over the last 5 years by province
  - Total amount spent for THCD
  - Estimate of total amount spent in Canada for 2007
Western Provinces

Public versus private pay per incident cancer case 2002-2007

BC

AB

SK

MB

Cancer Advocacy Coalition
Grassroots Action for Cancer Care
Public versus private pay per incident cancer case 2002-2007

ON

QC
Atlantic Provinces

Public versus private pay per incident cancer case 2002-2007

NB

NS

PE

Public data N/A for PEI

NL

Public data N/A for PEI

Private Insurance in 2007 for take home cancer drugs in Canadian provinces, expressed per incident cancer case in 2007
Public pay for take home cancer drugs in Canadian provinces, % increase 2002 to 2007 per incident cancer case

Private insurance for take home cancer drugs in Canadian provinces, % increase 2002 to 2007 per incident cancer case

Public data not available for PEI
Top 10 THCD for 2007

Total Spend: $555 M

($ in Millions, % of total)
What We Found

- THCD represent a major improvement in cancer care
  - Home vs. hospital; more effective cancer treatments; more convenient
- There is a seismic shift from intravenous drugs to THCD
  - Represent 50% of the costs ($555 million)
  - Increased reliance on private insurance
- An uncoordinated shift from public funding to private insurers
What It Means

- National Forum of all key stakeholders to address the challenges emerging from the transition of hospital-based to take home drugs
  - With focus on Atlantic Canada where access is the lowest and cancer mortality the highest
- Systematic education program for employers to increase awareness of the size of the cost burden for cancer drugs, which they will be expected to carry
A Primer on Private Health Plans

Chris Bonnett, President, H3 Consulting/businesshealth
What We Found

- Private drug plan costs account for about $9 billion, or 36% of Canada’s total expenditures on prescription drugs and cover over 20 million Canadians – employees and their families.

- Largest cost borne voluntarily by employers, some unions. In last 20 years, drug plan costs have escalated at 4X the CPI.

- Plans differ in design (region, industry, employer size, insurer) e.g., more limited coverage in Atlantic Provinces.

- Most plans are cost-shared with patients, commonly at 20%.

- Few plans outside Quebec have caps on out-of-pocket costs.

- Employer plans terminate with job loss, bankruptcy, and most often, retirement. Though 55% of cancers are diagnosed > age 65, just 20% continue their employer-sponsored drug plan post-retirement.
What We Found

  - Outside Quebec, there is still no national approach to protecting individuals from catastrophic drug costs
  - Given the shared funding model, an integrated public-private approach to managing drug claims is needed
- Quebec has had a universal, public-private drug regime since 1997
  - Insurers support a high-cost (catastrophic) drug claim pool that spreads risk across all players
What It Means

- Adequate access and financial protection depends on where you live, whether you work, and if you have private health insurance.
- Cancer patients are among the most exposed to the large and growing gaps in drug insurance coverage.
- A national risk pool is needed to protect employers and patients from rapidly rising drug costs; this is especially important for cancer drugs.
CACC’s Conclusion

- A National Forum needs to be convened to sustain access, resolve tensions, and fund cancer drugs.
- The Forum will include governments, insurers, employers, patient groups, and researchers.
- This time the result should be the introduction of integrated and universal, public-private drug insurance.
Questions & Answers