

The growing role of private sector payment for cancer care

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New drugs to treat cancer have become available over the last decades but they come at great cost — many of the newer agents cost from \$20,000 to \$50,000 for a course or a year of treatment. As public payers struggle to provide these medications with limited budgets, it has become increasingly difficult for patients to obtain these drugs within the publicly funded system. Canada has 13 separate provincial and territorial systems, each with varying success at providing cancer drugs.

We now have data showing that the proportion of cancer care costs borne by private insurers in Canada is growing faster than that paid for by provincial insurance: my colleagues and I at the Cancer Advocacy Coalition of Canada conducted a study whose findings were published in the 2008 Report Card on Cancer in Canada¹ and also were submitted as an abstract to the Canadian Association of Medical Oncologists (CAMO) 2009 Annual Meeting, published on page 43 of this issue of *Oncology Exchange*. Our study documented important differences among provinces in terms of availability of cancer drugs, total expenditures on these agents and proportions of public vs private payment.

The study examined expenditures on 43 take-home drugs (mainly oral) that are chiefly used to treat cancer patients. They were categorized as oral chemotherapy agents, hormone therapies, tyrosine kinase inhibitors (“targeted therapies”), supportive medications (e.g. antiemetics, bisphosphonates and hematopoietic stimulating factors, and miscellaneous (e.g. oral leucovorin, anagrelide and oral tretinoin). Data for the years 2002–2007 were collected from Brogan Inc. claims databases,² including anonymized data on claims made to private insurers (capturing about 67% of all private drug plan expenditures) and also take-home drugs paid for by provincial pharmacare plans (intravenous drugs were excluded). The public plans of BC, Alberta, Saskatchewan and Newfoundland, which do not participate in the Brogan databases, provided data independently. Public plan data for PEI was not available. We also extrapolated from the BC data to estimate total 2007 cancer drug spending in Canada.

To make meaningful comparisons, we reported expenditures per incident cancer cases, which was available from Statistics Canada.³ Some of our key findings were:

- Expenditures on take-home cancer drugs increased for both public and private payers, with the private payer expenditures growing four to five times more rapidly over the time period studied.
 - The availability of specific take-home cancer drugs varied substantially among different provinces.
 - Public expenditures were approximately \$2500 per incident cancer case in most provinces in 2007; however, in Atlantic Canada they were much lower.
 - The proportion of public vs private payer expenditures varied greatly among the provinces. It was greatest in the four Western Provinces, less so in Quebec and Ontario, and only slightly higher in Nova Scotia (as mentioned above, public data for PEI was not available). Public expenditures were much lower in Atlantic provinces; in fact, private expenditures exceeded public expenditures in New Brunswick and in Newfoundland and Labrador.
 - Quebec and Ontario spent the most overall on take-home cancer drugs in 2007.
 - Ten drugs out of the 43 accounted for 80% of total expenditures, with the top five being imatinib (15%), leuprolide and filgrastim (both 13%), goserelin (11%) and anastrozole (8%).
 - Roughly 50% of total expenditures in 2007 were on hormonal therapies, 20% on tyrosine kinase inhibitors, 19% on supportive care and 10% on cytotoxic drugs.
- Some important limiting factors in the data analyzed in our study are lack of adjustments for inflation, non-inclusion of manufacturer compassionate access and drug assistance programs, discrepancies over inclusion of rebates to provincial drug bodies, and variations in drug markups among provinces. Further, our study did not address the important issue of the costs of intravenous drugs and the growth of private sector delivery and payment for intravenous drugs — a situation that results in their sometimes being available only to those with applicable private insurance or the ability to self-pay, and availability of a centre (public or private) to provide the treatments. The amount spent on self-payment is another area on which data is needed to complete the picture of drug spending.

IMPLICATIONS FOR ONCOLOGISTS AND PATIENTS

Right now, Canadians need to be more aware that a growing number of drugs are only paid for through private insurance, and that even with insurance, the co-pay (amount not reimbursed) is significant for expensive drugs. Some drugs are not reimbursed at all under many policies, yet only about 10% of Canadians have “critical illness” insurance that ensures payment for all drugs.

Given the number of new compounds in development for treating cancer, oncologists will find it increasingly difficult to treat their patients according to the newer standards of care if we don’t develop ways to address the trends our study documents. They will encounter more paperwork, differences from one insurer to the other and differences between types of coverage plan. Patients will increasingly have to rely on self-pay and assistance from their families to access these drugs.

The finding that total take-home cancer drug expenditures were higher in Central Canada than in the Western provinces, despite Quebec and Ontario’s lower reliance on

public expenditure, requires further study. The processes for determining which patients receive which drugs may be a factor: for example, BC oncologists must submit key clinical data to a web-based drug submission system to obtain certain therapies for their patients, and in Alberta, access to certain drugs must be authorized by designated cancer specialists. A significant proportion of the Canadian population lives in communities without oncologists and likely has less access to many cancer therapies.


We calculated from the BC data that it would cost \$1.1 billion to provide the same coverage as in BC to the whole country for the 43 cancer drugs studied. We believe that out of the estimated \$27.5 billion spent on drugs in 2007⁴ (including prescription and non-prescription), this amount is not excessive for treating the second leading cause of death in this country. We believe that failure to address these issues could lead to further fragmentation and eventual dismantling of our publicly provided healthcare system.

FINDING SOLUTIONS

The Cancer Advocacy Coalition of Canada (CCAC) proposes that provincial and federal health ministers hold a forum to bring together all the payers to discuss the issues around cancer drugs and work out possible solutions. Every province has something to contribute. Quebec has already implemented a mandatory insurance scheme for take-home oral drugs (but not out-of-hospital intravenous drugs) whereby those not insured privately must pay into the provincial pharmacare plan (several European countries have similar mandatory public-private schemes). BC has developed a process that identifies and evaluates beneficial drugs efficiently as soon as evidence emerges from clinical trials, and makes these drugs available rapidly through an electronic adjudication system for special access. Alberta has had a system for many years that allows self-pay for selected cancer drugs. Manitoba has implemented a cancer order entry system that's used throughout the province; Alberta and Saskatchewan both have plans to use the same platform to disseminate care standards and practices across the province. Ontario has very sophisticated systematic evaluations of cancer interventions through Cancer Care Ontario's Program for Evidence-Based Care. Nova Scotia has developed an ethical framework for evaluating cancer drugs.

The trends that the Cancer Advocacy Coalition uncovered are important — and not only because of the surprise and difficulty foisted on people who are diagnosed with cancer and may have to choose between financial solvency or paying for the drug their oncologist recommends. Other important threats need discussion, starting with the simple question: What is the public health insurance system for? Billions are spent on relatively inexpensive drugs for minor ailments, including aspirin and acetaminophen, but many

truly unaffordable drugs for life-threatening disease are not covered. If the same approach were taken in other parts of the health system, governments would be paying for laboratory tests but not the treatments arising from the diagnosis.

So the dilemma for Canadian politicians and the Canadian public is to open up this discussion and sort out, with full disclosure, what is possible, what is not possible and what is right. Fear of this discussion has led us to the current trend, with ever-larger numbers of uninsured and under-insured Canadians vulnerable to financial crisis because of healthcare needs. 

References

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