Canadian Cancer Statistics 2007 estimated that there would be 159,900 new cases and 72,700 deaths from cancer across Canada in 2007, primarily due to a growing and aging population. However, with the recent innovation and advancement in cancer treatments, the number of deaths from most types of cancers has declined since 1994.

Although Health Canada approves cancer drugs for sale and marketing in Canada, this approval doesn’t ensure that the drug will be easily available to the patient who needs it. Factors such as provincial legislation and funding have a major impact on the accessibility of an approved drug within the Canadian healthcare system.

**Funding Imbalance**

In Canada, there are several sources of funding for cancer treatments: the federal government, the provincial government, pharmaceutical programs, third-party payers and self-payers. Examples of federal funding include $250 million granted to a new independent corporation, the Canadian Partnership Against Cancer (CPAC), to implement a cancer control strategy; and $300 million allocated to the provinces for the human papilloma virus (HPV) Vaccination Program, administering Gardasil® to Grade 8 girls to help prevent cervical cancer.

However, it’s the provincial jurisdiction that has the greatest impact on healthcare funding and drug accessibility. Take the HPV Vaccination Program, for example. Ontario, Nova Scotia, Newfoundland and Prince Edward Island initiated this program in the fall of 2007. British Columbia and Quebec will implement it in September 2008. Alberta, Manitoba, Saskatchewan, Northwest Territories, New Brunswick and Nunavut have not yet confirmed implementation of this program at all. This is just one example of how access to cancer drugs varies among the Canadian provinces—even though federal funding for the drugs is already available.

Depending on the province, there may be different sources of funding for different dosage forms and different locations where the drug is administered. For example, in British Columbia, the BC Cancer Agency coordinates funding for all dosage forms of cancer drugs. In Ontario, Cancer Care Ontario (CCO) coordinates funding for new intravenous (I.V.) cancer drugs when used in hospitals, while either CCO or the provincial formulary provides funding for non-intravenous drugs.

The type and number of publicly funded cancer drugs also varies across Canada. For example, Alimta®, for the treatment of pleural mesothelioma (cancer of the lining of the lung) and non-small cell lung cancer, is funded by the cancer board in British Columbia, but not in Ontario.

**Plan Sponsors and Other Private Payers**

With all of these factors already in play, how do private payers or plan sponsors fit into the picture? Since I.V. cancer drugs tend to cost more, let’s take a closer look at how they are funded in Ontario.

There are three funding sources for I.V. cancer drugs in Ontario.

Getting access to the best cancer drugs is a priority for those afflicted. But who bears the increasing costs of providing this coverage?

**BY PRISCILLA PO**
Injectable Cancer Drug Claims and Costs

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Aug. 1, 2005 to July 31, 2006 (prior to PWG recommendations)</th>
<th>Aug. 1, 2006 to July 31, 2007 (post PWG recommendations)</th>
<th>% Change - Total Drug Cost</th>
<th>% Change - # of Paid Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intron A®</td>
<td>$470,121</td>
<td>$853,834</td>
<td>82%</td>
<td>52%</td>
</tr>
<tr>
<td>Lupron®</td>
<td>$1,757,525</td>
<td>$2,446,219</td>
<td>39%</td>
<td>35%</td>
</tr>
<tr>
<td>Zoladex®</td>
<td>$1,302,614</td>
<td>$1,549,205</td>
<td>19%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Source: ESI Canada

New Drug Funding Program (NDFP) CCO supports this program and provides funding for approximately 75% of the overall I.V. cancer drug funding. This funding is specifically for newer I.V. cancer drugs that were approved after the implementation of the NDFP in 1997 and are to be administered in hospitals. Examples include Rituxan®, for the treatment of non-Hodgkin’s lymphoma and Herceptin®, for the treatment of breast cancer.

Hospital Funding The hospital budget provides funding for older I.V. cancer drugs that were approved in Canada prior to the implementation of the NDFP and are to be administered in hospitals. For example, Cisplatin (for the treatment of lung cancer) and cyclophosphamide (for the treatment of breast cancer) are both covered under hospital funding.

Private Funding Some I.V. cancer drugs such as Avastin® and Erbitux®, used to treat colorectal cancer, are funded neither by the NDFP nor by the hospital budget. Patients can obtain these drugs through private payment (i.e., third-party payers, plan sponsors or self-pay) and have them administered at designated Ontario hospitals or in private infusion clinics.

More and more private infusion clinics have been opened across Canada to increase drug accessibility for patients who obtain cancer drugs through private payment. With the increasing number of new cancer drugs and newly diagnosed cancer patients, along with the limited provincial funding for healthcare, third-party payers and plan sponsors should expect to pay an increasing proportion of cancer drug costs within the public system and through private clinics in the future.

Provincial Working Group in Action To help make unfunded I.V. cancer drugs more accessible, CCO supported the Provincial Working Group (PWG) in developing a recommended framework for the administration of unfunded I.V. cancer drugs to patients in Ontario hospitals.

Previously, hospitals only administered I.V. cancer drugs that were on the hospital’s formulary and were therefore funded by the government.

In July 2006, the PWG published its recommendations, which included suggestions on criteria for prioritizing patients for treatment, situations where unfunded drugs should be available for private payment, payment structure, purchasing and dispensing cancer drugs, documentation requirements and mechanisms to ensure consistent application across Ontario. Here are some of the PWG’s recommendations on payment for unfunded cancer drugs.

1. Patients should be charged only for the acquisition cost of the cancer drug (i.e., no pharmacy markup or dispensing fee).
2. If patients will be charged for non-drug-related costs such as nursing, pharmacy or laboratory services, the clinic can charge a $250 fixed infusion fee per visit.
3. Patients may be charged for additional drugs given as part of cancer therapy, including supportive drugs to prevent nausea, vomiting and allergic reactions induced by cancer drugs.
4. To ensure patient safety, cancer drugs should be purchased, prepared and dispensed by the hospital pharmacy department.
5. Hospitals should coordinate the billing process and confirm payment of privately funded drugs with patients prior to delivery.

Key stakeholders such as the Ministry of Health and Long-Term Care and the Ontario Hospital Association have received these recommendations, and some Ontario hospitals have already begun to implement them.

Effect on Private Drug Claims What are the ripple effects of the PWG’s recommendations? Are plan sponsors seeing an increase in the utilization and cost of cancer drugs as a result?

To find out, ESI Canada conducted a cancer drug claims analysis to examine the effect of the PWG’s recommendations on private drug plans. The sample period covered 12 months before and 12 months after the recommendations were published. The table above provides data for the top three injectable cancer drugs, in terms of highest cost paid: Lupron® and Zoladex®, for prostate cancer, and Intron A® for leukemia.

ESI’s findings show that, overall, there was an increase in drug usage and drug costs after the PWG published its recommendations. And this trend is even more prominent for newer and more expensive I.V. cancer drugs.

For example, Erbitux® had 12 claims totalling $20,533 in the 12 months prior to the recommendations. During the 12 months after the PWG issued its recommendations, the number of claims increased to 85—an increase of 608%—with the total drug cost increasing by 637% to $151,238. Avastin®, Rituxan® and Faslodex® all showed a similar trend increase. The most likely explanation for this trend is that an increasing number of patients are obtaining these drugs through private payment and receiving treatment in private clinics.

Interestingly, two cancer drugs, Herceptin® and Velcade®, actually showed a decrease in total drug cost and claims after the PWG made its recommendations—probably because both drugs were incorporated into the provincial NDFP. The NDFP initially funded Herceptin® for a more progressive form of breast cancer in August 2005, and coverage was later expanded to cover the less progressive form of breast cancer in March 2007. Similarly, the NDFP first funded Velcade® in July 2006. Within the 12 months after the provincial funding began, Velcade® had a 92% decrease in total drug cost (from $110,210 to $9,068) and an 82% decrease in the number of claims (from 44 to eight). These examples highlight the significant impact that public plan coverage decisions can have on the private sector.
Future Cost-Control Strategies
If plan sponsors should expect to reimburse a greater portion of cancer drug costs in the future, what can they do to help control the associated costs?

The most effective cost-control measure is to ensure that the appropriate drug is covered for the appropriate medical condition under the right circumstances. Coverage for cancer drugs should be based on several factors, including efficacy, safety, place in therapy, provincial and federal coverage, cost-effectiveness and location of drug administration.

Plan sponsors should also have a good understanding of how cancer affects the overall Canadian health system and the workplace, as well as the access and availability of different cancer treatments, so that they can refer patients to the appropriate resources at the right time. Getting the right education will empower plan sponsors to make better decisions and spend their healthcare dollars wisely.

To help educate plan members, plan sponsors may want to consider rolling out health awareness initiatives. The goal of these programs is upholding a healthy lifestyle, which can decrease the need for drug treatments and improve quality of life. For example, some plan sponsors run smoking cessation programs which, if successful, can decrease absenteeism and drug utilization.

Plan sponsors should also make it a priority to keep members informed about cancer prevention. In addition to quitting smoking, preventative strategies can include avoiding exposure to asbestos (which can cause cancer of the chest lining), considering the use of Gardasil® to prevent cervical cancer and lowering alcohol consumption to decrease the risk of colon cancer.

With more new and expensive biological cancer drugs available on the market every day and the ongoing need to enhance drug accessibility within a limited government budget, plan sponsors should be prepared for the increased costs of covering cancer drugs. And while there’s no magic formula, an emphasis on prevention and member education will help plan sponsors pave the way for cost control in the future.

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