

# 2009-2010 REPORT CARD ON CANCER IN CANADA™

## MEDIA BRIEFING

March 24, 2010

› Cancer Advocacy Coalition

Canada

Grassroots Action for Cancer Care

# Welcome

Dr. James Gowing  
Co-Chair, CACC

# About the CACC

- The Cancer Advocacy Coalition of Canada is a registered, non-profit cancer group dedicated exclusively to advocacy and education
- CACC's Board of Directors is comprised of unpaid volunteer oncologists, health sector executives and patient advocates
- CACC operates on unrestricted grants from sponsors based on guidelines that ensure the organization's autonomy
- CACC publishes the only independent evaluation of our cancer system's performance, the annual Report Card on Cancer in Canada™

# 2009-2010 Report Card

- A decade into the 21st century, Canadians are still waiting for access to innovative cancer care
- In this year's Report Card we ask, "What are we waiting for?"



# Insurance

## Does Private Insurance Protect Canadians From the Cost of Cancer Drugs?

**Chris Bonnett, MHS**

President, H3 Consulting

Co-founder and Editor, [businesshealth.ca](http://businesshealth.ca)

# Background

- Private health insurance is a security blanket for 20 million Canadians
- Majority of plans sponsored by employers, but employees pay an important share of costs
- Private drug plan payments are nearly equal to provincial drug plans: \$9.3 and \$9.5 billion respectively
- 70% of all new cancers are diagnosed, and 82% of cancer deaths occur, after age 60 when most people are no longer covered by private health insurance
- 80% of working Canadians lose private plan coverage at retirement which is at age 62 for the average Canadian

# What We Did

- Assessed insurers' drug plan coverage for small and large businesses
  - ▣ Manulife, Alberta Blue Cross, Pacific Blue Cross, Medavie Blue Cross, Sun Life, Great-West Life, and Green Shield
- Reviewed federal and provincial government drug plans for civil servants and legislators
  - ▣ Office of the Ontario Legislative Assembly declined to provide health plan information for MPPs

# What We Found

- Lack of protection vs. catastrophic costs, especially relative to income
- Significant variations in coverage quality
  - ▣ Poor data and no minimum standards regarding formulary breadth, prior authorization, or level of reimbursement
- Tremendous disparity between employer sponsored drug plans, whether private or public, and those without private insurance
  - ▣ Legislator and civil servant health plans provide reimbursement of cancer drugs that are not available to their constituents
- Declining access to post-retirement drug benefits

# Recommendations

- Implement a national catastrophic drug plan
- Enact measures to address shortfalls in private plans, including:
  - ▣ Explicit out-of-pocket cost limits to protect against catastrophic drug bills
  - ▣ National claim pooling mechanism to absorb high-cost drug claims
  - ▣ Coordinate planning between public and private drug plans to eliminate gaps in coverage
- Improve public drug plan coverage to the level of private insurance
  - ▣ Level the playing field
- Compile comprehensive data for good decision making

# Prevention

## **The Current Status of Bans on Smoking in Vehicles Carrying Children: A Canadian Perspective**

**David Saltman, MD, PhD**

Chair and Professor of the Discipline of Oncology,  
Faculty of Medicine, Memorial University, St. John's, NL

# Background

- 25 years of research has proven secondhand smoke (SHS) poses a significant health threat
- SHS smoke is a “Group A” carcinogen: definitive cause of cancer in humans
- Estimated 1,000 Canadians die of SHS smoke per year
  - ▣ Lung and other cancers, coronary and ischemic heart disease, respiratory disease and infant deaths
- WHO leads worldwide movement to ban smoking in public places and workplaces
  - ▣ All provinces have implemented comprehensive smoke-free laws
- Educational campaigns and voluntary smoking bans are not effective on their own

# What We Found

- No level of SHS exposure has been shown to be “safe” for children or adults
- Due to small interior volume, smoking in cars delivers extremely high smoke concentration, posing a significant health hazard
  - ▣ Equivalent to 100 times U.S. EPA 24-hour fine particle exposure standard
- Canadian Cancer Society study revealed 82% of Canadians support a ban on smoking in cars carrying children
  - ▣ 69% of smokers supported a ban
- Some provinces and territories have failed to enact laws banning smoking in vehicles with children
- Vehicles are legally considered a public space

# Where Are Children Protected?

Provinces/Territories in Canada that have banned smoking in vehicles carrying children

Jurisdiction	Applicable age	Date law in force	Date law adopted
British Columbia	under 16	April 1, 2009	May 29, 2008
Ontario	under 16	Jan 21, 2009	June 18, 2008
New Brunswick	under 16	Jan 1, 2010	May 1, 2009
Nova Scotia	under 19	April 1, 2008	Dec 13, 2007
Yukon	under 18	May 15, 2008	April 22, 2008
PEI	under 19	Sept 15, 2009	May 15, 2009
Manitoba	under 16	pending	June 11, 2009

# Where Are Children Still Waiting?

## □ Provinces:

- Alberta
- Saskatchewan
- Quebec
- Newfoundland & Labrador

## □ Territories:

- Nunavut
- Northwest Territories

# What It Means

- Second-hand smoke in vehicles is harming children and adults
- Lagging provinces and territories should enact laws to protect children against smoking in vehicles carrying passengers
- Authorities should consider a comprehensive smoking ban in vehicles protecting passengers of all ages
- Smoke-free laws coupled with education is most effective approach
- Tendency for self-enforcement of laws that are intended to define social behaviors
- Such laws are important in reducing cancer incidence in Canada

# Conclusions and Recommendations

- Smoking in cars produces dangerous levels of SHS
- 6 provinces and 1 territory in Canada have bans
- Widespread public support for bans in Canada
- Remaining jurisdictions should enact bylaws to reduce the adverse effects on children's health
- A need for media campaigns to publicize bans

# Biomarkers

## **The 21-Gene Assay: Impact on Breast Cancer in Canada**

*Ethically and economically when do we act?*

**Joseph Ragaz, MD**

Medical Oncologist & Clinical Professor, Faculty of Medicine & School of  
Population & Public Health, University of British Columbia  
Adjunct Professor, Medicine & Oncology, McGill University

# What We Know

- The 21-gene **recurrence score [RS]** predicts chemotherapy benefit in breast cancer patients
  - High RS: substantial benefit
  - Intermediate RS: undetermined degree of benefit
  - Low RS: virtually no benefit
- U.S. health system approves and funds RS assay for eligible candidates
  - Since 2007, 100,000+ U.S. patients have had assay
  - Approx. 25,000 breast cancer patients have avoided chemotherapy
- Pharmacoeconomic analyses show RS-guided therapy provides net cost savings, even excluding indirect costs
  - 20-35% fewer patients receiving chemotherapy

# What We Found

- No institution, or Canadian province or territory, funds the test apart from exceptional cases
  - ▣ Ontario now funding on patient-by-patient basis (March, 2010)
- Some 10,000 Canadian patients each year meet ASCO/NCCN guidelines for the 21-gene assay
- Annually, the health system may save up to \$1.2 million per 1,000 breast cancer patients
  - ▣ Savings would be higher if indirect costs were considered

# What It Means

- Canadian cancer centres participated in original breast cancer research which led to the 21-gene assay
- Most Canadian breast cancer patients are not yet benefiting from the 21-gene assay
- At least 1,500 Canadian breast cancer patients may be receiving unnecessary chemotherapy each year, without access to the 21-gene assay
- Unnecessary chemotherapy causes toxicity, immunosuppression, leukemia or even drug-induced death
- Our analysis indicates significant quality-of-life as well as cost benefit from the 21-gene assay for breast cancer patients

# Recommendations

- Incorporate 21-gene assay into Canadian guidelines for eligible breast cancer patients
- Fund the 21-gene assay for all newly diagnosed eligible breast cancer cases

# Additional Highlights

## **New Drugs and Indications for 2000-2009** **Patient Perspective: Electronic Health Records** **and Rare Cancers**

**Pierre Major, MD**

Medical Oncologist based in Hamilton, ON

Vice-Chair of CACC

Chair of 2009-2010 Report Card Committee

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# New Drugs and Indications

## □ Key Findings

- From 2005 to 2009, the number of new cancer drugs and indications has doubled compared to 2000 to 2004
- From 2000 to 2009, 88 new indications were approved for 42 new cancer drugs
- Funding lags behinds these federal approvals

## □ Questions for the Future

- How will funders determine their priorities?
- Will personal finances be the final determinant of who benefits and who does not?

# Patient Perspective

## □ **Power to the People: Electronic Health Records**

- A Toronto patient recounts her experience with electronic health records (EHRs), how they helped her feel more in control and engaged in her care
- As a remote caregiver to her mother in PEI who is also fighting cancer, the patient wonders why Canadians must continue to wait for access to this proven and empowering technology

## □ **Living with Rare Cancers**

- Patients with rare cancers are waiting for the health system to catch up with advances in diagnostics/treatment for their diseases
- The authors share their own stories about the unique barriers rare cancer patients face in their fight for equitable access to cancer innovation across the country

# Questions?

Please visit [www.canceradvocacy.ca](http://www.canceradvocacy.ca)  
to view the full **2009-2010 Report Card on Cancer**