REPORT ON

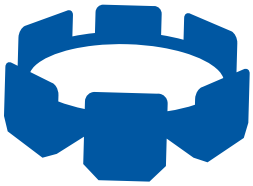
SECOND ANNUAL SYMPOSIUM ON

Cancer Drug Access

DECEMBER, 2010

Public Policy Forum
Forum des politiques publiques

ppforum.ca



Public Policy Forum

Building Better Government

The Public Policy Forum is an independent, not-for-profit organization dedicated to improving the quality of government in Canada through enhanced dialogue among the public, private and voluntary sectors. The Forum's members, drawn from business, federal and provincial governments, the voluntary sector and organized labour, share a belief that an efficient and effective public service is important in ensuring Canada's competitiveness abroad and quality of life at home.

Established in 1987, the Forum has earned a reputation as a trusted, non-partisan facilitator, capable of bringing together a wide range of stakeholders in productive dialogue. Its research program provides a neutral base to inform collective decision making. By promoting information-sharing and greater links between governments and other sectors, the Forum helps ensure public policy in our country is dynamic, coordinated and responsive to future challenges and opportunities.

1405-130 Albert St.
Ottawa, ON K1P 5G4
Tel: 613.238.7160 Fax: 613-238-7990
www.ppforum.ca

ISBN 978-0-9782281-6-3

Author:
Frank Richter, Research Associate,
under the direction of Paul Ledwell, Executive Vice-President

Contents

SECOND ANNUAL SYMPOSIUM ON

Cancer Drug Access

Executive Summary

Despite the tightening grip of cancer on the lives of so many Canadians, our health care systems too often fall short when it comes to supporting those afflicted by the disease and their families. Over the past few years, we have seen successes in the fight against cancer and many receive excellent care. We have, however, also seen thousands of cancer patients struggling to access the treatments they need.

Due to the importance of the subject matter and the importance of convening a variety of stakeholders, the Public Policy Forum has, for the second time, hosted a symposium which aimed to move forward issues central to cancer drug access in Canada. The symposium was held on September 30, 2010 in Ottawa and was organized in collaboration with Canadian Cancer Society and the Canadian Cancer Action Network.

The discussions of the day highlighted five areas of (mutual) concern:

1. Some provinces continue to fail their residents when it comes to ensuring some basic form of drug coverage, leaving cancer patients with major out-of-pocket costs.

2. Increasing numbers of employers can no longer afford to offer their employees extended health benefits plans which guarantee coverage of all drugs.

3. Provincial drug plans vary significantly in the selection of drugs they cover and in the degree to which patients are require to share some of the costs.

4. Timely coverage of new drugs by provincial and territorial plans continues to be a concern.

5. The exact process and criteria for making coverage decisions are not transparent and the fact that different provinces arrive at different decisions creates mistrust and dissatisfaction with the current regime.

The concerns are particularly pronounced in the context of cancer care. However, they are reflective of broader issues in Canada's health care systems resulting from provincial jurisdiction over health care and from the failure to include pharmacare for all residents in provincial health insurance plans. Internationally, Canada represents a unique model that brings with it a particular set of policy problems. The consequence of provincial sovereignty over healthcare and the long-standing reluctance of the federal government to press harder when it comes to enforcing conditions attached to transfers under the Canada Health Act is that some Canadians are without any drug insurance and that provincial health insurance coverage (including for cancer treatments) differs substantially across Canada. The reasons for the persistent differences include the complicated politics health care, fiscal transfers and federal/provincial relations, as well as vast income disparities among provinces.

Limiting public drug plans to certain populations such as seniors and recipients of social assistance, as is the case in most jurisdictions, means that many Canadians rely on private insurance for out-of-hospital drug coverage or have no coverage at all. Even patient groups covered by provincial health plans may still have to pay a significant portion of drug costs. This has become more problematic as cancer drugs administered outside of hospitals are becoming increasingly important as well as expansive, thus leaving patients with high out-of-pocket payments for drugs. Relying on private insurance for health care in itself is not the problem; it is the lack of legislation to ensure that every Canadian has some sort of coverage and that the coverage is adequate in the face of the rising costs of pharmaceuticals required for the treatment of life threatening diseases such as cancer. Many European

countries rely exclusively on private health insurance and still achieve universal coverage; similarly, Quebec achieves universal coverage with its mixed public/private model and a requirement of every resident to be ensured by a public or private plan. There is an overwhelming need for pan-Canadian standards on the quality and financial parameters of drug coverage to ensure that all Canadian cancer patients have timely and affordable access to the treatments they need.

The current system of mixed public and private health insurance in Canada also faces two related and unresolved challenges: (1) fast rising drug expenditures paired with (2) employers' demands to limit the cost of private health insurance benefits are forcing the private insurance sector to begin restricting the drug formularies and maximum payouts covered by their policies. No longer can patients assume their plan will cover all approved drugs or drug expenses. For some time now, public plans have been selective in adding new drugs to their formularies. However, the criteria and processes used to make such decisions lack transparency and are the cause of serious concern as well as distrust among the patient community, the pharmaceutical industry and the public alike. In order to move these issues up the political agenda, public awareness of current policies, practices and problems needs to be improved.

A number of issues and recommendations were repeatedly heard throughout the day, particularly during the group discussions:

- Participants generally agreed that we have seen a failure on the side of governments to implement some well-established solutions, first among them the proliferation of catastrophic drug plans across Canada (i.e. access to coverage for high cost drugs for those who lack drug insurance). Some participants called for broader reform of pharmacare in Canada; however, the immediate reform that should be moved forward, participants agreed, is to extend catastrophic drug plans to all Canadians.

- In light of a lack of leadership on the side of governments, participants called for other stakeholders to collaborate and drive the issue forward. Governments will need to be involved in this collaborative effort at some point, but the initiative, at this juncture, will have to originate from other stakeholders.

- Furthermore, participants showed frustration with the lack of transparency and inconsistency of the decision making processes in the health care system, including assessments and decisions about cancer drugs.

- It was also highlighted that there is an acute lack of awareness among the public of the key issues in cancer drug access, especially with respect to out-of-pocket costs, the pricing policies of pharmaceutical companies and the exclusion of drugs from the formularies of public plans and, increasingly, private plans.

Sommaire exécutif

Malgré la place de plus en plus envahissante qu'occupe le cancer dans la vie de nombreux Canadiens et Canadiennes, il arrive trop souvent que nos systèmes de soins de santé ne suffisent pas à soutenir adéquatement les personnes affectées par cette maladie et leurs familles. Au cours des dernières années, la lutte contre le cancer aura connu nombre de succès et les soins prodigués de nos jours sont excellents. En revanche, des milliers de patients atteints d'un cancer ont toujours de la difficulté à avoir accès aux soins dont ils ont besoin.

Étant donné l'importance de la question et compte tenu de la nécessité de réunir un large éventail d'intervenants, le Forum des politiques publiques organisait pour la deuxième fois un colloque destiné à se pencher sur les questions essentielles ayant trait à l'accès aux médicaments contre le cancer au Canada. Organisé en collaboration avec la Société canadienne du cancer et le Réseau canadien de lutte contre le cancer, le colloque s'est tenu à Ottawa le 30 septembre 2010.

Les discussions de la journée ont permis de jeter la lumière sur cinq secteurs communs de préoccupation :

1. Certaines provinces manquent toujours à leur parole envers leurs résidents en n'offrant aucune couverture pour les médicaments, aussi minime soit-elle, obligeant ainsi les patients atteints d'un cancer à assumer seuls d'importants déboursés directs.
2. De plus en plus d'employeurs n'ont plus les moyens d'offrir à leurs employés une assurance-maladie complémentaire leur garantissant la couverture des médicaments.
3. Les régimes d'assurance-médicaments provinciaux diffèrent grandement les uns des autres quant aux médicaments qu'ils couvrent et au pourcentage des coûts que doivent assumer eux-mêmes les patients à ce chapitre.
4. La couverture opportune des nouveaux médicaments par les régimes provinciaux et territoriaux demeure une préoccupation.
5. Les procédés et les critères exacts de prise de décision en matière de couverture ne sont pas transparents; de plus, le fait que différentes provinces en arrivent à différentes décisions est source de méfiance et de mécontentement à l'égard du régime actuel.

Les préoccupations se font particulièrement criantes en ce qui a trait aux soins aux cancéreux. Elles sont toutefois le reflet de problèmes plus généraux au chapitre des systèmes canadiens de soins de santé; ces derniers découlent, d'une part, du fait que les soins de santé sont de compétence provinciale et, d'une autre part, de la non-inclusion d'un programme d'assurance-médicaments dans les régimes d'assurance-santé provinciaux. Sur le plan international, le Canada constitue un modèle unique, mais qui présente un ensemble particulier d'enjeux en matière de politiques. Le fait que les soins de santé sont de compétence provinciale et la réticence de longue date du gouvernement fédéral à exercer davantage de pression lorsque vient le temps de faire appliquer les exigences de transfert prévues par la Loi canadienne sur la santé, font en sorte que certains Canadiens se retrouvent sans aucune assurance-médicaments et que la couverture d'assurance-maladie (y compris au chapitre des traitements anticancéreux) varie considérablement d'une province à l'autre, au Canada. Les enjeux politiques relatifs aux soins de santé, les transferts financiers entre gouvernements et les relations fédérales-provinciales — sans oublier les écarts de revenus importants entre les provinces — constituent autant de raisons qui expliquent pourquoi ces différences persistent.

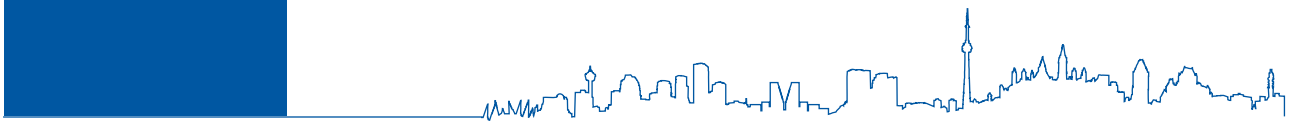
Le fait de limiter — comme le font la plupart des gouvernements — les régimes publics d'assurance-médicaments à certains segments de la population, tels que les aînés et les bénéficiaires de l'aide sociale, veut dire que de nombreux Canadiens doivent souscrire une assurance privée pour la couverture de médicaments non donnés à l'hôpital, ou s'en passer complètement. Même les groupes de patients couverts par les régimes d'assurance-maladie provinciaux peuvent devoir défrayer une partie importante du coût de leurs médicaments. Cela pose un problème de plus en plus marqué, étant donné que les médicaments contre le cancer administrés à l'extérieur de l'hôpital prennent de plus en plus de place et sont toujours plus dispendieux, obligeant ainsi les patients à assumer une portion importante du coût des

médicaments. Les régimes privés d'assurance-maladie ne représentent pas un problème en soi; c'est plutôt l'absence d'un cadre législatif permettant d'assurer à tous les Canadiens une couverture, quelle qu'elle soit, et que cette couverture soit adéquate, compte tenu de la montée du coût des produits pharmaceutiques nécessaires au traitement des maladies pouvant mettre la vie en danger, comme le cancer. De nombreux pays d'Europe dépendent exclusivement de régimes privés d'assurance-maladie, tout en atteignant une couverture universelle; dans le même ordre d'idées, le Québec jouit d'une couverture universelle grâce à son modèle public/privé et en raison de l'exigence voulant que tous les résidents soient assurés par l'entremise du régime public ou d'un régime privé. Il est urgent d'établir des normes pancanadiennes quant à la qualité et aux paramètres financiers en matière de couverture des médicaments, afin de s'assurer que tous les Canadiens atteints d'un cancer aient un accès abordable et opportun aux traitements dont ils ont besoin.

Le système actuel de régimes publics et privés d'assurance-santé au Canada est également confronté à deux défis connexes et non résolus : (1) la montée rapide des dépenses liées aux médicaments et (2) la demande des employeurs pour limiter le coût des prestations des régimes d'assurance-maladie privés obligent le secteur privé de l'assurance-maladie à commencer à restreindre les listes de médicaments et les remboursements maximaux couverts par leurs polices. Les patients ne peuvent plus prendre pour acquis que leur régime couvrira tous les médicaments approuvés ou toutes les dépenses liées aux médicaments. Depuis un certain temps déjà, les régimes publics ont dû faire des choix quant à l'ajout de médicaments sur leurs listes. Cependant, les critères et les procédés utilisés pour rendre de telles décisions ne sont pas transparents et causent de sérieuses inquiétudes et une certaine méfiance, tant auprès des patients que de l'industrie pharmaceutique et du grand public. Si nous voulons faire progresser le dossier politique sur ces questions, il faudra sensibiliser davantage le public aux politiques, aux pratiques et aux problématiques actuelles en la matière.

Tout au long de la journée — en particulier lors des discussions de groupe — les participants ont soulevé un certain nombre de questions et émis certaines recommandations :

- En règle générale, les participants s'entendent pour dire que les gouvernements n'ont pas réussi à mettre en place des solutions bien définies, notamment au chapitre de la prolifération de régimes d'assurance pour médicaments onéreux à l'échelle du Canada (c.-à-d., l'accès à une couverture des médicaments à coût très élevé pour celles et ceux qui n'ont pas d'assurance-médicaments). Certains participants ont réclamé une réforme majeure de l'assurance-médicaments au Canada; cependant, tous se sont mis d'accord sur la réforme la plus pressante à réaliser, soit celle d'étendre l'accès aux régimes d'assurance de médicaments onéreux à tous les Canadiens.
- Étant donné le manque de leadership des gouvernements, les participants ont réclamé de la part des autres intervenants qu'ils collaborent entre eux afin de faire avancer la question. Il faudra éventuellement faire participer les gouvernements à un tel effort de collaboration, mais à ce stade-ci, ce sont les autres intervenants qui doivent faire avancer l'initiative.
- Qui plus est, les participants ont exprimé leur frustration quant au manque de transparence et à l'incohérence des processus décisionnels du système de soins de santé, notamment en ce qui a trait aux évaluations et aux décisions relatives aux médicaments contre le cancer.
- Il en est également ressorti une profonde méconnaissance du public quant aux principaux enjeux importants au chapitre de l'accès aux médicaments contre le cancer, notamment en ce qui concerne les déboursés directs, les politiques d'établissement des prix des entreprises pharmaceutiques et l'exclusion de certains médicaments des listes de médicaments approuvés en vertu des régimes publics et, de plus en plus, des régimes privés.



Introduction

"Cancer" is the devastating diagnosis that about 175,000 Canadians will receive in 2010. Despite the large number of cancer diagnoses, guaranteeing timely and affordable access to advanced cancer care for all Canadians[1] continues to be a distant goal. Due to the high costs of drugs, and the central role that drugs play in cancer treatments today, cancer patients often face substantial financial and bureaucratic challenges that complicate access to promising treatments. The challenges are not unique to cancer; however, the particular nature of modern cancer care, and the large number of affected patients and families, makes access to cancer drugs a particularly pressing issue in the field of health care. In fact, a poll released by the Canadian Cancer Society a few days before the symposium highlights that, after Canadians were given detailed information on the issue, 94% were concerned about the availability of and co-payments for cancer drugs.

Building on the success of the initial symposium in 2009,[2] the Public Policy Forum collaborated with the Canadian Cancer Society and the Canadian Cancer Action Network to organize a one day symposium to discuss and formulate specific strategies to address key gaps in cancer drug access. The symposium convened representatives from stakeholder groups relevant to cancer care, including the patient community, governments, the private insurance industry, the pharmaceutical industry, physicians, pharmacists as well as health care experts and researchers.

Specifically, the event brought together stakeholders for a deliberative session to discuss possible actions to address four major issues:

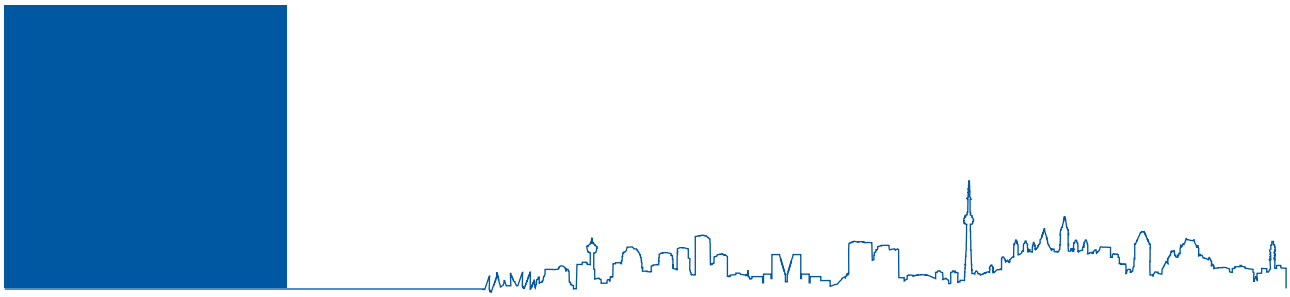
- Drug plan coverage: Inequities in coverage by private and public drug plans
- Promising models to reduce barriers (such as out-of-pocket expenses) to cancer drugs while ensuring financial sustainability
- Value for money: What health benefits do new and often expensive drugs provide and how can spending on drugs maximize health outcomes?
- Collaboration: Models of collaboration between all stakeholders to address cancer drug access

A keynote address from André Picard, national public health reporter with The Globe and Mail, set the context for the day. It was followed by presentations and discussions featuring several Canadian experts and leaders in the health field.

The meeting agenda explored how different jurisdictions from around the world are addressing the important issues of cancer drug access and discussed the potential application of these models in Canada. Participants engaged in a group exercise to develop a set of criteria that can be applied across Canada to improve our systems of cancer drug coverage.

The program closed with a point-counterpoint discussion about cancer drug prices - focusing on how drug prices are determined, and the implications of high cancer drug prices for patients, payers and health professionals.

1. "Canadians" in this report refers to residents of Canada, not Canadian citizens
2. More information on the 2009 event, including a summary report can be found here: http://www.ppforum.ca/publications/optimizing-access-cancer-drugs-canadians



Pressing issues in cancer drug access

Cancer captures a class of diseases that, according to the Canadian Cancer Society, over one in three Canadians will develop in their lifetime. The growing number of new cases per annum, and the severe impact the diagnosis has for the patients' lives and for their friends and family, explains why cancer care has received so much attention over the past years. Patient groups, provincial and federal governments have taken action by funding a national cancer strategy, establishing designated cancer care agencies, assessing new cancer drugs by separate agencies, investing in cancer research and by raising awareness about cancer in its various forms through many public campaigns. Despite all these efforts and some notable successes, cancer is predicted to cause 76,200 deaths in Canada in 2010 and many of the fundamental problems remain unresolved. [3]

Out-of-pocket cost: a massive barrier for some Canadians

Some Canadians are without insurance for drugs administered outside of hospitals, potentially leaving them with the bill for tens of thousands of dollars in treatment costs if they are diagnosed with cancer. This astonishing situation has not been resolved even though, as André Picard reminded the audience, catastrophic drug coverage was agreed upon as part of the 2003 Health Accord, and despite a reiteration of that commitment at a 2008 Health Minister's meeting. Catastrophic drug insurance schemes pay for any out-of-hospital drug treatment costs that exceed a certain threshold (often 3% of income). While some provinces have implemented such insurance plans, others have not, leaving millions of Canadians at risk.

Private insurance: policies no longer guarantee coverage

In contrast, Canadians with private drug insurance (mostly provided by their employer) could, for the longest time, count on extensive coverage for all drugs approved by Health Canada. However, symposium speakers warned that private drug plans no longer guarantee coverage of all drugs. Increasing costs of new treatments and the increased utilization of out-of-hospital treatment regimes have escalated the cost of comprehensive insurance policies. The private insurance industry and employers who provide health benefits are now beginning to consider curtailing their coverage of certain drugs and many are requiring employees to pay a greater proportion of costs.

Variations in coverage among provincial plans

Provincial and territorial (hereafter referred to as 'provincial') drug plans differ significantly in the cancer drugs they include and the cost-sharing mechanisms they employ — a fact that collides with visions of equal coverage for all Canadians. For years patient groups have pointed out that the quality of care depends on where one lives in Canada. Such differences are extremely frustrating for patients who find themselves in a province that does not cover a treatment they are told is covered elsewhere in the country and could address their health issues. Some may choose to pay for treatments out of their own pockets if they are not satisfied with the options covered by their provincial plan. Others may not have the financial resources to do so.

3. See page 1 of Canadian Cancer Statistics 2010: http://www.cancer.ca/Canada-wide/About%20cancer/Cancer%20statistics/Canadian%20Cancer%20Statistics.aspx?sc_lang=en

Timely coverage of new drugs by provincial and territorial plans

Patients and industry are concerned about the speed at which new drugs are assessed and added to provincial formularies. On average, a significant amount of time passes from when Health Canada approves a new drug to when provincial drug plans decide whether or not to add it to the plan's formulary, which leaves cancer patients waiting months or years for new, potentially life-saving, treatments.

How are coverage decisions made and how should they be made?

The process and criteria for making coverage decisions are central to many of the issues in cancer care. There is concern about the speed of coverage processes and whether they serve cancer patients well regardless of where they live in Canada. The fact that decisions differ from province to province is difficult for patients to fathom and accept. The differences are even harder to accept when patients and the public at large cannot discern and understand what criteria decisions are based on. How and on what criteria these decisions should be made was a recurring theme throughout the day. These questions will become even more pressing as pressures on health care budgets increase and private insurers begin to follow public plans in rejecting coverage for some drugs.

Canadian cancer and health care in international

Concerns in cancer care are reflective of broader health care issues in Canada

Structural problems that plague Canadian health care systems at large must be considered in order to understand and effectively address the issues in cancer care. The presentations by André Picard, Neil Palmer and Prof. Jeffrey Hoch highlighted some of the key characteristics of Canadian health care systems, how they differ from other countries' systems, and the challenges that the particular set-up of Canadian health care systems poses to finding viable solutions to the issues at hand.

Canadians often define their health care systems by pointing to differences with the American system. All too often, this comparison leads to the conclusion that Canada's approach is the best and only sensible way to provide health care. However, as symposium speakers suggested, comparisons to other OECD[4] health care systems can be more insightful and helpful in finding solutions to some of challenges in cancer care.

Basic models and international examples of organizing health care

Internationally, government supported health care has a tradition that goes back long before the creation of Canada's Medicare in 1962. Germany was the first country to introduce universal health care for workers in 1883; accident insurance followed in 1884 and pensions for the old and disabled in 1889. Since then, many OECD countries have introduced universal health care systems which, with the exception of Canada, include coverage for pharmaceuticals (pharmacare). Even though they are all universal health care systems, they accomplish universal health coverage in different ways. Health care systems can be divided into two broad parts: (1) the insurance aspect, which raises and distributes funds; and (2) the delivery, which the raised funds pay for. Health care systems differ substantially in how the two parts are organized. Each task can be given to public, not-for-profit or for-profit sector (or a mix of the three).

Health care funds are generally raised through the tax system or individual insurance contributions to government run, not-for-profit or private plans. In addition, many systems have introduced co-payments to discourage overutilization.

Germany achieves universal coverage (including drugs) with mixed public/ private system

Germany and Britain are two good examples of well established systems with virtually universal coverage. Unlike in Canada, health care in Germany is not financed by taxes. Unchanged since universal health care for workers was introduced under Bismarck, insurance premiums are charged on employment income by not-for-profit health insurers. The government exercises strict regulatory oversight to ensure equality of coverage for all members of public insurance plans. High income earners, the self-employed and many public sector employees can choose to join private, for-profit insurance plans instead. Insurance companies are allowed to tailor these private plans to a larger extent. Pharmacare is a central part of both not-for-profit and for-profit insurance plans. Health care delivery is provided by private for-profit entities (doctors, and some hospitals) as well as not-for profit entities (many hospitals). Today, Germany's system of delivery and mixed private and public insurance provides virtually

universal coverage and demonstrates that universal coverage can be accomplished, whether insurance and delivery are provided publicly or privately.

Great Britain and the NHS: one of the most centralized and government controlled universal systems

The National Health Service (NHS) in Great Britain, by contrast, is an entirely public health care system. It is funded from the general budget, and services are delivered by NHS (government) institutions. This makes it one of the most centralized universal systems in the world — a stark contrast to the German or Canadian systems.

The United States: excellent care for a few, limited access for many, extremely high costs

The system in the United States embodies the opposite extreme to Great Britain's centralization. With a myriad of different insurance and delivery schemes, it is an outlier both in its complexity and inefficiency. Major federal taxpayer financed insurance schemes (Medicare, Medicaid and insurance for military personnel) coexist with a large private insurance sector which offers employer provided insurance as well as individual plans. The system leaves a significant number of Americans without insurance coverage, because they have pre-existing conditions; do not qualify for government programs; cannot afford to buy individual insurance; and/or their employer does not provide health benefits. Unlike in other systems that rely, at least in part, on private insurance (such as in Germany, the Netherlands or Switzerland) the US government has been unable to guarantee universal coverage and protection for patients from health insurance companies refusing to reimburse treatments on questionable grounds. In other words and contrary to popular believe, the widely publicised problems with American health care are likely the result of a combination of ill-designed public policies and regulations, rather than the result of private sector involvement per se. Some improvements may come as the Obama health reforms are implemented over the coming years.

Canada's cancer drug access in international comparison

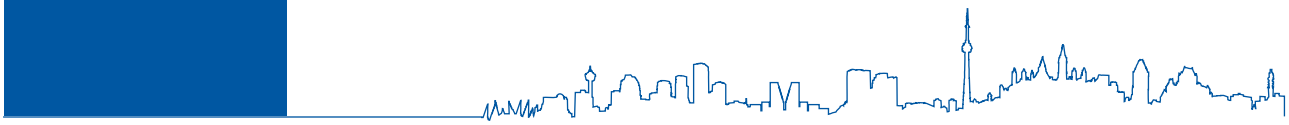
Despite Canada's health care spending being among the highest of all OECD countries,[5] and the cancer care envelopes growing fast within that total, Canadians' access to cancer drugs is unfavourable according to some statistics presented by Neil Palmer. Palmer referred to a 2010 report by Professor Sir Mike Richards which has Canada ranked 13th out of 14 over the past five years when it comes to listing new cancer drugs. Canada's current ranking is down from 12th and 11th in the two previous five year intervals.[6] This statistic supports the view of many patient groups that Canadian health plans are exceptionally reluctant and slow in adding new drugs to their formularies.

The United States and Germany, along with Switzerland, rank significantly higher than Canada. Contrastingly, the United Kingdom, along with New Zealand and Australia, constantly share the bottom ranks with Canada. According to Mr. Palmer, the bottom performing

5. "In level terms, Canada's per capita health spending in 2008 was fifth highest in the OECD..." OECD, (2010). OECD economic surveys: Canada 2010. OECD Economic Surveys, 2010/14. Page 124-5.
6. Extent and causes of international variations in drug usage. A report for the Secretary of State for Health by Professor Sir Mike Richards CBE. July 2010

countries all use very similar models and criteria for health technology assessments and coverage decisions. These assessment methodologies may systematically hinder access to cancer drugs and need to be reconsidered in this light.

On a cautionary note, it should be noted that some of these rankings are not altogether easy to interpret. For example, a high rank may be the outcome of a lack of rigour when it comes to assessing the benefits of new drugs, and may thus indicate a waste of precious health care resources on untested treatments as well as a lack of incentives for the pharmaceutical industry to innovate. Canada and other low ranking countries, may, according to this logic, be particularly good at only covering drugs that are truly innovative. Alternatively, a high ranking could indicate a system that provides better access to the latest innovative drugs. (This is a distinct possibility, as the discussion of decision making models covered below will demonstrate.) However, as so often is the case in the field of health care, we lack reliable and comparable data that compares health outcomes with costs needed to make sound judgements on these questions.



Cancer care in Canada's health care systems

Provinces and territories are responsible for organizing health care

The Canadian system is unique in several respects against international comparisons. First, there is not one single system in Canada, but rather 13 separate provincial or territorial systems. Under the Canada Health Act, these systems are similar in many important ways, but also differ in some respects – a point which often frustrates cancer patients and other stakeholders.

All provinces provide near universal coverage for their residents, with the important exception of pharmaceuticals, through tax financed government insurance plans. Health care is delivered by private, not-for-profit hospitals and for-profit entities, notably pharmacies, laboratories and doctors, who are generally self employed contractors.[7] Canada's health care systems, hence, rely on the private sector to deliver heath services, while provincial ministries provide the majority of financing from the general tax pool.

A common feature of all Canadian health care systems: a blend of public and private insurance

Canada stands out among countries with universal health care for excluding coverage for the use of prescription drugs outside of hospital care. All provinces and territories have opted to provide publicly financed coverage for drugs taken outside hospitals for at least some of their residents (although most require co-payments from patients). Private insurance is available to many Canadians through employer subsidised private health plans. In fact 65% of the population has private health insurance and 29.8% of all health care expenditures are paid by private insurers and patients directly.[8] But a significant proportion of the population does not have a private insurance plan because they are self-employed, unemployed, employed part time or their employer has chosen to not provide health benefits to employees.

This arrangement formerly was more tenable when pharmaceutical use outside of hospitals played a relatively minor role. Over the years, however, more and more drugs have been developed for treatment at home. Cancer is one disease group which is now significantly treated outside of hospitals with costs per treatment in the tens of thousands of dollars range. Individuals without private insurance are often faced with major out-of-pocket expenses, and not all provinces provide financial support for those who can't afford the treatment.

Symposium speakers warned that private health insurance companies and their customers (mostly employers) are struggling with the fast growing cost and prevalence of drug treatment outside of hospitals. Private insurance plans traditionally covered all drugs approved by Health Canada. However, as costs for providing health benefits for employees are growing fast, businesses are beginning to demand plans that exclude some drugs from the formularies in order to lower premiums. Some employers are even considering dropping health benefits altogether due to the escalating costs.

7. Flood, C, & Thomas, B. (2010). Blurring the public/private divide: the Canadian chapter. European Journal of Health Law, 17, 257-278.
8. See Mr. Palmer's slides or Flood, C, & Thomas, B. (2010).

The private insurance system in Canada is struggling under a financial burden that it was never intended to carry. Private insurers today are facing the same cost pressures that public insurance plans have felt for years and they are beginning to respond by limiting coverage, just as public plans have. As a result, the number of Canadians who face barriers in accessing cancer drugs is growing and will continue unless addressed.

Federal transfer payments and the Canada Health Act impose a degree of uniformity

Even as the provinces and territories hold responsibility over health care, the federal government has managed to impose some uniformity across jurisdictions through the Canada Health Act (CHA) and its predecessors. It does so by tying fiscal transfers to provincial governments to five conditions: comprehensiveness, universality, portability, public administration and accessibility. The five conditions guarantee that all Canadian health care systems have at their centre a public insurance plan (single payer) for hospital and physician services. However, to the detriment of cancer patients, the CHA does not include pharmacare, limiting the pressure the Federal Government can exert over provinces.

Nonetheless, André Picard reminded the audience that some of the transfers agreed to in the 2003 Health Accord were earmarked for provinces to establish catastrophic drug insurance programs. The failure to enforce that part of the agreement demonstrates how difficult (at least politically) it is for the Federal Government to enforce the terms of transfer agreements.

Health care decisions often vary across provinces and territories

A major point of divergence in Canadian health care is that provinces frequently make differing decisions, even though the processes and authorities responsible for decisions are broadly similar across jurisdictions, with the exception of Quebec which does not directly participate in interprovincial processes.

For cancer patients, coverage decisions for new cancer drugs are of course most relevant. New drugs need to pass a lengthy series of assessments before they are added to public health plans.

1. Health Canada approves new health technologies for medical use in Canada.

2. The newly-established pan-Canadian Cancer Drug Review (pCODR) assesses the clinical and economic value of new cancer drugs and makes recommendations to the participating provinces. Responsibility for the final funding decision continues to lie with the provincial Ministries of Health.

3. The Patented Medicine Prices Review Board (PMPRB) ensures that the price charged for new (patented) drugs is not excessive.

4. Provincial Ministries of Health or cancer agencies conduct their own assessments of the drug in question to determine the budget impact of covering the drug, and whether the cost is justifiable according to their own policies.

5. Provincial ministries or cancer agencies make the final decision whether to add a new drug to the formulary of their plan.

Despite efforts to move towards more consistent coverage of cancer drugs across Canada, patient groups and experts continue to report significant variations. Given that it will begin operations in early 2011, it remains to be seen if pCODR will bring about more consistency. The fact that provinces will continue to make the final decisions, paired with differing priorities and financial capacity in these provinces, raises legitimate concerns about whether pCODR will be able to make a material difference.

It is necessary to question whether provincial drug plans provide timely access to new and effective drugs and whether other decision-making models may be more effective. Other countries clearly provide faster access to new drugs because their policies and decision-making approach are different. France and Germany, for example, add new drugs to their formularies immediately after their approval for medical use. In this model, the performance and value of the drugs are assessed sometime after they have been added and they may be delisted if they are found not to perform well enough to justify funding.

Another model for providing timely access, especially for expensive drugs, is for insurance plans to enter risk-sharing agreements with the pharmaceutical companies. Under such an agreement, a drug would be listed and then monitored for its performance. If the drug does not provide the benefits promised by the supplier, the company would carry some of the cost incurred by the insurance plan during the trial-period and the listing will be reconsidered.

Canadian cancer patients may benefit if public and private health plans were willing to experiment with some of the policy ideas pursued abroad.

Provinces' and territories' ability to pay for health care varies widely

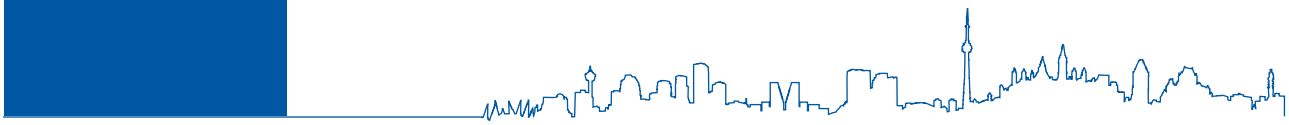
Even as the Federal Government provides billions of dollars to provincial health plans, provinces differ in what health care services they can afford. Disparities in gross income between Canadian provinces are significant and make it virtually impossible for poorer provinces to afford the same kind of health care investments that richer provinces can afford. For example, Alberta's GDP per capita is roughly $81,000, which is 78% percent more than Ontario's $45,500, and 2.2 times as much as in Nova Scotia. Some health care costs (notably local wages) will be lower in poorer provinces as well, but other costs, for example for cancer drugs, will be the same across the country. The differences in income per capita are not only important in terms of the tax base, but because they also limit how much companies and individuals can spend for private health insurance. Symposium speakers outlined how variations in income do not correspond precisely to health coverage across Canada's jurisdictions, although some correlation does exist. Caution was given, however, on the push to uniformity across Canada as that will likely drive coverage levels in some provinces down rather than up.

Unique features of the Quebec system

While Quebec's health care system shares many of the key features of other provinces, it differs in some important respects that benefit cancer patients in that province. Most importantly, like some other jurisdictions internationally, Quebec legally requires all residents to be covered by a public or private drug plan. Individuals who do not have access to a private drug plan (e.g. through their employer) are required to join the public plan. At the same time private insurers are tightly regulated to ensure minimum coverage and prevent

excessive co-payments and deductibles. The system hence manages to achieve universal drug coverage while leaving many of the historic features of Canada's health care systems in place. It therefore is an example of how universal health coverage (including drugs) can be accomplished without requiring major changes to existing health care structures in the provinces. (It was noted that there was still room for improvement in Quebec in terms of formulary coverage of new cancer drugs and out-of-pocket expenses for its lower-income residents, however its unique model warrants consideration.)

Quebec has kept its distance from attempts of cooperation among federal, territorial and provincial governments on assessing and recommending drugs and other health technologies. As a result, all past and current attempts to bring about a convergence in provincial formularies (such as the Canadian Agency for Drugs and Technologies in Health and pCODR) have no impact on coverage in Quebec. Recent legislative reforms to Quebec's health technology assessment and decision making processes suggest that Quebec will continue to remain absent from national initiatives for the time being.



Outcomes of the symposium

The discussions of the day, especially the reports from the group sessions, clearly showed several areas of agreement and urgency for collaborative action.

1) Failure of leadership on the side of Governments

We have witnessed a failure on the side of governments to take collective leadership and guarantee access to cancer drugs for Canadians regardless of their socio-economic background or geographic location. Catastrophic drug insurance is a central goal in this respect.

2) Wide range of stakeholders wants to collaborate to move agenda forward

All discussion groups suggested collaboration among a wide range of stakeholders to develop solutions on issues in cancer care access and to work with government to take collective action. Some suggested all non-governmental stakeholders should collaborate and approach governments with agreed upon policy suggestions; others envisioned government to be engaged in the collaborative effort all along. Either way, an emphasis was placed on non-governmental stakeholders taking the initiative rather than waiting for government initiatives.

This symposium is an example of the type of leadership required to move this agenda forward. However, as stated during the final presentation of the day, simply convening stakeholders to discuss issues on an annual basis is wholly inadequate. Rather, immediate action must be taken by all interested parties and the annual symposium used to check in on our collective progress.

To illustrate this point, as a result of the symposium a cancer patient working group[9] was formed by several symposium participants as a way to work more effectively with the pan-Canadian Oncology Drug Review (pCODR) to advance the goal of greater patient engagement. The cancer patient working group will also be a point of contact with the Industry Oncology Working Group, consisting of manufacturers of cancer drugs, to discuss mutual areas of concern regarding drug access.

3) Catastrophic drug insurance for all

Participants agreed that all Canadians should be covered by a catastrophic drug insurance plan. Some participants expressed a preference to see a more comprehensive pharmacare plan but did not disagree with catastrophic drug insurance as an important immediate and urgent improvement. A catastrophic drug plan would cover drug costs for any patient that exceeds a certain (relatively high) threshold. The 2002 Romanow report suggested a threshold of $1500 per person per annum but an income-based threshold (for example 3% of pre-tax income) has also been suggested as a viable solution. Some provinces already have such a plan but others do not. Several participants suggested that the Federal Government has an important role to play in driving this initiative and in encouraging all provinces to establish a catastrophic plan that meets some basic minimum standards. Extending catastrophic coverage to all provinces likely requires federal transfers of tax funds linked to this specific policy initiative.

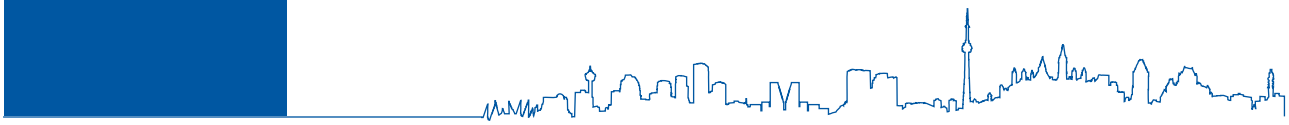
9. The exact name of the group has not yet been decided.

4) Health care systems and decisions need to become more transparent

The health care systems and decision making processes within it need to become more visible to stakeholders and in ways that are understandable to ordinary citizens. The current lack of transparency creates a sense of mistrust among cancer patients, as well as Canadians at large, and complicates meaningful engagement with governments and cancer agencies. To put it simply, it is impossible to have a fruitful discussion about the provinces' decision making processes for cancer treatments when governments are unwilling to disclose details about those very processes.

5) Need to broaden awareness of challenges in cancer drug access

The public, as well as patients and governments need to be educated about the problems that cancer patients face, how the health care system functions and how it fails to deliver in some cases. As the national poll on "Canadians and Cancer Drug Access" commissioned by the Canadian Cancer Society starkly demonstrated, 81% of Canadians report they are "not very familiar" or "not at all familiar" with "the prescription cancer drug and supportive drug regime in your province – that is, the availability and out-of-pocket costs to cancer patients in your province of these drugs." If problems with cancer drug access are to be addressed, broader awareness of the issues is critical to ensure a level of political pressure for change that cannot be ignored.



Conclusion

The support for a collaborative effort to move issues in cancer care forward was a significant outcome of the symposium and should send a clear signal to all governments that Canadians expect an equal level of leadership when it comes to cancer care and pharmaceuticals policy more broadly. The coming together of so many stakeholders in cancer care, including patient groups, health professionals, cancer agencies, academics, government, health policy experts, the pharmaceutical industry, and private insurers, is an important step in moving a complex issue such as cancer care forward.

Similarly, demands to make the health care system more transparent and to educate the public about the challenges the system and patients face is a notion that deserves unconditional support. It will ideally open up an honest debate about the future of Canadian health care, including cancer care. This symposium generated agreement to collaborate on some specific issues in cancer care, such as catastrophic drug insurance, but it also highlighted some broader issues that affect cancer care today and will become more pressing tomorrow.

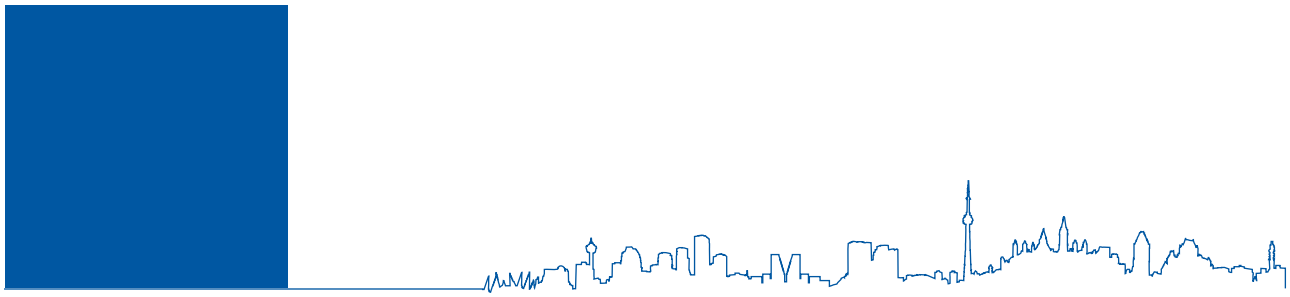
Both public and private insurance plans are struggling in the face of escalating costs. As both try to cut cost, more Canadians will be at risk of falling through the cracks of the system. Many are also worried that fewer and fewer have access to the newest and most effective, but more expensive, drugs. Hence, the healthcare system must become better at allocating resources efficiently. At the same time it needs to provide incentives for innovation so that better health outcomes can be accomplished without breaking the bank.

The question that becomes increasingly important as growth in health expenditures continue to outpace the growth of incomes is: how and based on what criteria should we make health care decisions? This is a question that surfaced again and again throughout the day but it was apparent that we are a long way from a consensus answer. The question is difficult for anyone to answer. As Chris Bonnett, President of H3 Consulting, highlighted in his summary of the day, the answer involves many extremely difficult trade-offs: cost vs. quality; diseases versus disease; doctors versus drugs versus hospitals; passion versus reason; benefit to the population versus benefit to the individual; etc. It is a difficult question, but it needs to be addressed openly. The answers need to be acceptable to all stakeholders, based on discussion and compromise on all sides.

When it comes to concrete reforms, the politics of health care are complicated; however, proposals need to be considered to change the existing system. For example, as André Picard highlighted, the next federal election will probably be decided in a relatively small number of ridings in the suburbs of Montreal, Toronto and Vancouver. Proposals for ways for the federal government to be more involved need to find acceptance there. The fact that individuals in those ridings have comparatively good insurance coverage could be a major hurdle to action by the federal government.

Any proposals to make access to cancer care, and health care at large, more equal across the country may also be faced by resistance from well-off provinces which would likely subsidise the improved access in some way.

Given those challenges, small, pragmatic changes are the areas on which efforts should be focused over the next months. The most promising proposal is to implement nationwide catastrophic drug insurance.



Appendix 1: Speakers' Biographies

David Mitchell

President & CEO, Public Policy Forum

David J. Mitchell became President and CEO of the Public Policy Forum in January of 2009. The Forum is an independent non-governmental organization, dedicated to improving the quality of government in Canada through multisectoral dialogue and research on governance and public service.

Previously, Mr. Mitchell served as Vice-president at three Canadian universities: Queen's, the University of Ottawa and Simon Fraser University. Directing fundraising and external relations at each institution, he achieved notable successes in strategic positioning and fund development. At the University of Ottawa, for instance, he led an important branding initiative and completed a major fundraising campaign which exceeded its $200 million objective more than a year ahead of schedule.

David Mitchell's diverse career path has also included senior positions in both the public and private sectors. Serving as a Member of the British Columbia Legislature from 1991 to 1996, he was a watchdog on a broad range of issues including parliamentary reform, advanced education, resource management and labour relations. He had previously gained experience in parliamentary procedure and legislative processes as Deputy Clerk of the Saskatchewan Legislature.

Mr. Mitchell also has significant private sector business experience, having held executive positions within western Canadian resource industries, including vice-president of marketing and general manager of industrial relations.

David Mitchell holds a Master's degree in Canadian and American history from Simon Fraser University. An award-winning writer and former newspaper columnist, Mr. Mitchell contributes to several newspapers and magazines and serves as a frequent public affairs commentator on television and radio.

The father of two daughters, he is married to author and media critic, Shari Graydon. He is a board member of the Parliamentary Centre in Ottawa and the Centre for the Study of Democracy at Queen's University.

Jack Shapiro

Chair, Canadian Cancer Action Network

For decades, Mr. Jack Shapiro has worked tirelessly as a strong patient advocate committed to improving patient care and advancing patient interests. Currently serving as Chair of the Canadian Cancer Action Network, Mr. Shapiro has been instrumental in helping advance countless health care organizations over the years.

Having held numerous key leadership roles, Mr. Shapiro served as Vice Chair of the Canadian Strategy for Cancer Control whose work lead to the creation of the Canadian Partnership Against Cancer; past chair of the Toronto Board of Health and past chair of Cancer Care Ontario. Mr. Shapiro is also a past board member of the Princess Margaret Hospital; a past board member of the University Health Network and a catalyst for the establishment of medicare in Saskatchewan.

In May of 2003, Mr. Shapiro was presented with the Order of Canada, Canada's highest civilian honour recognizing a lifetime of distinguished service in or to a particular community, group or field of activity.

Now retired, Mr. Shapiro resides in the city of Toronto and continues to focus on ensuring an informed patient voice remains a key element to the evolving cancer control strategy.

André Picard

Health Journalist, *The Globe and Mail*

André Picard is the public health reporter at *The Globe and Mail* and author of the best-selling books Critical Care: Canadian Nurses Speak For Change and The Gift of Death: Confronting Canada's Tainted Blood Tragedy. He is also the author of A Call to Alms: The New Face of Charity in Canada.

André has received much acclaim for his writing, including the Michener Award for Meritorious Public Service Journalism, the Canadian Policy Research Award, and the Atkinson Fellowship for Public Policy Research. In 2002, he received the Centennial Prize of the Pan-American Health Organization as the top public health reporter in the Americas. In 2005, he was named Canada's first Public Health Hero by the Canadian Public Health Association. In 2007, André was awarded a National Newspaper Award for his contribution to a series about cancer care in Canada.

He is a former member of the advisory committees of the Canadian Institute for Child Health, Active Healthy Kids Canada, Centraide/United Way Montréal, and the Canadian Medical Association Journal. He is also a parent representative on the Montreal School Board.

W. Neil Palmer

PDCI Market Access Inc

Neil Palmer is President and Principal Consultant of PDCI Market Access Inc (PDCI) a leading pricing and reimbursement consultancy founded as Palmer D'Angelo Consulting Inc (PDCI) in 1996. He leads a senior team of market access professionals with pricing & reimbursement engagements covering Canada, Europe, and the United States. In December 2006, PDCI became a subsidiary of RTI Health Solutions of RTP North Carolina where Neil served as global vice president before re-acquiring the company in 2009.

Prior to PDCI, Neil worked with the Canadian Patented Medicine Prices Review Board (PMPRB) where his responsibilities included policy development, overseeing the price review of patented medicines and conducting economic research. Prior to the PMPRB, he worked with the Health Division of Statistics Canada where he was responsible for economic and statistical analysis of health care costs and utilization.

After completing his studies at the University of Western Ontario, Neil began his career in Montreal with the research group of the Kellogg Centre for Advanced Studies in Primary Care.

He has written extensively on pharmaceutical pricing and reimbursement issues and is a frequent speaker at pharmaceutical conferences in North America and Europe.

Prof. Jeffrey Hoch

Co-Director, Applied Research in Cancer Control, Director, Pharmacoeconomics Research Unit, Cancer Care Ontario

Research Scientist, Li Ka Shing Knowledge Institute, St. Michael's Hospital

Associate Professor, Department of Health Policy, Management and Evaluation, University of Toronto

Jeffrey Hoch received his PhD in health economics from the Johns Hopkins School of Public Health. Dr. Hoch also holds a Masters in Economics from the Johns Hopkins University and a Bachelor of Arts degree in Quantitative Economics and Decision Sciences from the University of California at San Diego. Dr. Hoch has taught Health Economics and Economic Evaluation classes in Canada, the United States and internationally. Currently, Dr. Hoch is pursuing research on how to make health economics more useful to decision makers. Special interests include health services research related to cancer, mental health and other health issues affecting poor and vulnerable populations. Dr. Hoch is an award-winning teacher and is the recipient of a Career Scientist Award from the Ontario Ministry of Health and Long Term Care.

Paul Ledwell

Executive Vice President,
Public Policy Forum

Paul Ledwell joined the Public Policy Forum in April 2009. He brings to the Forum over 15 years leadership experience in policy, research, and public advocacy, and extensive work with partners in government, academe, private and voluntary sectors, and the media.

Previously, Paul served as President of the Institute on Governance, as the first Director of Government Relations at the University of Ottawa, as Executive Director of the Canadian Federation for the Humanities and Social Sciences and as the Chair of the Canadian Consortium for Research. He has provided senior leadership on national initiatives, including the National Dialogue on Higher Education and the Congress of the Humanities and Social Sciences. He has been a commentator in the media, an invited speaker to conferences in Canada and around the world, and has appeared before many parliamentary and other national committees on matters related to social and economic policy.

Internationally, Paul has been engaged on issues related to democratic development in Asia and the Middle East, and on innovation and higher education policy in the US and Europe.

Dr Eugene Vayda, D, FRCP, FACP

Canadian Cancer Action Network

Professor Emeritus;

A physician and cancer survivor;

Trained in Internal Medicine at University Hospitals of Cleveland and the Boston Veterans Hospital and as a postdoctoral fellow in epidemiology and health services research at Yale University;

Awarded a Milbank Foundation Faculty Fellowship in Community Health;

Joined the faculty of the new McMaster Medical School in Hamilton, Ontario, Canada as Professor of Clinical Epidemiology and Biostatistics and Medicine;

He then became Professor and Chairman of the Department of Health Administration and Associate Dean for Community Health at the University of Toronto.

Mark Ferdinand

Vice President, Policy Research & Analysis, Rx&D

Mark Ferdinand is Vice President of Policy Research & Analysis, leading pharmaceutical, health and economic policy development at Rx&D. Between 2005 and 2009, Mark was Vice President, Policy, Research, Regulatory and Scientific Affairs at Rx&D. Prior to assuming this role, he served as Rx&D's Director of Policy Development.

Before working at Rx&D, Mark advised senior federal Cabinet Ministers in both the Chrétien and Martin governments, and also worked as a federal public servant in the fields of Cabinet Affairs, economic and social policy development at the Atlantic Canada Opportunities Agency (ACOA), Human Resources Development Canada (HRDC) and Citizenship and Immigration Canada (CIC).

Mark started his professional career as a public servant at the Office of the Commissioner of Official Languages (OCOL). Mark is a graduate of the Faculty of Law of the University of Montréal and holds a Bachelor degree (First Class Honours) in Italian from McGill University.

During a long history of local volunteerism, Mark has served various constituencies, most recently as a member of the Advisory Committee of the Québec Educational Mathematics and Science Alignment Project (2007-2009) and as a member and then Chairperson of the Board of Directors of a community-based Legal Aid Clinic in Ottawa (1999-2003).

Theresa Marie Underhill

COO, Cancer Care Nova Scotia

Theresa Marie Underhill is a senior executive with experience managing complex organizations and initiating large scale projects to effective completion in all sectors within the health system. Ms Underhill is elected Chair of CAPCA (Canadian Association of Provincial Cancer Agencies). In her current role as COO, she directs strategic, operational planning and policy development. In addition to supervising day-to-day operations, she analyzes trends in both the cancer system and the broader health care sector to ensure CCNS is responsive and appropriate in its programs and activities. She provides national leadership and advice on issues related to cancer control, working closely with the Canadian Partnership Against Cancer and all provincial cancer agencies.

Theresa Marie brings to this position extensive experience in planning, policy development and program management in many aspects of the health system. Her past professional experiences include work with Health Canada, Atlantic Region, in the areas of policy, planning and intergovernmental relations. Committed to disease prevention, she has also chaired national committees on tobacco control and lifestyle modification. She holds both Bachelors and Masters degrees in Education from Dalhousie University and a Masters in Health Services Administration from the University of Alberta.

Connie Wong
Director, Pharmacy Benefits, Manulife

Connie Wong is Manulife's Director of Pharmacy Benefits for Group Benefits. Connie holds a Bachelor of Science in Pharmacy from the University of Toronto's Faculty of Pharmacy and is a practicing Pharmacist.

Connie started in Hospital Pharmacy where she specialized in Geriatric Care before moving to the retail sector where she managed a number of pharmacies for various large retail pharmacy chains. From there, Connie owned and operated her own independent pharmacy.

Connie then joined TELUS Health Solutions, Canada's largest Pharmacy Benefit Manager which manages the pharmacy benefits for 2 of the 3 largest Canadian insurers. At Telus, she sat on their Pharmacy and Therapeutics committee to evaluate new drugs for inclusion on managed care formularies. In the Pharmacy Services area, Connie's primary responsibilities were the design and development of drug formularies and ensuring their compliance with provincial regulations, as well as the development of cost-containment drug programs including the Prior Authorization program, Step Therapy and other cost-containment strategies.

Connie then moved into the Sales and Marketing area at TELUS Health Solutions as a National Account Executive where her focus was on Business Development.

Connie recently joined Manulife Financial in the capacity of Director of Pharmacy Benefits and over the coming months will be focused on product development and business development.

Mark Lievonen
President, Sanofi-Pasteur

Mark Lievonen is President of Sanofi Pasteur Limited and a member of the company's North American Board of Directors. He is responsible for all of the company's operations in Canada and serves on a number of Sanofi Pasteur's global operating committees.

Mr. Lievonen has been with the company since 1983. He started in the treasury department and was promoted to Corporate Vice President, Finance, in 1988. Since 1990, Mr. Lievonen has held a number of senior management positions, including responsibility for the company's commercial operations.

Prior to his appointment as President in March 1999, Mr. Lievonen was Senior Vice President and General Manager of the Oncology Business Unit. He was responsible for the strategy and funding of Sanofi Pasteur's Cancer Vaccine Program and the global marketing and sales of its cancer immunotherapeutic products.

Mr. Lievonen holds a BBA in accounting and an MBA in finance and marketing from the Schulich School of Business, York University. He is a Chartered Accountant and received his designation in 1981 while working with PricewaterhouseCoopers.

Mr. Lievonen is currently the Chair of the Board of the Ontario Genomics Institute and Vice-Chair of the Ontario Institute for Cancer Research and YORKbiotech. He is a member of the Board of Directors of Oncolytics Biotech Inc. and BIOTECanada, where he served as Chair from 2000 to May 2003. He was Chair of the Steering Committee for the BIO 2002 International Conference which was held in Toronto. He has also served on a number of industry and community boards and councils such as the BIOCouncil, an advisory group to the Government of Ontario in biotechnology, and as a member of the United Way of Greater Toronto Cabinet chairing the Health Care Division.

Peter Goodhand

President & CEO, Canadian Cancer Society

Peter Goodhand joined the Canadian Cancer Society in 2004 as the chief executive officer of the Society's Ontario Division. During that time, Mr Goodhand was instrumental in leading initiatives in organizational change that have benefited the Society across the country.

Mr Goodhand brings with him more than 20 years of international experience in the healthcare industry. Before joining the Society, he was the President and CEO of MEDEC, a national association of Canada's medical technology industry. In this role, he represented the industry to the Senate Committee and Romanow Commission on healthcare reform and at Canada's Innovation Summit.

In the private sector, his career included roles as vice president of sales and marketing and vice president of global marketing with leading healthcare companies.

Mr Goodhand has also worked with several not-for-profit organizations towards the goal of enhancing the overall performance of the healthcare system and ultimately improving the quality of patient care. Currently, he is the volunteer Chair of the Health Technology Exchange.

He became a patient advocate and caregiver as the result of his personal experience with cancer and its impact on his family.

Chris Bonnett

President, H3 Consulting

Chris Bonnett is President of H3 Consulting, which he established in 1999. H3 assists organizations in developing workplace health strategy, and provides health policy research and analysis, specializing in pharmaceuticals and the private sector. Chris is also co-founder and Editor of businesshealth, a publication that addresses employer issues and opportunities in health benefits and healthier workplaces

Prior to establishing H3, Chris enjoyed 18 years of progressive experience in the employee benefits industry. He sits on the national Advisory Board and has been the principal writer of the benchmark sanofi-aventis Healthcare Survey, now in its twelfth year. Over his career, he has interviewed leaders in the private and public sectors, organized and facilitated many Advisory Boards, and provided over seventy presentations and workshops across Canada and in the United States.

Chris has volunteered as a Board member for a small, rural hospital and a Toronto Community Health Centre, and served on an Executive Committee of the Ontario Hospital Association. He holds a Master's degree in Health Science from the University of Toronto, and has recently started work on a PhD in the Work and Health program at the University of Waterloo.

Appendix 2: Agenda

8:00 am – 8:30 am	**Breakfast**
8:30 am – 8:45 am	**Welcome, Introductions and Setting the Context** • Paul Ledwell, Executive Vice President, Public Policy Forum • Jack Shapiro, Chair, CCAN • David Mitchell, President & CEO, Public Policy Forum
8:45 am – 9:30 am	**Keynote Address and Q&A** Cancer Drugs – a journalist's reflections on the public dimensions of this issue • Andre Picard, Health Journalist, the Globe & Mail
9:30 am – 10:15 pm	**Overview of models to provide coverage for cancer drugs from various jurisdictions** • W. Neil Palmer, PDCI Market Access Inc.
10:15 am – 10:45 am	**Health Break**
10:45 am – 11:05 pm	**Building compromise through light or heat?** • Prof. Jeffrey Hoch, University of Toronto
11:05 am – 12:30 pm	**Panel Response: What learnings can apply across Canada?** Chair • Paul Ledwell, Executive Vice President, Public Policy Forum Panellists • Dr Gene Vayda, Canadian Cancer Action Network • Mark Ferdinand, Vice President, Policy Research & Analysis, Rx&D • Theresa Marie Underhill, COO, Cancer Care Nova Scotia • Connie Wong, Director, Pharmacy Benefits, Manulife
12:30 pm – 1:15pm	**Lunch**

1:15 pm – 2:45 pm	**Table Discussions** Participants will be assigned to 7 tables with 10-12 participants each. Each table will have an assigned facilitator and will discuss the same set of questions (below). After the break, a participant from each table will report on the responses to the three questions. *Canadians should have equitable access to cancer drugs. This means that all Canadians must be able to obtain, without financial hardship, the most promising drugs approved for their condition.* • ***Question 1:*** *What are the current obstacles to equitable access to cancer drugs?* • ***Question 2:*** *What structures and relationships need to be in place to achieve equitable cancer drug access?* • ***Question 3:*** *What immediate steps can each stakeholder group take to implement needed change?*
2:45 pm – 3:00 pm	**Health Break**
3:00 pm – 3:30 pm	**Report Back from Table Discussions** Each speaker will be given 3 minutes to summarize his/her table's responses to the three questions.
3:30 pm – 4:00 pm	**The value and cost of cancer drugs: a moderated discussion** • Mark Lievonen, President, Sanofi-Pasteur • Peter Goodhand, President & CEO, Canadian Cancer Society Moderator • David Mitchell, Public Policy Forum
4:00 pm – 4:10 pm	**Summary** • Chris Bonnett, President, H3 Consulting
4:10 pm – 4:15 pm	**Closing Remarks** • Paul Ledwell, Executive Vice President, Public Policy Forum

Appendix 3: Registered Participants

John Anacleto
Manager
Applied Management Consultants

Bruce Beamer
Bayer Inc

Tara Bingham
Government Affairs Manager, Federal
AstraZeneca Canada Inc

Catherine Black
Canadian Cancer Action Network (CCAN)

Alain Boisvert
Vice President
Novartis Pharmaceuticals Canada Inc

Chris Bonnett
President
H3 Consulting

Stephen Bornstein
Director
Centre of Applied Health Research
Memorial University of Newfoundland

Pamela Bowes
Manager, Program Development
Wellspring Cancer Support Foundation

Allison Bunting
Research Assistant
Public Policy Forum

Wayne Critchley
Senior Associate
Global Public Affairs

Carlo De Angelis
President
Canadian Association of Pharmacy in Oncology (CAPHO)

Aldo Del Col
Canadian Cancer Action Network (CCAN)

Pamela Delmaestro
Canadian Cancer Action Network (CCAN)

Dan Demers
Canadian Cancer Society

Jeremy Depow
Senior Policy Strategist
Pfizer Canada Inc

John-Paul Dowson
Senior Manager
AstraZeneca Canada Inc

Philip Emberley
Director, Pharmacy Innovation
Canadian Pharmacists' Association

Mark Ferdinand
Vice President
Canada's Research-Based Pharmaceutical Companies (Rx&D)

Bryan Ferguson
Partner
Applied Management Consultants

Anthony Fuchs
Canadian Cancer Society

Kim Furlong
Director, Federal Government Affairs
AMGEN Canada Inc

Scott Gavura
Director, Provincial Drug Reimbursement Programs
Cancer Care Ontario

Geneviève Giroux
Politiques de santé et remboursement
Novartis Pharmaceuticals Canada Inc

Peter Goodhand
President and Chief Executive Officer
Canadian Cancer Society

Dianne Gravel-Normand
Senior Project Administrator
Public Policy Forum

Martha Harczy
Manager - BMORS - Oncology Division
Health Canada

Sarah Hicks
Director of Communications
Canadian Partnership Against Cancer

Prof. Jeffrey Hoch
Professor
University of Toronto

Christine Jackson
Executive Director
Canadian Skin Patient Alliance

Gerry Jeffcott
Principal Consultant
Health and Pharmaceutical Consulting

Birthe Jorgensen
Director
Government of Ontario

Kong Khoo
Medical Oncologist and Vice Chair
Cancer Advocacy Coalition of Canada

Leanne Kitchen-Clarke
Vice-President, Performance Measures and Communications
Canadian Partnership Against Cancer

Paul Ledwell
Executive Vice President
Public Policy Forum

Charlene Lee
Manager, Health Economics and Access
Janssen-Ortho Inc

Christine Lennon
Head, Health Policy and Reimbursement
Novartis Pharmaceuticals Canada Inc

Kevin Leshuk
General Manager
Celgene

Aaron Levo
Assistant Director, National Public Issues
Canadian Cancer Society

Mark Lievonen
President
Sanofi Pasteur Ltd.

Shirley MacLeod
Canadian Cancer Action Network (CCAN)

Jill Magis
Health Environment Specialist
Great-West Lifeco Inc.

Stewart McMillan
Board Chairman
Saskatchewan Cancer Agency

Jackie Manthorne
Chief Executive Officer
Canadian Breast Cancer Network

Deborah Maskens
Canadian Cancer Action Network (CCAN)

Lorena McManus
Canadian Cancer Action Network (CCAN)

Lisa Mineo
Manager, Health Benefits
Canadian Life and Health Insurance Association Inc

David Mitchell
President and Chief Executive Officer
Public Policy Forum

Marjorie Morrison
Executive Director
Canadian Cancer Action Network

Debbie Murray
Director, Policy Development
Canada's Research-Based Pharmaceutical Companies (Rx&D)

Jason Muscant
Manager, Public Policy, Advocacy and External Communications
Canadian Diabetes Association

Tanny Nadon
Canadian Cancer Action Network (CCAN)

Rob Nuttall
Canadian Cancer Society

W. Neil Palmer
Principal
Palmer D'Angelo Consulting Inc

Kathleen Perchaluk
Canadian Cancer Society

André Picard
Health Journalist
The Globe and Mail

Jean Pruneau
A/Executive Director
Health Canada

Dvorah Richler
Senior Manager Oncology
AMGEN Canada Inc

Frank Richter
Research Associate
Public Policy Forum

Sue Robson
Canadian Cancer Action Network (CCAN)

Barbara Rotter
Director, Bureau of Metabolism, Oncology, and Reproductive Science
Health Canada

Mona Sabharwal
Executive Director
Pan-Canadian Oncology Drug Review

Colleen Savage
President and Chief Executive Officer
Cancer Advocacy Coalition of Canada

Kathryn Seely
Canadian Cancer Society

Jack Shapiro
Chair
Canadian Cancer Action Network (CCAN)

David Shum
Director
Hoffmann-La Roche Ltd

Helen Siomos
Manager, Market Access
Bristol-Myers Squibb Canada Inc

Ellen Snider
Canadian Cancer Society New Brunswick

Ron Soreanu
Account Director
Hill and Knowlton Ottawa

Laura Thorpe
Strategic Partnership Manager, Ontario
Eli Lilly Canada Inc

David Tremblay
Manager, Stakeholder Relations - Oncology
Novartis Pharmaceuticals Canada Inc

Sabrina Tremblay
Senior Manager, Public Affairs
Bristol-Myers Squibb Canada Inc

Leslie Turcotte
Director, Stakeholders and Partnerships
Canada's Research-Based Pharmaceutical Companies (Rx&D)

Theresa Marie Underhill
Chief Operating Officer
Cancer Care Nova Scotia

Gene Vayda
Canadian Cancer Action Network (CCAN)

Phil von Finckenstein
Principal
PvF Consulting

Bridget Wells
Director, Regional Government Relations and Health Policy
Hoffmann-La Roche Ltd

Liz Whamond
Canadian Cancer Action Network (CCAN)

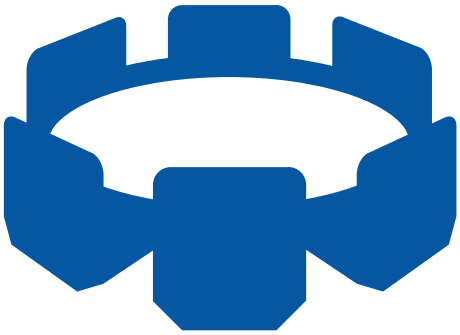
Connie Wong
Director, Pharmacy Benefits
Manulife Financial

Acknowledgements

Thank you to our partners:

CCAN RCLC
Canadian Cancer Action Network
Réseau canadien de lutte contre le cancer

Canadian Cancer Society
Société canadienne du cancer



Public Policy Forum
Forum des politiques publiques

ppforum.ca