

CANCER ADVOCACY COALITION OF CANADA RELEASES ANNUAL REPORT CARD ON CANCER IN CANADA™

LEADING SCIENCE, LAGGING SYSTEMS

Among challenges facing cancer system: 1) restrictive HPV vaccine programs among provinces with highest rates of cervical cancer; 2) little use of electronic health records in remote communities that need them most; time to give cancer patients full access to their own electronic health records 3) an alarming shift in drug funding from public to private payers 4) catastrophic drug costs endured by cancer patients

Toronto, ON - February 10, 2009 – Many Canadians living with cancer have yet to benefit from important advances in drug development, information technology and innovative insurance models, according to the Cancer Advocacy Coalition of Canada (CACC). The group today released its annual *Report Card on Cancer in Canada*, the country's only independent evaluation of the cancer system performance.

This year's Report Card highlights several unsettling themes: under-use of electronic health records linking distant communities to their regional cancer centres, potentially robbing patients of opportunities for better health outcomes; a disturbingly lower rate of the HPV vaccine program among several provinces with the highest incidence of cervical cancer; the rapid shift in drug funding from public to private payers; and catastrophic drug costs for cancer patients.

"We have leading science and lagging systems. For example, if patients can access their financial records from anywhere in the world, why not their health records?" says Dr. William Hryniuk, medical oncologist and past-chair, CACC. "If they could, their disease management would greatly improve and many system changes would quickly follow."

REPORT CARD HIGHLIGHTS

1) HPV VACCINATION PROGRAMS IN CANADA: ARE WE HITTING THE MARK?

CACC study reveals many of the most restrictive HPV vaccination programs are in provinces with the highest rates of cervical cancer

The province of Quebec offers the most comprehensive immunization program against human papillomavirus (HPV), with 100 per cent of eligible females included, while Manitoba, Nova Scotia,

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Prince Edward Island, Saskatchewan, Yukon Territory, New Brunswick and Alberta have very restrictive programs, with less than 55 per cent of eligible females included. Ironically, Nova Scotia, PEI and Alberta have the highest rates of cervical cancer in Canada, and Quebec the lowest rate.¹

“Our research reveals that the vaccination programs bear absolutely no relationship to the risk of cervical cancer in each province,” says Rosemary Colucci, lead author of the study. “Sadly, the differences in provincial programs may eventually result in differences in effective control of cervical cancers.”

In 2007 the federal government allocated \$300 million over three years to the provinces and territories on a per capita basis to support the launch of a national vaccination program against human papillomavirus (HPV), the cause of cervical cancer. All of the provinces and the Yukon Territory responded by introducing vaccination programs targeting various cohorts of females between the ages of 9 and 17.

2) COMMUNITY ONCOLOGY AND ELECTRONIC HEALTH RECORDS: WHAT GIVES?

CACC research reveals little or no use of electronic health records in remote communities that need them the most

Cancer patients should be given immediate and continuing access to their health record to ensure optimal care, especially if they live a distance from a regional cancer centre. Yet according to a CACC survey of oncology clinics located more than two hours from a regional cancer centre, most aren't using electronic health records to record vital information.

Of 11 clinics surveyed across the country, only 7 had access to an integrated EHR system linking them to the tertiary centre; and of these seven, only three allowed clinicians to enter data.

“The net result in these cases is that tertiary centre oncologists who originally devised the treatment plans were not able to follow whether treatment was being given, or what complications were encountered,” says Dr. William Hryniuk, past chair of CACC and lead author of the study. “This raises the possibility that patients in these communities may not be getting the full benefits of care in terms of efficacy, safety, and efficiencies received by patients in direct proximity to regional cancer centres.”

Management of cancer requires, in virtually every case, multidisciplinary treatment delivered by a large number of health care personnel located in different locations, says Dr. Hryniuk.

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¹ Canadian Cancer Society, Canadian Cancer Statistics, 2008

“Use of an EHR would seem to be unique and appropriate for optimizing treatment and care. It might even be viewed as a critical component of any provincial or regional program when toxic chemotherapy prescribed by specialists at the tertiary care centre must be delivered in distant communities by non-specialists.”

Based on the survey, the potential of electronic health records to improve patient outcomes is not being realized even where systems are now in place. The CACC recommends giving patients access to their own electronic health records, as the Edmund Odette Regional Cancer Centre at the Sunnybrook Health Sciences Centre in Toronto does, to empower patients and help overcome institutional barriers to optimum use of the technology.

3) SEISMIC SHIFT IN CANCER DRUG FUNDING TO PRIVATE PAYERS

CACC study reveals steady shifting of drug costs from public to private insurers; millions of Canadians to be left without access to newest therapies and insurance coverage.

Canadians without full-time jobs or health insurance plans take note: a new study reveals that funding for oral “take at home” cancer drugs is being shifted from public to private insurers at a rapid rate, leaving employers and individuals to shoulder the increasing burden of cost. And, with the number of cancer patients expected to grow by 55 per cent by 2020, aging baby boomers and part-time workers may be most at risk of not accessing the newest therapies.

“Expenditures for oral, take-at-home therapies now represent approximately half of the total for all cancer drugs,” says Dr. Kong Khoo, a B.C. medical oncologist and lead author of the study. “Employers and insurers should be made aware of the magnitude and pace of these shifts.”

For the study, CACC researchers reviewed oral, take-at-home cancer drug expenditures in each province, for the years 2002-2007, using data from Brogan Inc. and the provinces. Cancer drugs studied included oral chemotherapy agents, hormonal therapies, tyrosine kinase inhibitors (new “targeted” therapies) and supportive medications used to treat the symptoms of cancer (antiemetics, bisphosphonates, hemotopietic stimulating factors). Key findings include the following:

- In the western provinces the proportion paid for take-at-home cancer drugs by the public system is much higher than by private insurers. This proportion decreases east of the Manitoba border and is reversed in the Maritimes
- While both public and private payer expenditures for take-at-home cancer drugs are increasing, private payer expenditures are increasing at a much faster rate across all provinces
- The shift of funding to the private sector is steadily increasing the burden on employers and individuals who are ill prepared to deal with the costs

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- A small number of newer agents (10 of 43 studied) accounts for more than 80 per cent of the total expenditure on all take-at-home drugs
- Apart from Quebec, where supplementary drug insurance is mandatory, private and public insurers in the other provinces have yet to come to grips with what is happening and coordinate their drug coverage plans

4) A PRIMER ON PRIVATE HEALTH BENEFIT PLANS

CACC study reveals need for integrated and universal public-private drug insurance to protect Canadians from catastrophic drug costs.

Private insurance plays a critically important role in assuring access to medically necessary prescription drugs. Like their government plan counterparts, employers face many cost pressures, but unlike public plans, there is no requirement to provide these benefits.

“Costs have escalated at about 400 per cent of the Consumer Price Index over the last 22 years,” says Chris Bonnett, president, H3 Consulting/businesshealth. “Particularly in this economic climate, relatively open access and willingness to continue to fund their \$9 billion stake will be sorely tested.”

Private health plans provide incredibly important peace-of-mind to over 20 million employees and their families; a recent survey reported that 61 per cent would rather have their health benefit plan than \$20,000 cash.

Largely a silent partner over the last 40 years, the scale and importance of these plans now makes them an important part of our national health policy deliberations. Oncology drugs are usually made available much sooner under private plans than government plans, and most new products are tablets, and therefore they do not have to be administered in hospital and funded by the public purse. While cancer most often occurs in older Canadians, almost 30 per cent (48,000 people) are diagnosed annually in the working age population, those 18 to 60 years old. Most private plans terminate at retirement, leaving those most at risk unprotected from significant financial cost.

Health benefit plans are funded most often by employers, but almost always, employees have a significant cost-sharing role. For smaller plans, the insurer takes the full risk, but larger employers (over 100 employees) typically self-insure their drug plans, and therefore have the final say on what and who is covered, and what coverage exclusions exist.

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The bigger issue, however, is that a reasonable 20 per cent co-pay on a \$60 average drug becomes unaffordable when the drug costs \$25,000 or more. This is a major policy void that neither the insurance industry nor our governments have yet solved, despite significant study over the last decade and a generally successful working model in Quebec. Pooling high cost drug claims, often catastrophic to patients and their families, is an idea whose time is long overdue.

ABOUT THE CACC

The Cancer Advocacy Coalition of Canada is a full-time, registered, non-profit cancer group dedicated to citizen advocacy. The CACC is not a charity and operates on un-restricted grants based on guidelines that ensure the organization's autonomy. For more information visit our website at www.canceradvocacy.ca

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The full Report Card is available on-line at www.canceradvocacy.ca
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