Ministère de la Santé et des Services sociaux

Direction générale du personnel réseau et ministériel

CC-ARCC
Plenary conference:

Sustainability: Issues for the Health System with a focus on Cancer

Chantal Kroon, B.Sc.Inf, M.A., Conseillère cadre
Direction de la planification de la main d'œuvre et du soutien au changement

25 mai 2015

Québec

Challenges for the health and social services related to cancer

- **Increase in the overall number of cancer patients;**
- **Increase in the number of elderly patients;**
- **Availability of human, material and financial resources**

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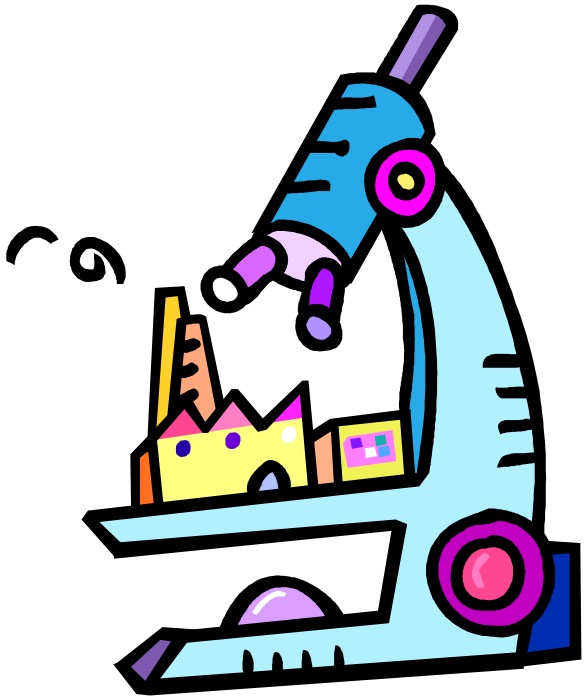
A few observations



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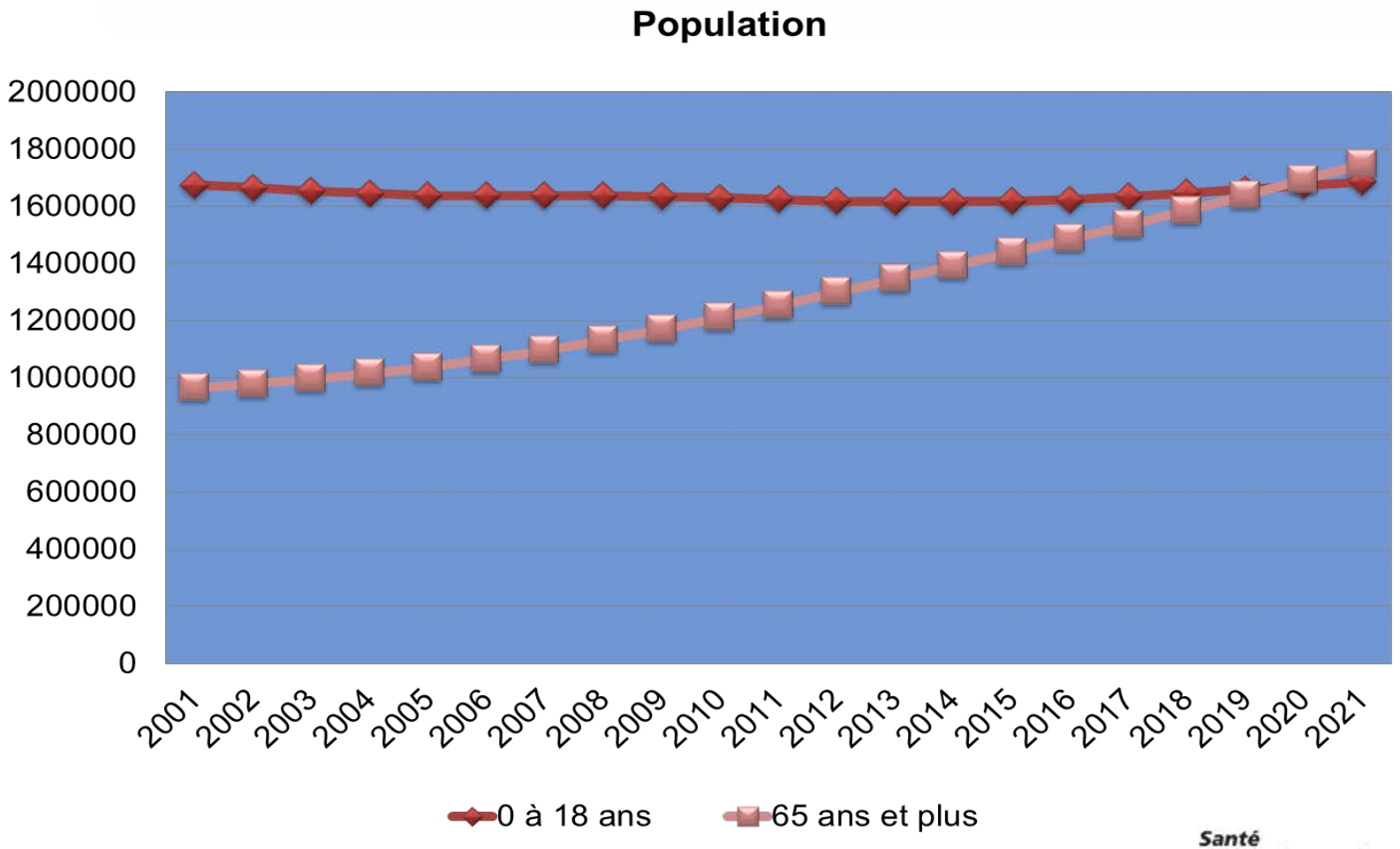
Past and yet to come



Québec Province, 2011

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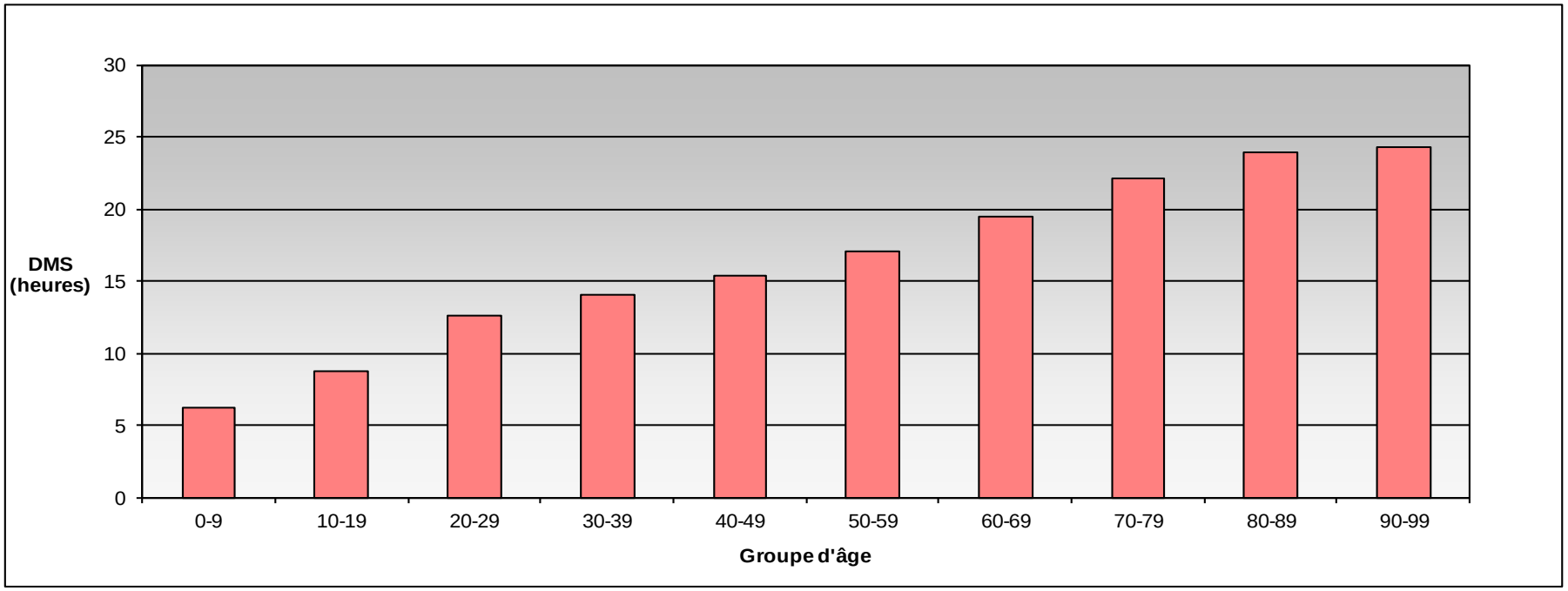
Length of stay of patients per age group, Gurneys in emergency departments Province of Québec (2010-2011)



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- **Not true for every emergency department: some manage to have similar LOS no matter what age group**

- **LOS data by age groups tend to be (unfortunately for the elderly) similar from one year to another**

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Impacts when elevated LOS on gurneys in emergency departments

Overcrowding will induce:

- Risk of nosocomial infections;
- Sleeping related problems;
- Risk of developping geriatric syndrome (eg. Immobility… and pressure ulcers, delirium, incontinence, etc);

- Overtime for staff

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Reduced or insufficiant access and no surcapacity

upstream or downstream from EDs

=

OVERCROWDING in ED

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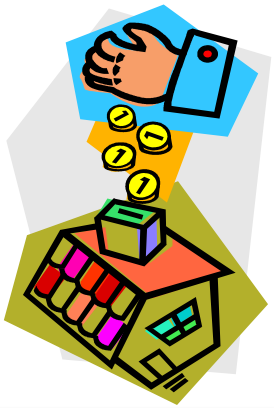
All these limited accesses… costing more $$$ and worforce energy

Paying for costly services delivered at the wrong place for the patient's needs



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After working so hard to stabilize the cancer problems!

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Québec

Obstructions in the flow: a few illustrations and explanations

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Springbreak for the lucky ones

Québec

Springbreak 2015: the day after… 09h00 AM people waiting in the corridor for the lab's waiting room

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On that same morning:

Hemato oncologists, amongst other specialists,

had to wait an extra 2 hours before their patients' results came in…

The patients were waiting in another corridor to get to the hemato oncology waiting room…

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Flow problems explained by

- **Difficult access to specialized services:**
  - **ED :**
    - **Specialist consultations;**
  - **Hospitalization :**
    - **Blocked beds:**
      - **Nosocomial infections;**
      - **Vacations / Holidays;**
      - **Budget constraints;**
      - **Prolonged LOS related to**
        - **Internal processes**
        - **Acess to external services.**

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Flow problems explained by

- **Difficult access to specialized services:**
  - Lab and/or radilogy dptm
  - Ambulatory / external specialized clinics
- **Difficult access to services in the com**
  - Primary Care
  - Home care
  - Convalescence
  - Rehab

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Are there some solutions???

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Access

- **<u>Primairy care</u>:**

- Info-Santé (dial 811)
- GMF and network clinics
- Homecare
- Palliative and end of life care
- Community settings and organizations, associations (ex. SCC,…)

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Access

- Specialized services(Radiology and labs, ED
- Liaison & « infirmières-pivot en oncologie »
- Access to specialists & preparation before the consultation

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Continuity

- **« Infirmières-pivot en oncologie » aka Cancer nurse coordinator, Pivot Nurse**
- **Liaison**
  - **(ex. liaison nurse in the hospital)**
- **GP-specialist-GP**

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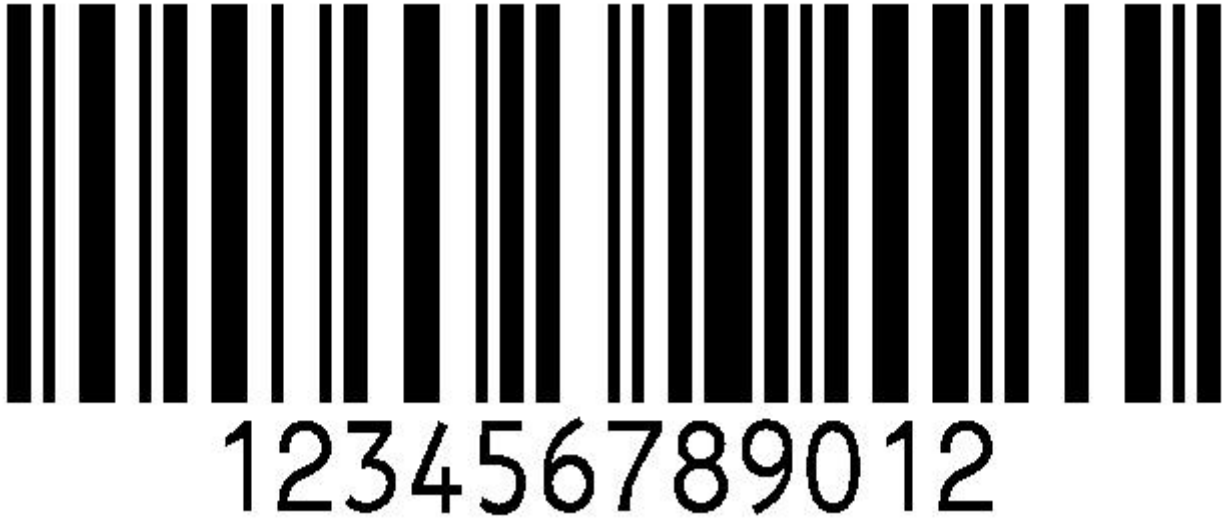
Diffficulties that are characteristic to each organization



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Diffficulties that are characteristic to many or most organizations

Will call for systemic measures

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Planning for services:

A link between needs and services in oncology:

A few examples

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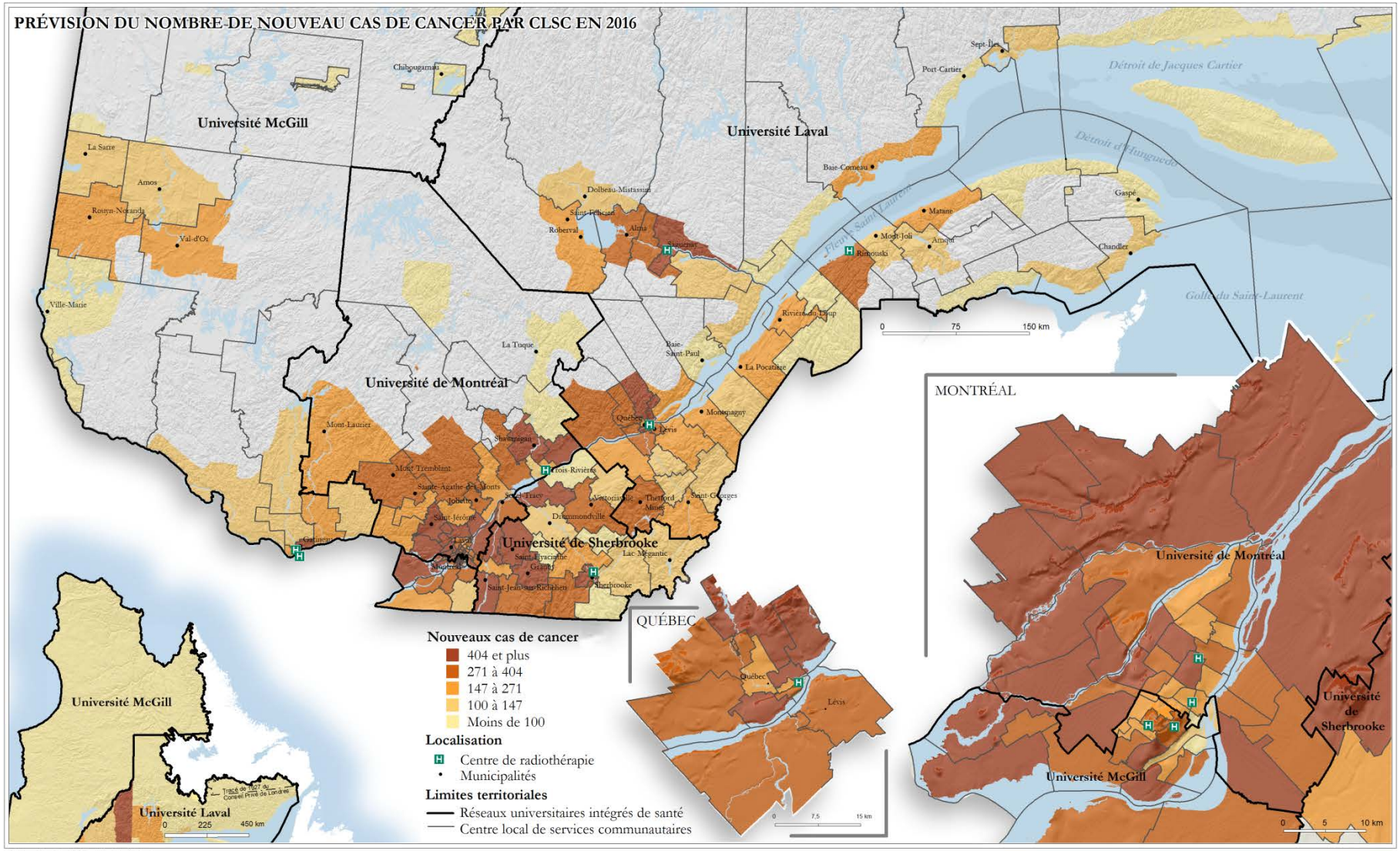

Guillaume Fontaine, ASSS de la Capitale-Nationale
Direction de la gestion intégrée de l'information,
Direction générale adjointe aux ententes de gestion,
Ministère de la Santé et des Services Sociaux, Avril 2012

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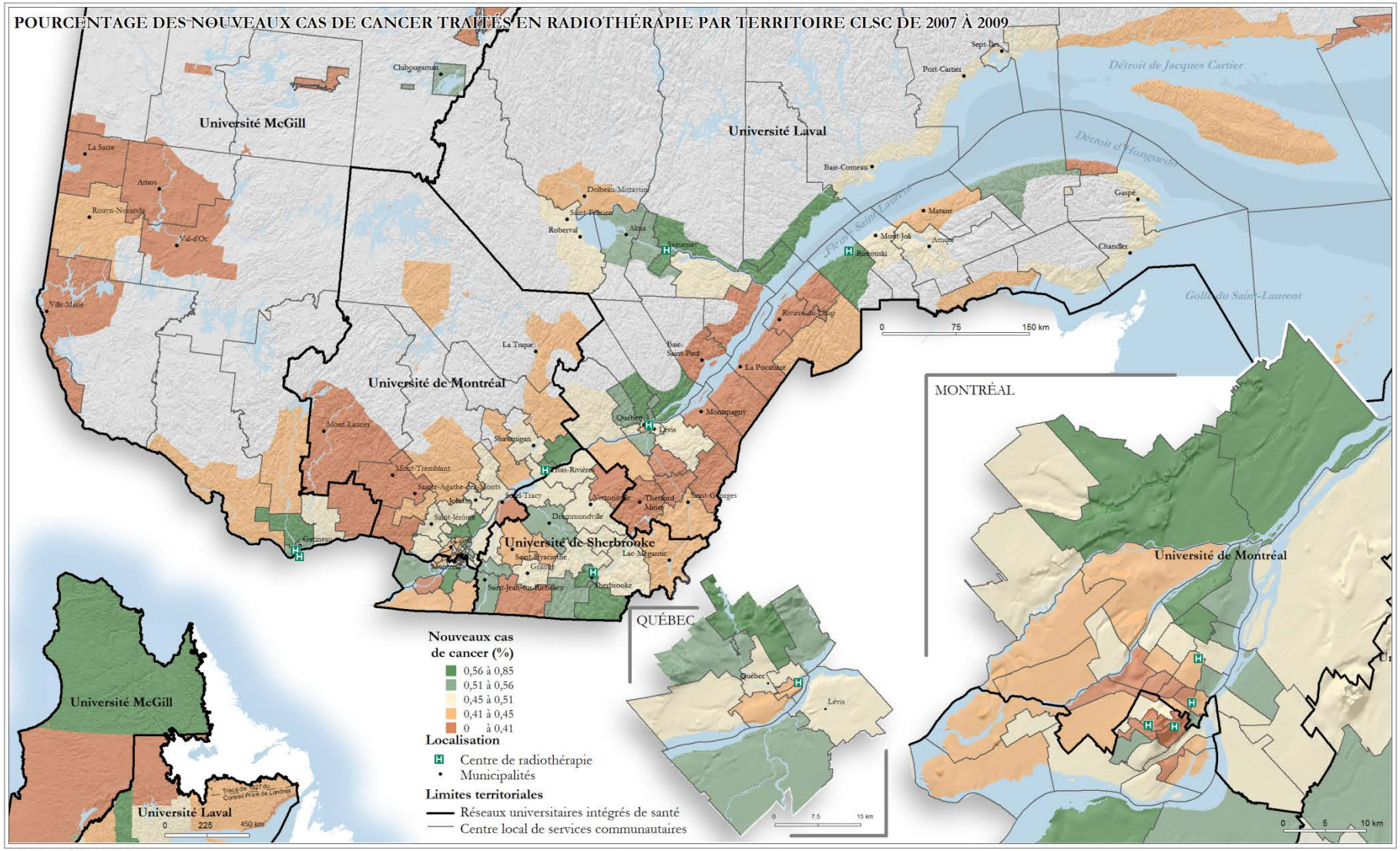
Sources : Fichiers cartographiques, MRNF
Limites territoriales des RUIS et des CLSC, MSSS, 2011
Projections des nouveaux cas de cancer, SDET, MSSS



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Limites territoriales des RUIS et des CLSC, MSSS, 2011
Projections des nouveaux cas de cancer, SDET, MSSS

Workforce planning

- Portraits for different job titles and projections (quantitative) :
  - Data from the pay system on a historical basis
  - Prepared on a yearly basis

- Local plans with estimated needs(qualitative): obligation for the health autorities to renew their evaluation and actions every year

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Regional workforce planning

Plan de main-d'œuvre 2014-2015

SOMMAIRE DES PLANS DE MAIN-D'ŒUVRE RÉGIONAUX

Titres d'emploi / Région / Agence	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
1. Audiologiste	01	02	03	04	05	06	07	08	09		11	12	13	14	15	16
2. Ergothérapeute	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
3. a) Infirmière clinicienne bachelière	01				06				09	10	11	12	13	14	15	
Infirmière praticienne												12				
b) Infirmière technicienne (DEC)	01				06				09	10	11	12	13	14	15	
Infirmière (global)	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
4. Infirmier auxiliaire	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
5. Inhalothérapeute	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
6. Orthophoniste	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
7. Pharmacien d'établissement	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
8. Physiothérapeute	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
9. Préposé aux bénéficiaires	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
10.Psychologue	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
11.Technologiste médical	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
12.Travailleur social (Diplômé travail social)	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16

SOMMAIRE POUR LES AUTRES TITRES D'EMPLOI À SOUTENIR RÉGIONALEMENT

Autres titres d'emploi / Région / Agence	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
Agent administratif (secrétariat)	01	02	03	04	05		07	08	09			12	13	14	15	16
Agent administratif (administratif)	01	02	03	04	05			08	09			12	13	14	15	16
Agent d'intervention				04				08								
Agent de relation humaine	01	02		04	05		07	08	09			12			15	16
Archiviste médicale							07	08								
Assistant technique pharmacie			03	04				08	09			12				
Assistant en réadaptation																
Auxiliaire aux services de santé et sociaux	01		03	04	05			08				12			15	
Cytologiste								08								
Diététiste-Nutritionniste		02					07	08				12				
Hygiéniste du travail																
Métier (plombier, électricien, etc.)	01	02	03		05			08	09					14	15	16
Psychoéducateur	01	02		04	05							12				
Responsable d'unité de vie et/ou de réadaptation																
Secrétaire médicale	01	02	03		05			08				12	13	14	15	16
Spécialiste en activités cliniques																
Spécialiste en orientation et en mobilité		02	03													16
Spécialiste en réadaptation en déficience visuelle		02	03													16

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Workforce planning

- **Analysis of estimated needs are shared with partners:**
  - Different sectors inside the health and social services ministry
  - Education ministry
  - Local health and social services authorities
  - Associations and unions
- **Partnership towards identifying actions to implement and evaluate the results obtained**

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Some human resources objectives

- Having sufficient quantities of personnel
- Making sure that new recruits possess expertise and skills
- Offering continuus training (updates, specialization)
- Supporting organizations in changes that must be implemented

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Answers to worforce specific needs for the cancer system

- Specialization of an existing category of medical archivists :
  - Oncology registrar (priority given to a college level specific training in our provincial continuus training plan)

- Medical Physicists & radio-oncology technicians:
  - Plan 2008-2013 carried out ≈ equilibrium for these two job titles

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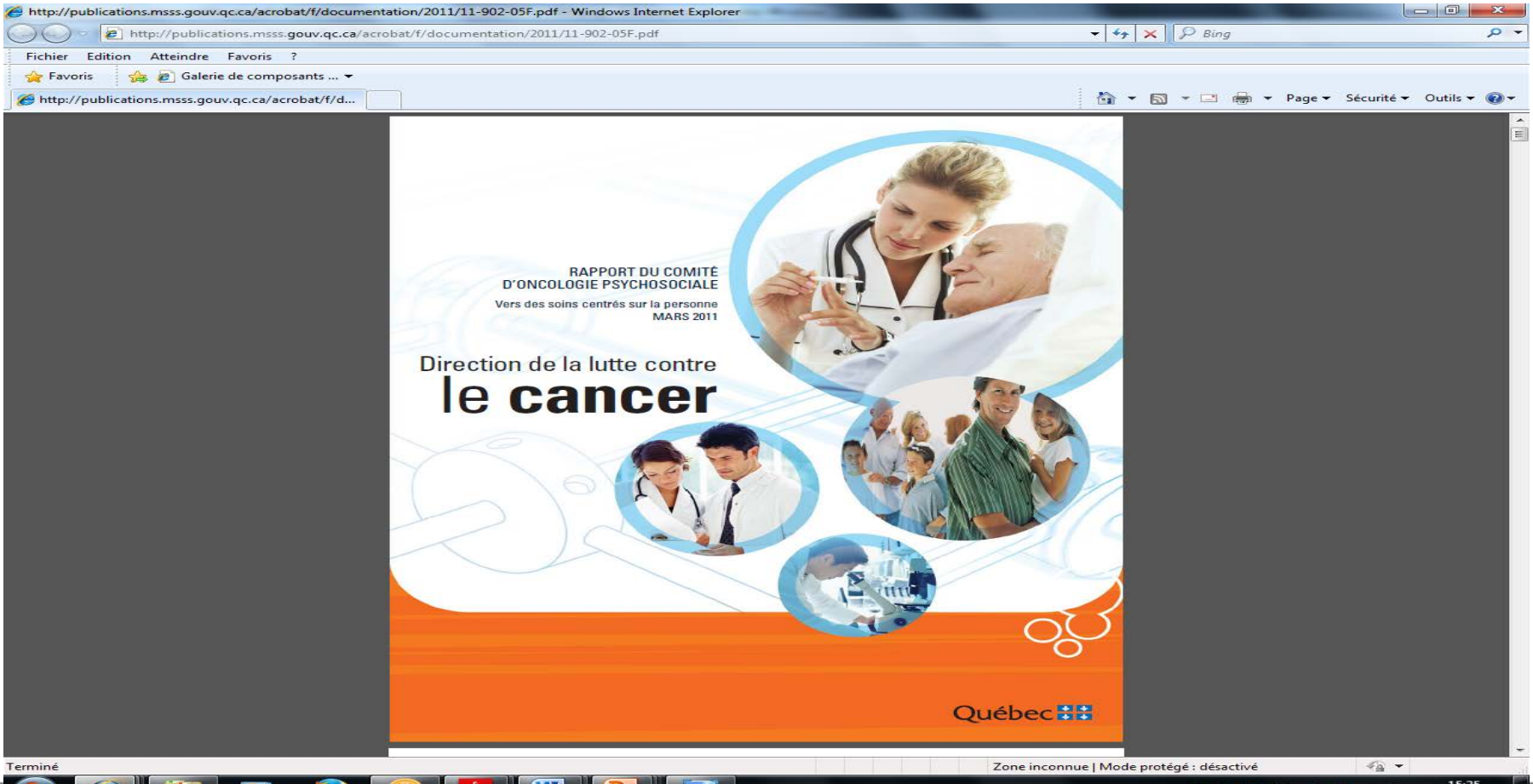
Expertise development and support towards change

- Guides, tools:



Other solutions: examples

- Bursaries for professional studies;

- Télé-medecine: support towards developping this field

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Other solutions: examples

Encouraging work organization and process reviewing (ex. Lean, Six Sigma…)

CSSS Chicoutimi:

- ↑ patients treated in hemato-oncology;

CSSS Lanaudière Nord:

- Waiting time reduction for ambulatory tx in hemato-oncology by identifying and removing some non added value activities (NVA) in the treatment room;

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Other solutions: examples

Encouraging work organization and process reviewing (ex. Lean, Six Sigma…)

CSSS Laval:

- Improving access to new consults in hemato-oncology

CHU-Sherbrooke:

- Process reviewing for the Programme Québécois de Dépistage du Cancer Colo Rectal (PQDCCR) in order to increase efficiency and meet the planned costs structure.

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Issues and lessons learned

Of great importance:

- **Implicating patients in steering and other comitees implcated in changing processes;**
- **Foreseeing impacts of change on other services given upstream or downstream ($$, moving bottlenecks elsewhere or creating new ones…);**
- **Implicating the right actors at the right moment, and going with the champions;**
- **Planning sustainability for new measures that are implemented.**

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Other solutions: exemples

Primary care

- Post acute pre-determined pathways
- Professionals available in GP clinics
- Access to GPs prioritized for cancer patients who are without a GP, and capacity to see him/her (attendance rate measurement)

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Other solution: examples

- **Initial training**
  - Updating programs by including more contents in cancerology

- **Continuus training**:
  - Palliative and end of life care
  - Pivot nurse in oncology (Webinars)
  - Adapted approach for hospitalized elderly patients

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Prospects for the future

Interdisciplinarity

that transcends

organizational boundaries

and different networks

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Prospects for the future: improbable friends

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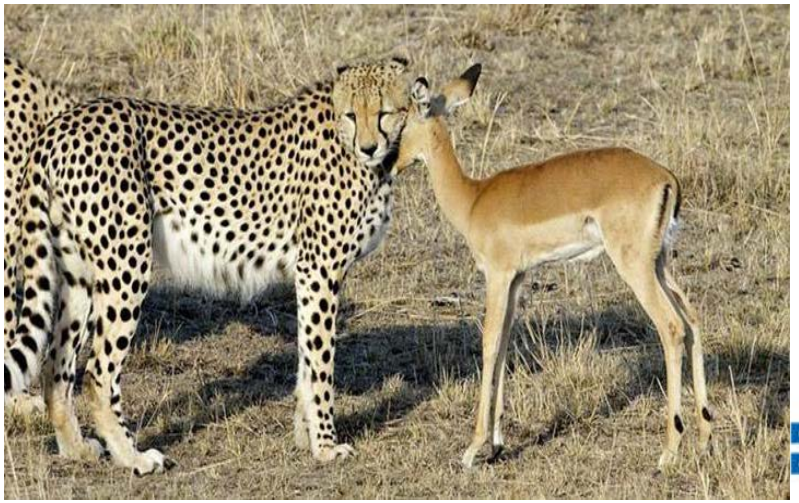
Unlikely or unusual friends?



Other networks:

Mental health;

Geriatricians and geriatric multidisciplinary teams:

- **For guidance, scientific support and knowledge transfer :**
  - **Choice of treatment /evaluation of its potential impacts in terms of frailty and autonomy**

Ethics specialists:

- **For difficult issues to face and decision making**

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Special thanks to

MSSS

- Dr Jean Latreille
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- Mme Brigitte Laflamme
- Mme Régina Lavoie
- M. Jacques Rhéaume
- M. Charles Madet
- Mme Marika Harbour
- M. Gilles Lebeau

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For the invitation and support towards the organization of this conference

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And thank you!

chantal.kroon@msss.gouv.qc.ca

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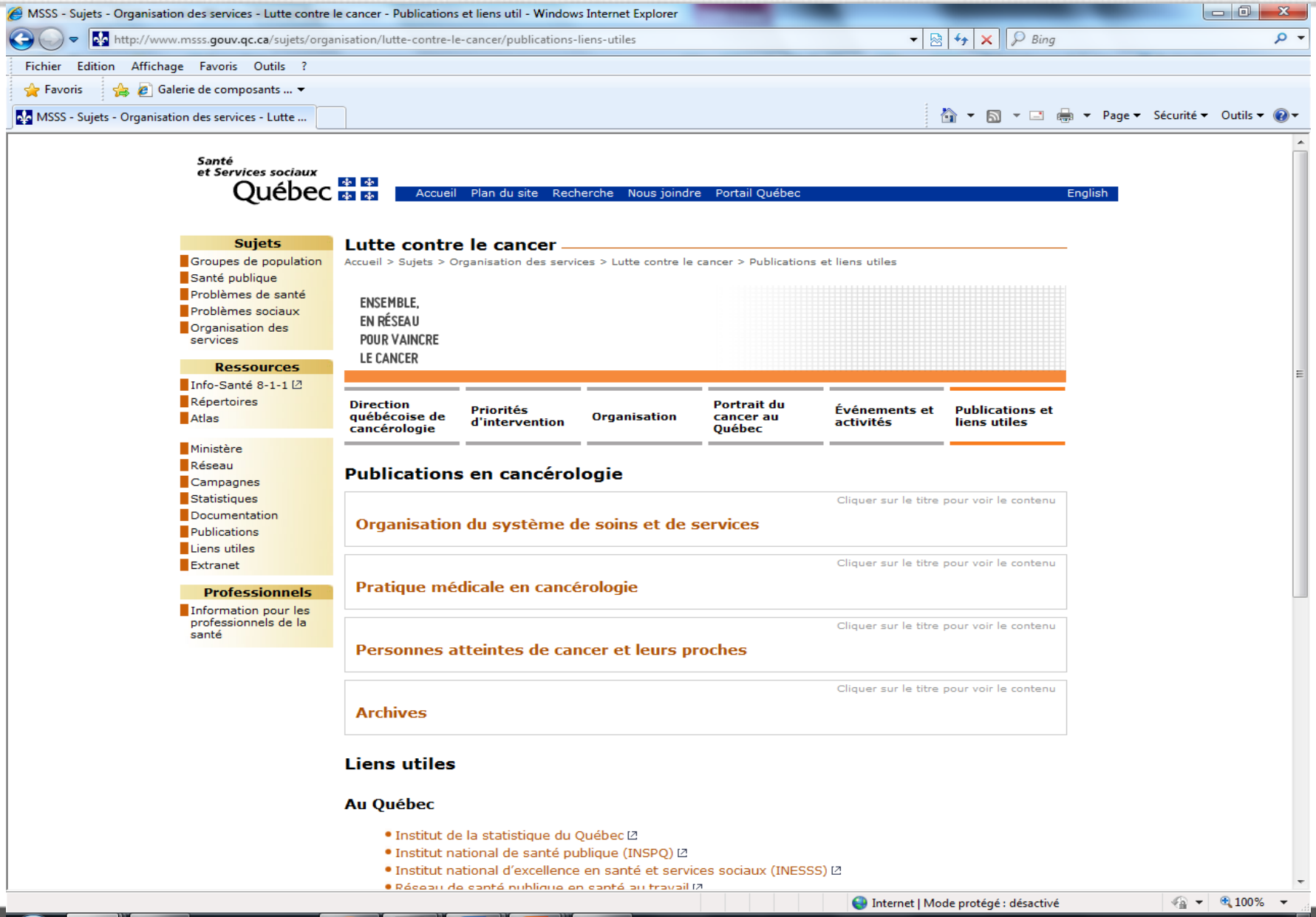
Some useful references

Direction québécoise de la cancérologie + statistics:

http://www.msss.gouv.qc.ca/sujets/organisation/lutte-contre-le-cancer/

Formation infirmières pivot

http://www.msss.gouv.qc.ca/professionnels/cancer/infirmieres-pivots.php


MSSS - Sujets - Organisation des services - Lutte contre le cancer - Publications et liens util - Windows Internet Explorer
http://www.msss.gouv.qc.ca/sujets/organisation/lutte-contre-le-cancer/publications-liens-utiles
Bing
Fichier Edition Affichage Favoris Outils ?
Favoris
Galerie de composants ...
MSSS - Sujets - Organisation des services - Lutte ...
Page Sécurité Outils
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Répertoires
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Réseau
Campagnes
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Liens utiles
Extranet
Professionnels
Information pour les professionnels de la santé
Lutte contre le cancer
Accueil > Sujets > Organisation des services > Lutte contre le cancer > Publications et liens utiles
ENSEMBLE, EN RÉSEAU POUR VAINCRE LE CANCER
Direction québécoise de cancérologie
Priorités d'intervention
Organisation
Portrait du cancer au Québec
Événements et activités
Publications et liens utiles
Publications en cancérologie
Cliquer sur le titre pour voir le contenu
Organisation du système de soins et de services
Cliquer sur le titre pour voir le contenu
Pratique médicale en cancérologie
Cliquer sur le titre pour voir le contenu
Personnes atteintes de cancer et leurs proches
Cliquer sur le titre pour voir le contenu
Archives
Liens utiles
Au Québec
Institut de la statistique du Québec
Institut national de santé publique (INSPQ)
Institut national d'excellence en santé et services sociaux (INESSS)
Internet | Mode protégé : désactivé
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Some useful references

- ***Enquête québécoise sur la qualité des services de lutte contre le cancer 2013 - L'infirmière pivot en oncologie et l'expérience patient***, Institut de la statistique du Québec (ISQ) 2014

  http://www.stat.gouv.qc.ca/statistiques/sante/services/cancer/qualite-cancer_experience_patient.html

- ***Formulaire d'évaluation initiale du client suivi en oncologie***, Ordre des infirmières et Infirmiers du Québec (OIIQ) 2013:

  https://www.oiiq.org/publications/repertoire/formulaire-devaluation-initiale-du-client-suivi-en-oncologie

- ***Patient Navigation: An Update on the State of the Science*** Paskett, E. D., J. P. Harrop, et al. (2012). CA Cancer Journal for Clinicians 61(4): 237-249

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Sustaining optimal care:
When are circumstances truly exceptional?

Raghu Rajan

MONTREAL GAZETTE

PRUST STARTS HOPELESS FIGHT

Challenging ref a very bad idea: Todd **C1**

CELEBRATING A BLOODLINE

Carlene Carter pays tribute **A14**

TUESDAY, MAY 5, 2015 • SINCE 1778 POSTMEDIA

NEWS

TRANSPORT

Battle throttles up over electric car sharing in the city **A3**

JUSTICE

Privacy of

Quebec is denying access to better lymphoma drugs

KAREN SEIDMAN
MONTREAL GAZETTE

When Jean-Pierre Garneau was diagnosed with non-Hodgkin lymphoma in the spring of 2007, he prayed that researchers would come up with a treatment that could give him a better chance of surviving the life-threatening blood cancer.

They did. But imagine Garneau's bewilderment and anguish upon discovering that, as a Quebec resident, he is living in the only province in all of Canada that won't pay for the drug cocktail — bendamustine/rituximab (BR) — and won't even consider it for approval.

"There is a treatment that improves survival and quality of life," Garneau said from his home in Blainville on Monday. "It was the good news I was hoping for — but I don't have access to this treatment in Quebec."

Doctors here have actually counselled patients from other provinces to return home in order to obtain BR, which is widely recognized to double life expectancy for indolent NHL patients. A study presented at the world's leading conference for hematologists last December showed that patients using BR can hope to enjoy at least five more years compared with the usual treatment, known as R-CHOP. And newly diagnosed patients can expect six years without progression of the illness.

SEE LYMPHOMA ON **A4**

MONTREAL GAZETTE

TOP OF PVM GETTING A FACELIFT

Observatory, restaurant to open in '16 A3

SHATTERING THE MYTH

Up-close look at Cobain's life C1

FRIDAY, MAY 8, 2015 • SINCE 1778 POSTMEDIA

NEWS

PROPOSAL

Projet wants a Ste-Catherine of terrasses, open areas A2

Breast cancer drug denied

Quebec remains the only province that is refusing funding for Perjeta

KAREN SEIDMAN
MONTREAL GAZETTE

Jennifer Jones should have a lot to celebrate Friday on her birthday.

Her stage four breast cancer has been kept at bay with the help of a new drug, Perjeta, and she has been well enough to work and keep up with her activities.

But she was approaching her birthday this week with a heavy heart because her private health insurance will end once she turns 65 on Friday. And the drug she credits with improving her chances of survival has not yet been approved in Quebec — the only province in the country still not funding Perjeta for stage four breast cancer patients.

"I see this as a fight for everybody," Jones said during an emotional interview on the eve of her birthday. "If these are the government's cost-cutting measures, it makes no sense. It would cost a lot more to keep me in a hospital bed, but with this drug I'm working and well."

Perjeta, which is used in conjunction with Herceptin and docetaxel to treat patients with HER2-positive metastatic breast cancer (MBC) — a disease associated with aggressive tumour growth and poor clinical outcome — was approved by Health Canada in 2012.

SEE DRUGS ON A6

Management of anticancer treatments in Quebec

- Anticancer agent formulary not separate
  - Same mechanism as for other agents
- Outpatient and inpatient/clinic handled differently
  - Leads to some variation between centers
- This framework may shed light on appropriate exceptions to standard management

Non-formulary requests

- Hospital formulary
  - Pharmacist-in-chief responsible in consultation with the pharmacy and therapeutics committee (P&T) – reports to CPDP (council of physicians, dentists and pharmacists)
- Non-formulary (NF) requests
  - May be made by clinicians when deemed appropriate for a particular patient

Non-formulary requests

- Authorization of requests
  - By CPDP, granted to P&T
- Historically requests generally approved
- Increasing number of requests (40-50/month), much higher acquisition costs

Non-formulary requests

- More structured process developed for evaluation of NF requests
  - triaged by secretary of P&T (pharmacist)
  - Reviewed by chair of P&T (physician) and pharmacist-in-chief
  - Also reviewed by director of professional services (physician) if request declined or difference of opinion

Approved by INESSS

Drug requested	Health Canada status	Requested indication status in Canada	Provincial drug formulary / INESSS status	MUHC RECOMMENDATION
Drug approved in Canada and INESS for the indication	APPROVED	As per Canadian Drug monograph	APPROVED	- Drug already available on the MUHC Drug formulary have been considered - Request for drugs on the regular RAMQ list will be approved - Request for drugs on the Médicament d'exception list - Will be approved if meets the RAMQ criteria

Not yet evaluated by INESSS

Drug requested	Health Canada status	Requested indication status in Canada	Provincial drug formulary / INESSS status	MUHC RECOMMENDATION
Drug approved in Canada, but not yet evaluated by INESSS for the indication	APPROVED	As per Canadian Drug monograph	Not evaluated Or Ongoing evaluation (decision from INESSS not available at the time of request)	Case by case evaluation The request must be reviewed at a departmental meeting (Tumor Board for example) before submission.

Trastuzumab emtansine

- Phase III study for second line treatment in metastatic breast cancer
- Showed significant overall survival advantage (30.9 vs 25.1 months)
- Requested prior to INESSS evaluation

Rejected by INESSS

Drug requested	Health Canada status	Requested indication status in Canada	Provincial drug formulary / INESSS status	MUHC RECOMMENDATION
Drug approved in Canada but REJECTED by INESSS for the indication	APPROVED	As per Canadian Drug monograph	Rejected by INESSS	Request will likely be declined

Cabazitaxel

- For metastatic castrate-resistant prostate cancer
- Significant overall survival benefit (15.1 vs 12.7 months) in phase III trial in second line
- Rejected by INESSS on pharmacoeconomic grounds

Approved for other indication

Drug requested	Health Canada status	Requested indication status in Canada	Provincial drug formulary / INESSS status	MUHC RECOMMENDATION
Drug approved in Canada but NOT for the requested indication	APPROVED for other indications	Not as per Canadian Drug monograph	Will NOT be evaluated by INESSS	Case by case evaluation The request must be reviewed at a departmental meeting (Tumor Board for example) before submission. Research protocol option should be considered

Bendamustine

- Approved by INESSS for CLL
- Requested for relapsed Hodgkin lymphoma – not evaluated by INESSS for this indication
- Phase II evidence showing activity in heavily pretreated patients

Drug not commercialized in Canada

Drug requested	Health Canada status	Requested indication status in Canada	Provincial drug formulary / INESSS status	MUHC RECOMMENDATION
Drug NOT commercialized in Canada (Special Access Program)	NO	N/A	Will not be evaluated by INESSS	Case by case evaluation The request must be reviewed at a departmental meeting (Tumor Board for example) before submission. Patient should sign consent form Research protocol option should be considered

Ramucirumab

- phase III trial for metastatic gastric cancer
- Significant overall survival benefit (9.6 vs 7.4 months) when combined with paclitaxel compared with paclitaxel alone
- FDA-approved
- Compassionate use program by manufacturer

Unique circumstances?

- Approved based on ECOG PS of patients in study – gefitinib for lung cancer
- New agent approved for first-line treatment - initial use in later lines of treatment – bevacizumab for colorectal cancer
- Approved for first-line only in metastatic setting, however the alternative first-line treatment already given as adjuvant treatment – paclitaxel nanoparticle for pancreatic cancer

Unique circumstances?

- Rare disorder, unlikely to be evaluated by INESSS
- Approved for one malignancy, recognized as effective in another but Health Canada approval not sought
- Non-approved treatment with clear efficacy commenced in other jurisdiction, wishes to continue

Perspectives

- Clinician/department
  - Signature from chief of division
  - Discussion at tumour board
- Patient
  - Reactions to refusals of requests
- Manufacturer
  - Potential influence on clinicians

Perspectives

- CPDP/P&T
  - Emphasis on evidence of clinical benefit
- Pharmacy/administration
  - Drug budget 10 - 12% overall budget
  - Oncology drugs approximately 40% of drug budget
  - Approximately 10% represented by NF requests
  - Potential for budget adjustments limited
  - Agent rejected by INESSS generally not reimbursed
  - Concern re: referrals from other institutions

Alternative strategies

- The Programme de gestion therapeutique des medicaments (PGTM) is an initiative of the five Quebec teaching hospitals
- Potential to approach the government to revisit certain funding decisions
- A more centralized evaluation of NF requests being considered – possibly involving INESSS and/or PGTM

Request for patient with lymphoma

- 63 year old man with follicular lymphoma for first line bendamustine/rituximab
- Single agent bendamustine approved by INESSS, however combination not approved
- Combination not evaluated by INESSS as is not Health Canada approved
- Combination approved by pCODR in view of net clinical benefit observed in clinical trials

Request for patient with breast cancer

- 60 year old woman with metastatic breast cancer for pertuzumab in first line
- 6 month survival benefit seen in RCT for first line treatment when pertuzumab added to docetaxel/trastuzumab
- Rejected by INESSS on basis of cost-effectiveness

Conclusions

- A mechanism to evaluate medication requests for exceptional circumstances is necessary for optimal patient care
- The appropriate degree of latitude cannot be strictly defined

ARCC
Canadian Centre
for Applied Research
in Cancer Control

Why don't we ever DE-list anything?

Craig Earle, MD MSc FRCPC

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

a place of minc
UBC

Canadian Cancer Society
Société canadienne du cancer

UNIVERSITY OF TORONTO

Cancer Care Ontario
Action Cancer Ontario

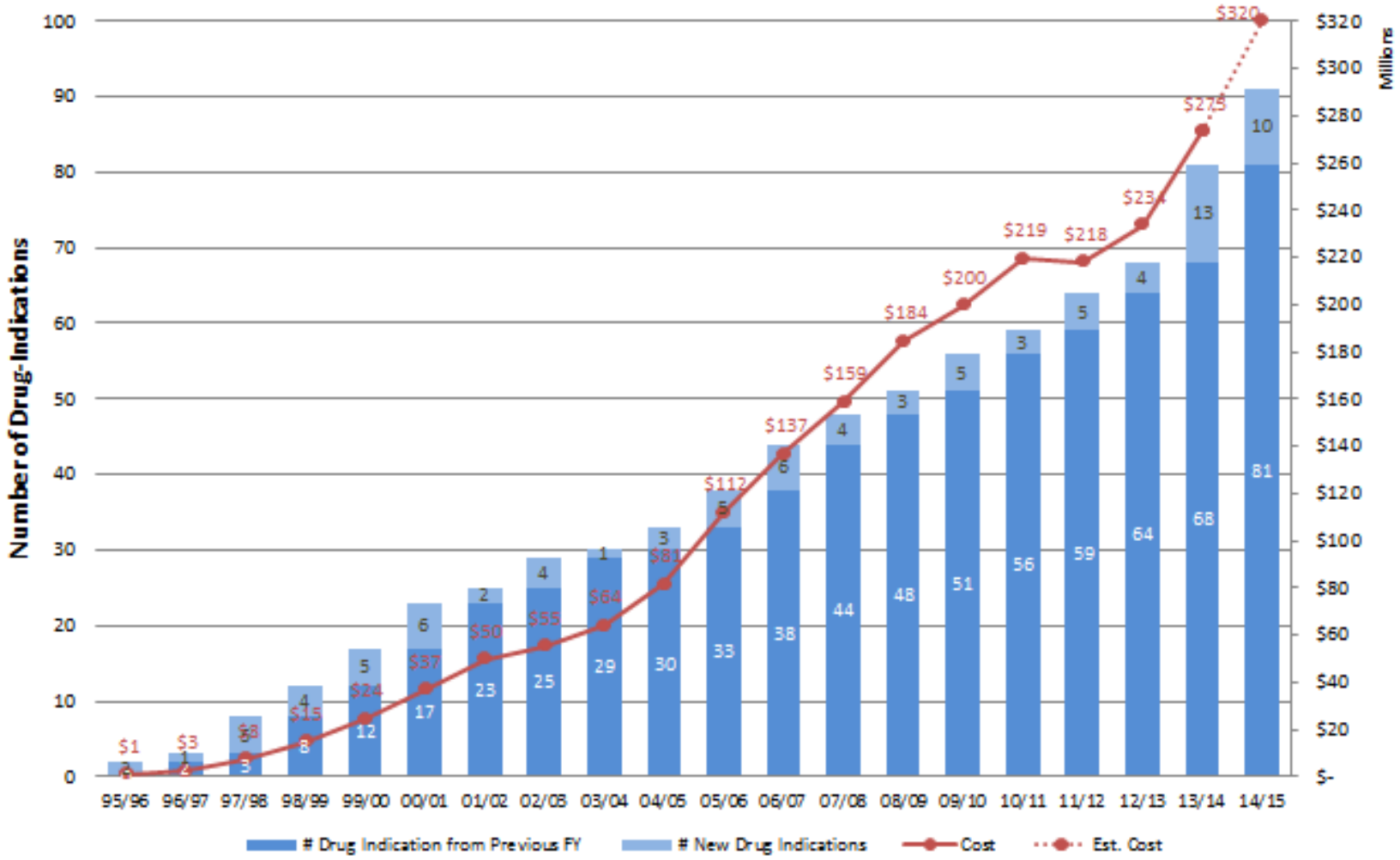
“We need ‘new math’ in oncology: We’re very good at addition. We’re not so good at subtraction”

- Dr. Leonard Kaizer

“Reasonable access to necessary care…”

-CANADA HEALTH ACT

NDFP Expenditures and Drug-Indications from FY95/96 to FY 14/15



NDFP drugs only from FY95/96; NDFP + EBP drugs from FY11/12 to present

Research Letter | April 02, 2015

Five Years of Cancer Drug Approvals

Innovation, Efficacy, and Costs FREE ONLINE FIRST

Sham Mailankody, MB BS[1]; Vinay Prasad, MD, MPH[1]

[+] Author Affiliations

JAMA Oncol. Published online April 02, 2015. doi:10.1001/jamaoncol.2015.0373

The price of cancer drugs has risen, drawing criticism from leading academics.[1,2] The annual cost of a new cancer medication now routinely exceeds $100 000, and medical bills have become the single largest cause of personal bankruptcy.[2] Although some contend that the high cost of drugs is required to support research and development efforts,[3] the fact remains that when costs and revenues are balanced, the pharmaceutical industry generates high profit margins.[4]

High profits may be justified if novel products offer significant benefits to patients (thus producing indirect economic value through the patients' restored health) or if they represent significant pharmacologic advances over their predecessors—offering new mechanisms of actions and emblematic of high-risk research. We investigated whether novelty of medications or their relative benefits affected drug pricing.

METHODS

“Our results suggest that the price of cancer drugs…”

- “is independent of novelty”
- “little difference…based on time-to-event analyses”

“Our results suggest that current pricing models are not rational, but simply reflect what the market will bear”

Current Oncology, [S.l.], v. 19, n. 3, p. e165-176, Jun. 2012.

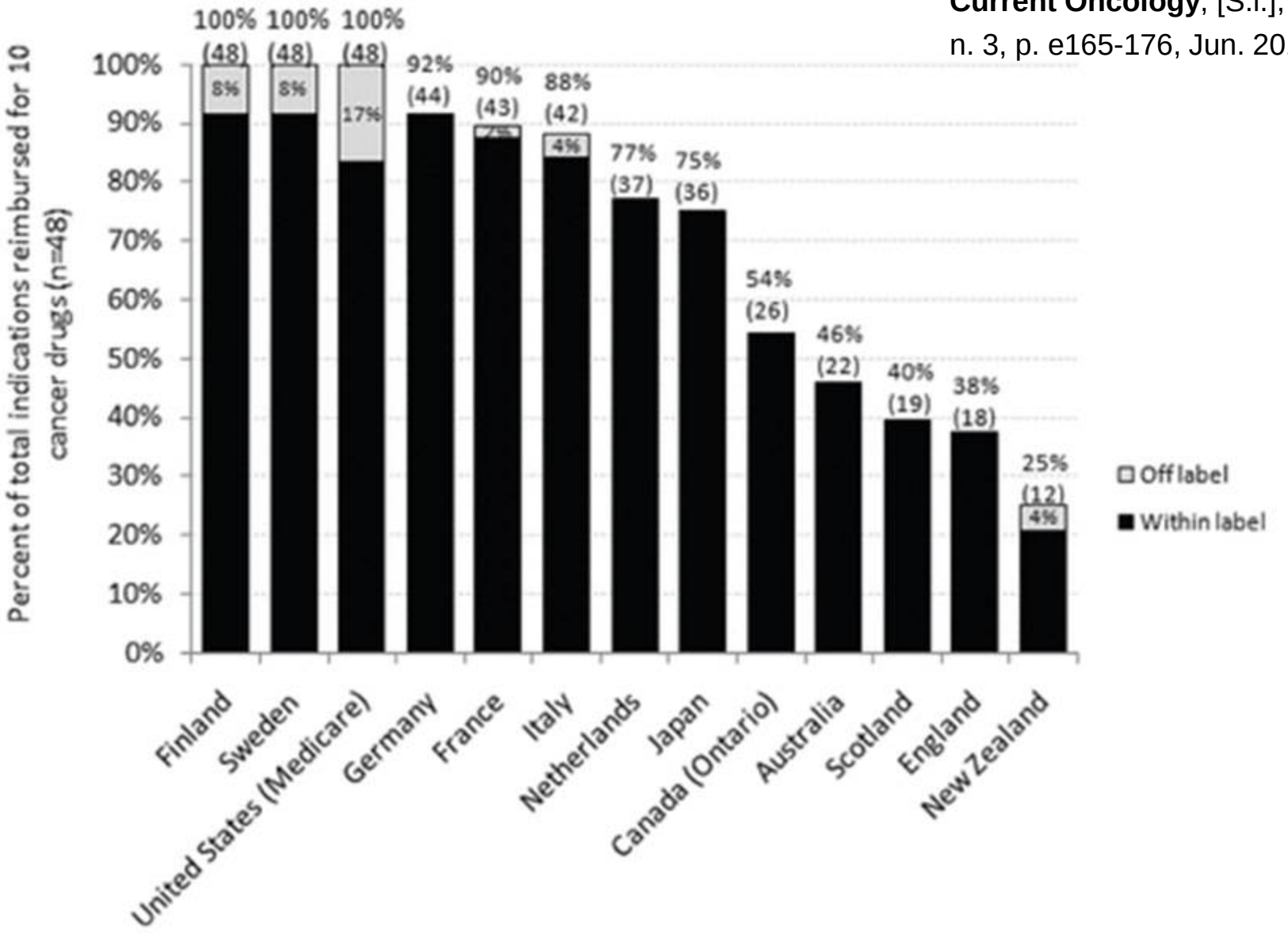


FIGURE 1 *Percentage of all licensed indications (n = 48) reimbursed for 10 cancer drugs as of February 28, 2010*

A REPORT OF THE ONTARIO CITIZENS' COUNCIL

MANAGING THE DRUG FORMULARY

Submitted to:

Diane McArthur
Assistant Deputy Minister And Executive Officer
Ontario Public Drug Programs
ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE
Hepburn Block
80 Grosvenor Street, 11th floor
Toronto, Ontario M7A 1E9

June 19, 2011

Options

- Raise taxes
- Decrease spending elsewhere
  (education, social programs)
- Remove things from the basket

When do drugs come off formulary?

- Cheaper alternative/generic (for cancer drugs)
- Stops being made by manufacturer
- Very old (levamisole)
- When there's harm (Avandia)
- When the cost/utilization is unexpectedly high (diabetic test strips)
- 'Me too' drugs (COX2 inhibitors)

Why don’t we de-list?

- There is no systematic process for review
- Reviewing a drug for delisting is costly and time consuming
- Behavioural economics: it’s harder to lose something we have than to not get something we don’t have

$\Rightarrow$Fear of patient groups, industry, MD etc reactions

The Telegraph

Monday 04 May 2015

25 cancer drugs to be denied on NHS

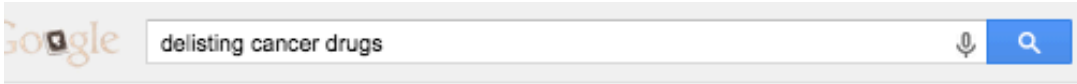
Charities have expressed outrage as the NHS announced plans to stop funding 25 treatments for cancer, including those for breast, prostate and bowel disease

On Monday, NHS England is due to announce how many of the drugs will be "delisted" Photo: PA

By Laura Donnelly and Gregory Walton

5:00PM GMT 12 Jan 2015

Eight thousand cancer patients are likely to have their lives cut short



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25 cancer drugs to be denied on NHS - Telegraph
www.telegraph.co.uk › News › Politics
Jan 12, 2015 - The Coalition introduced a special **Cancer Drugs** Fund in 2011, ... will be "**delisted**" - meaning they cannot normally be funded for NHS patients.
You visited this page on 01/05/15.

Three breast cancer drugs delisted from the Cancer Drugs ...
www.breakthrough.org.uk/.../three-breast-**cancer-drugs-delisted-cancer**-...
Jan 12, 2015 - You will have seen a lot of media coverage about NHS England removing **drugs** from the **Cancer Drugs** Fund (CDF) list. Some of the coverage, ...

Article > CDF to revisit delisting of Lilly's Alimta - PharmaTimes
www.pharmatimes.com/.../CDF_to_revisit_**delisting**_of_Lilly_s_Alimta.a...
Mar 12, 2015 - Lilly's appeal against the **Cancer Drugs** Fund's decision to **delist** its lung **cancer drug** Alimta (pemetrexed) has been upheld. NHS England has ...

Cancer Drugs Fund delisting of cabazitxel comes into effect ...
prostate**cancer**uk.org/.../**cancer-drugs**-fund-**delisting**-of-cabazitxel-comes...
Mar 12, 2015 - We know that cabazitaxel's manufacturers are challenging the decision to remove this **drug** from the **Cancer Drugs** Fund, so we'll report any ...

Cancer Drugs Fund: Life-extending drugs to be denied to NHS
www.independent.co.uk › Life › Health & Families › Health News
Jan 12, 2015 - Sixteen life-extending **cancer drugs** will no longer be available to patients in England from March after the NHS announced it would not pay for ...

Pharma condemns Cancer Drugs Fund cuts - PMLiVE
www.pmlive.com/.../pharma_condemns_**cancer_drug**_fund_cuts_63044...
Jan 13, 2015 - Sanofi's Zaltrap is one of several **drugs** to be **delisted** from England's **Cancer Drugs** Fund. NHS England has cut almost one third of the **drug** ...

Prime Minister David Cameron: Stop delisting life extending ...
https://secure.avaaz.org/.../David_Cameron_Prime_Minister_Protect_acc...
Jan 13, 2015 - I can only imagine this goes for at least some of the other **drugs** too. ... Minister David Cameron: Stop **delisting** life extending **cancer drugs** ...

NHS backtracks on Cancer Drugs Fund de-listings ...
www.pharmafile.com/news/.../nhs-backtracks-**cancer-drugs**-fund-**de-listi**...
Mar 12, 2015 - NHS backtracks on **Cancer Drugs** Fund de-listings ... has accepted **delisting** of everolimus in this indication rather than agreeing to a situation ...

Delisting of Everolimus by the Cancer Drug Fund - James ...
www.jameswhalefund.org/james-whale-fund-for-kidney-**cancer**-calls-for...

One on, one off

- Periodically review both literature & real world data on effectiveness, budget impact, and other related costs (hospital etc.)
  - Requires good data about actual price, utilization

$\Rightarrow$ Rank/rate them

Within the limitation of that year's budget

  - Increased for growth & aging
  - Space made by coming off patent, etc

- Compare a new drug to something rated low and see if it's preferable

“Right size” the formulary

- Ideally, relate the cost of chemotherapy across the entire cancer system, health system, or public spending
  - Do we pay for Avastin vs. more hospice nurses, vs First Nations education?

Requires

- Transparent process
- Public education/communication/socialization
- Appropriate notice to/feedback from
    - health care workers
    - patients
    - industry
- Keep them available through EAP for a time
- Facilitate and encourage private drug/critical illness insurance
    - Government could sell this

Problems

- Limits choice
- Equity concerns
- Volatility in what's covered year-to-year
- Substitution for other covered drugs
- Price may rise after de-listing
  - 43% rise in France
  - But might it exert downward pressure on prices?
- Increase in other medical costs

  (less relevant for cancer?)

Conclusion

De-listing should be on the table as a potential option for cancer drug funding sustainability