The podium may change, but for our healthcare clients, what it takes to come in first at the finish line still remains the same: **more brand energy, engagement, value and trust**. Sudler & Hennessey adds that “more”, and it’s as embedded in our culture as the ampersand in our logo.

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COUNTRY REPORT

Canada

OVERVIEW

GDP: $1.574tn (2010 est.)
% GDP spent on health: 11.7 (CIHI, 2010 est.)
Country size: 9,984,670 sq km
Population: 34,173,900 (World Bank, 2010)
Language: English and French

Source: CIA

INTRODUCTION

Canada is one of the wealthiest nations in the world, boasting a high per capita income ($39,400, CIA) and one of the highest living standards globally, securing its place at number eight on the global Human Development Index. Its diversified economy is supported by abundant natural resources, including vast reserves of natural gas, and reliant upon trade, most notably from the US through the North American Free Trade Agreement.

It is the second largest landmass globally (second only to Russia), comprising 10 provinces and three territories, but has a population of just 34.2 million (a fifth of that of Russia), 90 per cent of whom live less than 200km from the US border. The federal governments of the 10 provinces are responsible for the majority of social programmes, including healthcare, and collectively gross more revenue than the federal government, making it almost unique among federations.

The federal government uses its spending powers to initiate nationwide policies in the provinces, such as the Canada Health Act. At a provincial level, governments can choose to opt out of federal government policies but rarely do, instead following the lead of Saskatchewan, Alberta and British Columbia, which have led the way in introducing social welfare and health initiatives historically, including the introduction in 1947 of universal healthcare coverage in Saskatchewan (see healthcare section).

Canada may be heavily reliant on its primary sector (oil and gas, logging) but as an industrial nation it also has vibrant and developed science and technology industries. According to the Organisation of Economic Cooperation and Development (OECD) Regions and Innovations Policy, Quebec is at the heart of the action when it comes to R&D.

Government

Canada’s parliamentary system is rooted in robust democratic traditions and is a member of numerous global bodies, including G20, NATO, OECD, the World Trade Organisation, Asia-Pacific Economic Cooperation and the United Nations.

In May 2011, Stephen Harper won his third consecutive term in office. The Prime Minister’s Conservative government was toppled by the opposition two months earlier after the Liberal Party, backed by two other opposition parties, claimed that Harper and his government were in contempt of parliament for failing to provide estimated costs for a number of spending programmes. Despite the declaration and dissolution of the 40th Canadian Parliament after the vote of no confidence, on May 2, Harper’s Conservative Party secured a majority government by winning 166 seats.

HEALTHCARE

After more than four decades of reform, the publicly-funded healthcare system in Canada has remained true to its core principle of providing care on the basis of need, not ability to pay.

Spend on publicly-funded healthcare provision varies dramatically across Canada and is directly related to demographics such as the age and density of the population. In 2010, healthcare expenditure was 11.7 per cent of GDP, representing $5,614 CDN per person. In the same year, public funds accounted for seven out of every 10 dollars spent on healthcare; the remaining three dollars came from private means and covered supplementary services, such as drugs prescribed in primary care.
There has been a radical shift in the past 30 years in where healthcare spend is allocated. Spending on hospitals and physicians has dropped significantly while spending on drugs has soared. In the mid-1970s, 45 per cent of the healthcare budget was spent in hospitals, but by 2010 this had dropped to just 29 per cent. Drug spend has grown to 16 per cent (2010), with spend on physicians coming in third place at 14 per cent.

For the fourth year in a row, growth in physician spending has outpaced growth in hospital and drug spending and was expected to grow by an estimated 6.9 per cent in 2010, with spend on physicians coming in third place at 14 per cent.

For the fourth year in a row, growth in physician spending has outpaced growth in hospital and drug spending and was expected to grow by an estimated 6.9 per cent in 2010, with spend on physicians coming in third place at 14 per cent. As a result, the share of total health dollars spent on physicians was forecast to rise by 1.5 per cent, while the share spent on drugs was expected to drop by 0.4 per cent.

Constitutional rights
Canada’s Constitution sets out the powers of the federal, provincial and territorial governments. Under the Constitution Act, 1867, the provinces were responsible for establishing, maintaining and managing hospitals, asylums and charities; federal governments were responsible for marine hospitals and quarantine. Until 1919, when the Department of Health was created, the Department of Agriculture was responsible for healthcare.

Before World War II, healthcare in Canada was privately delivered and funded. In 1947, the government of Saskatchewan introduced a province-wide hospital healthcare plan; by 1950, British Columbia and Alberta had rolled out similar schemes. By 1960, the federal government had passed the Hospital Insurance and Diagnostic Services Act (1957), which offered to reimburse or cost-share half of proportional and territorial costs for specified hospital and diagnostic services, giving publicly administered universal coverage under agreed terms and conditions. Four years later, all provinces were providing publicly-funded inpatient hospital and diagnostic services.

Modification and major reform have dominated the healthcare landscape in Canada over the last 50 years. In 1966, the Medical Act was passed which saw reimbursement and cost-share agreements for half provincial and territorial costs in a primary care setting. By 1972 all Canadian provinces had implemented universal physician services insurance plans. In 1984, the Canada Health Act was passed, replacing the federal hospital and medical insurance acts and consolidating their principles by establishing five criteria:

- **Portability**: Provincial and territorial plans must cover all insured people when they move to another province or territory in Canada and when they are travelling abroad. The plans often include limits on coverage for healthcare services abroad and prior approval for non-emergency procedures may be required.
- **Accessibility**: Provincial and territorial plans must provide all insured people with reasonable access to hospital and physician services without financial or other barriers.
- **Universality**: Provincial and territorial plans must entitle all insured to health coverage under uniform terms and conditions.
- **Comprehensiveness**: Provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners and dentists working in hospital.
- **Public administration**: Provincial and territorial plans must be administered and operated on a non-profit basis by a public authority accountable to the provincial or territorial government.

The Act prohibits extra billing and user fees for insured services.
Provincial and territorial governments

Provinces and territories are responsible for the majority of healthcare provision in Canada and, through insurance plans, are expected to meet national principles set out under the Canada Health Act. Provincial and territorial governments’ duties include:

- Administration of their health insurance plans
- Planning and funding of care in hospitals and other health facilities
- Services provided by doctors and other health professionals
- Planning and implementation of health promotion and public health initiatives
- Negotiation of fee schedules with health professionals.

Across the country, most provincial and territorial governments fund supplementary benefits for certain groups in the community, for example for low income families and senior citizens, including drugs prescribed in primary care, ambulance costs and ENT treatments not covered by the Canada Health Act.

For the majority of the population, these services must be financed privately through a number of means, including out-of-pocket payments, workplace insurance plans or private insurance. For the most part, the law prevents insurers from offering insurance plans that cover services that are publicly funded.

Provision of healthcare

The publicly-funded healthcare system can be characterised as an ‘interlocking’ network of 10 provincial and three territorial health systems, known as medicare.

Primary care is the first port of call for those seeking non-emergency treatment. The numbers of services under the primary care umbrella are growing and are increasingly comprehensive, including everything from disease prevention and treatment to referrals for specialist care and rehabilitation services.

Patients who require specialist treatment are referred to secondary care organisations where care is funded through a nationwide budget that includes spending limits or targets (as being distinct from fee-for-service arrangements), which are negotiated with the provincial or territorial ministry of health, or with a regional health board or authority. The system is currently operating with what it terms a ‘global’ budget approach to hospital reimbursement but a handful of provinces are experimenting with supplementary funding.

Long-term or chronic care services can be delivered in the home; for the most part, these are not covered by the Canada Health Act, but most provinces and territories pay for certain home and continuing care services. Across the region, regulation and delivery of these services varies, in particular between the densely populated areas near the US border and the sparsely populated provinces in the north.

Trends and challenges

Cost-containment looms large on the healthcare horizon in Canada and is accompanied by concerns about the healthcare needs of an ageing ‘baby boomer’ generation, service delivery and the high cost of new technology. Over the last few decades, the delivery of medical services and where they are delivered has changed thanks to a significant drop in the number of in-patients and the number of nights spent in hospital, as new technology has boosted the number and type of treatments possible in an outpatient setting.

Although the model has served the country well for years, the ageing population, together with the rising rate of chronic diseases, is putting a tremendous strain on the system and the healthcare professionals who staff it.

Reforms have focused on treatment provision in primary care and resulted in 24-hour on-call services in the community, greater emphasis on promoting health and wellbeing and managing chronic diseases, alongside increased efforts to integrate and coordinate comprehensive health services.

Advances and influence of technology

As with a growing number of countries globally, Canada has been focusing on eHealth technologies, including electronic medical records (EMRs) and telehealth to increase the quality of healthcare provision as well as reduce long term spending.

Speaking to PricewaterhouseCoopers (PwC) during an interview for HealthCast: The Customization of Prevention, Diagnosis, Care and Cure, Canadian Compendium, Sharon Baker, Chief Corporate Affairs & CFO, Ontario Association of Community Care Access Centres, said: “We in healthcare are doing ourselves a disservice by continuing to separate ehealth from healthcare. An EMR is not an end in itself – the goal should be to enable better healthcare delivery and outcomes through the application of technology.

“When we talk about banking we no longer distinguish between banking and ebanking – it’s interchangeable. I believe the time has come to reintegrate ehealth into healthcare.”

Far from being a technology issue, the success of these ehealth initiatives is grounded in gaining buy-in from clinicians, which requires a shift in mindset away from tried and trusted traditional methods that no longer provide the levels and frequency of care that the ageing population requires at a cost the state can afford.

Ensuring widespread use of technology in seeking healthcare advice is also reliant on a sea change in the way people access information about their health. HealthCast conducted in-depth interviews with 500 consumers, 50 business leaders and 35 experts, and found that 72 per cent of Canadians still prefer to seek medical advice through a face-to-face consultation with their doctor.

“In an interview for the report, Tom Closson, president and CEO of the Ontario Hospital Association, said: “To achieve successful health outcomes, there should be a combination of good processes, good technology and good incentives. Incentives aimed at providers, the public and patients, and to encourage innovation and collaboration are needed, along with consistent, evidence-informed improvements in how diagnosis and care are delivered.

“We also need technologies that support decision-making at point-of-care, monitor system performance and facilitate communications between the individual and providers for improved decision-making. This combination is essential for change in the future of healthcare delivery and improved health outcomes in Canada.”

PHARMA

The country’s domestic drug industry is dominated by a handful of multinationals and local generic producers, the largest being Toronto-based Apotex. Local research-based companies tend to be small development-stage operations, while a number of multinationals also have manufacturing facilities in Canada.

The industry is mostly clustered around the metropolitan areas of Montreal and Toronto. The location of R&D facilities is strongly influenced by the location of major biosciences clusters and supportive government policies.
Earlier this year, Business Monitor International’s Canada Pharmaceuticals and Healthcare Report Q3 2011 stated that the Canadian pharmaceutical market was a refuge for the leading drug manufacturers. It added that the country would remain one of the most attractive pharma markets, in part due to its high per capita spending on medicines, which topped $629 in 2009, as well as population expansion and ageing. The market is being driven by the strong growth of cancer and musculoskeletal treatments.

Currently, only one-third of Canadian companies are profitable, with half of companies surveyed generating profit of $5m or less, according to PricewaterhouseCoopers’ Canadian Life Sciences Industry Forecast 2011, which was compiled using results from an online survey of 100 respondents from corporate, academic and government organisations, in collaboration with BIOTECanada.

Of the companies that were not making a profit, more than 70 per cent believed that it would take more than three years to generate profit, with more than 30 per cent stating that it would take more than five years to reach this point.

The Canadian pharma market is forecast to post a compound annual growth rate (CAGR) of 4.34 per cent in local currency terms, reaching $299.9bn CDN in value by 2014, according to Business Monitor International’s report. Growth during the period 2009-2019 will slow to 3.09 per cent, although the forecast suggests that the patented medicines segment should be boosted by the use of more personalised therapies and novel medicines over time.

**Intellectual property law**

Canada is somewhat unique when compared to other developed nations in that its patent laws are inconsistent, particularly when compared to those of US. Under the current provision, companies operating in Canada have less time to realise the value of their intellectual property (IP).

In May 2011, the issue reached a head when president of Pfizer Canada, Paul Levesque, demanded that Canada’s IP laws be aligned with Europe and allow for patent term restoration. He also said that companies should have the right to appeal when they lost patent challenges. Some pharma companies believe that stronger IP laws will result in greater R&D expenditure in the country.

**“Large companies with very little in the R&D pipeline are turning to collaborations, M&A and equity investment to fuel innovation”**

The patent expiries of major brands such as Pfizer’s Lipitor and Norvasc, Nycomed’s Pantoloc, AstraZeneca’s Crestor and Nexium and Johnson & Johnson’s Pariet, are set to result in generic competition eroding more than $2bn of sales by 2013.

PwC concluded that the way to succeed in Canada lies in changing the business model to a more collaborative approach. It suggests that new ways to incentivise risk capital in Canada, through an extension of the flow-through share rules or enhanced R&D tax credits or low tax rates for special economic zones or tax incentives for venture capital investing, will boost the industry.

Tracy Leferoff, global managing partner of the venture capital practice at PwC, said: “Large companies with very little in the R&D pipeline are turning to collaborations, M&A and equity investment to fuel innovation.”

According to the PwC’s Canadian Life Sciences report, 90 per cent of respondents said that being acquired or being part of a merger was one of the top three most likely scenarios for a successful Canadian life sciences business, while 70 per cent of respondents said that licensing or selling IP or co-development partnerships was also likely. The number of deals announced in North America in the third quarter of 2010 was 63, with a disclosed value of $30bn.

**MARKET ACCESS AND P&R**

Canada’s pharma market currently ranks 10th in the world and is likely to move up to 9th place by 2013, according to IMS Health predictions, demonstrating the importance of the industry both nationally and internationally.

Of a population of 34.2 million (World Bank, 2010), 86 per cent of Canadians are located in the four largest provinces of Ontario, Quebec, British Columbia and Alberta.

Prescription drugs are paid for through government-funded schemes (45 per cent), private insurance (37 per cent) or directly out-of-pocket by consumers (18 per cent), according to 2009 figures for distribution from Canadian Institute for Health Information (CIHI).

There are federal/provincial drug plans for those over the age of 65, those on welfare benefits and where drug costs are high relative to income. In-patients are covered by the hospital budget, with cancer, vaccines and blood products having their own funds. Private insurance covers member company employees and their families, leaving those with no cover or insurance, along with those wanting non-reimbursed drugs, such as lifestyle drugs, to pay out-of-pocket.

Patented drug prices are overseen by the Patented Medicine Prices Review Board (PMPRB), a federal agency set up in 1987 to ensure that prices for new medicines are within the range of prices for drugs in the same therapeutic class. However, some innovative drugs may attain higher prices.

The PMPRB uses an international price reference scheme, under which prices cannot exceed the highest level paid in seven other countries: the US, Germany, Switzerland, Sweden, UK, France and Italy.
The PMPRB revised its excessive price guidelines in 2010 and uses different price tests depending on the level of clinical improvement offered by a new drug. A breakthrough drug is compared to the median international price; one offering a substantial improvement is tested against the higher of the therapeutic class comparison and the international median; one giving moderate improvement is examined against the mid-level therapeutic class comparison and the international median, while those providing little or no improvement are tried against the therapeutic class comparison or reasonable relationship test.

"Figures for January 2011 show that 51 per cent of the 170 decisions made under CDR were negative – a normal rate of refusal that is likely to be maintained in future. Furthermore, of those drugs receiving a positive recommendation, most have conditions attached. In addition, provincial plans tend to follow the CDR recommendations.

In the past, the provinces have been slow in implementing positive recommendations, primarily owing to concerns over budgets. This has resulted in the development of ‘Listing Agreements’ over the past few years. In 2006, Ontario passed Bill 102, the Transparent Drug System for Patients Act, designed to reform the provincial drug system and deliver better value for money, through agreeing volume discounts for drugs and establishing a mechanism for recognising financial payments from industry, for example. Other provinces have followed suit and are negotiating their own agreements, with some provinces making them a requirement for listing.

Oncology decisions are handled by the pan-Canadian Oncology Drug Review (pCODR), which replaced the interim joint Oncology Drug Review (jODR) in the Spring of 2011.

Generics
Generic substitution is regulated at provincial level, with drug plans limiting reimbursement to the lowest cost alternative, which is usually a generic.

Canada’s generic prices have long been higher than those in most other countries, and much higher than those in the neighbouring US, which has led to high levels of parallel trade.

Specific pricing policies exist in some provinces with, for example, Ontario setting the range of 25-50 per cent of brand price, while Quebec stipulates the lowest price in Canada. Payments made to pharmacists are highly regulated. In the past, generics manufacturers could pay ‘allowances’ to pharmacists which were estimated to be about 40 per cent of the drug cost.

Generics pricing in Canada and the assertion that Canadians pay more for non-branded drugs are controversial. A report by Canada’s public policy think-tank the Fraser Institute, entitled Average Personal Affordability of Prescription Drug Spending in Canada and the United States 2011, found that prescription drugs were equally affordable in Canada and the US.

The report’s co-author and associate director of health policy studies at the Fraser Institute, Mark Rovere, said: “Canadian health policies are based on the assumption that many people won’t be able to afford prescription drugs unless government regulates the market and controls process. But personal drug costs in the US are just as affordable, on average, as Canada.

“The evidence shows that affordability is not a valid justification for broad-based government intervention in prescription drugs.

**FOREIGN VS CANADIAN PRICES 2009**

<table>
<thead>
<tr>
<th>Country</th>
<th>Price Ratio</th>
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<tbody>
<tr>
<td>Canada</td>
<td>1.00</td>
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<tr>
<td>Italy</td>
<td>0.80</td>
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<tr>
<td>France</td>
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<td>UK</td>
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<td>Germany</td>
<td>1.08</td>
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<tr>
<td>US</td>
<td>1.71</td>
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Source: PMPRB
market, and that means the public cost of supporting this government intervention is basically wasted money."

Extensive reforms are being proposed ahead of the renegotiations of the current Health Accord (core to the five principles of the Canada Health Act), which is set to expire on March 31 2014. First ministers have described the current level of spending on prescription drugs in the National Pharmaceutical Strategy as catastrophic, which is expected to lead to some policy changes and further cost-cutting.

**BIOTECH INDUSTRY**

Since the discovery of insulin as a treatment for diabetes by Ontario-born Dr Frederick Banting and his assistant Charles Best, in 1922, Canada has maintained a long history of biotech developments. The sector contributes over 7 per cent of GDP (2010), worth $86.3bn CDN, and has overtaken the automotive ($61.5bn CDN) and aerospace ($14bn CDN) sectors to sit third behind oil & gas ($163.9bn CDN) and ICT ($126.3bn CDN). According to government department, Industry Canada, the country is in the top five in the world in the field.

The federal government has developed economic and innovation policy in an attempt to stimulate Canada’s research infrastructure, providing large pools of post-graduate and post-doctoral researchers, world-class academic, public and private sector researchers and entrepreneurs, as well as a supportive business climate.

The biotech industry is led by companies involved in health, medicine and pharmaceutical manufacturing, which comprises 64.4 per cent of Canada’s bioeconomy, worth $55.7bn CDN, ahead of agriculture and food bio-processing (26.1 per cent and $22.6bn CDN) and organic chemical manufacturing (9.5 per cent and $8.2bn CDN).

Growth has been due largely to a strong base of scientific expertise and continuous investment in research and development. The biotech industry invested $1.7bn CDN in R&D in 2005, an increase of 15 per cent on the $1.5bn CDN allocated to R&D in 2003.

Specialised organisations and agencies, such as Genome Canada, Canadian Institutes of Health Research, the Canada Foundation for Innovation (CFI) and the Natural Sciences and Engineering Research Council, work to ensure focus, direct funding and to attract the best researchers.

The independent CFI was established in 1997 to promote world-class research and technology development followed, in 1999, by Genome Canada with the aim of helping the country become a world leader in genomics and proteomics research. However, the venture capital arm of the Business Development Bank of Canada (BDC) is the Canadian government’s key tool for encouraging venture capital investments in the sector.

Although hit by the global recession, along with business and regulatory obstacles, the industry has taken steps to maintain its position against strengthening international competition. In 2008, BIOTECanada, an industry organisation with over 250 member companies, published *Canadian Blueprint: Beyond Moose and Mountains*. The Blueprint outlines three priority areas for action over five years: people, capital and the operating environment. It calls for the building of a pan-Canadian framework to develop technology throughout its life cycle, through financial support for scientists and entrepreneurs and for steps to be taken to ensure regulations do not impede innovation and growth.

Today, biotech companies face challenges in getting their products to patients, with restricted market access and slow adoption of new technologies. BIOTECanada is working with federal, provincial and territorial review bodies such as the CDR to create a better environment for the adoption of breakthrough therapies and greater recognition of the value of innovation. It also works alongside the PMPRB to ensure that pricing regulations and guidelines for biopharma generate competition in the marketplace and to ensure pricing policies are unambiguous.

The organisation is working with government to establish a forward-looking Orphan Product Policy that will both provide patients with access to medicines and give companies an incentive to develop and introduce products for orphan diseases.

The regulatory process for granting marketing licences to Subsequent-Entry Biologics (SEBs) is also under discussion. Health Canada describes a SEB as: “a biologic product that is similar to, and would enter the market subsequent to, an approved innovator biologic product”. BIOTECanada states that it supports the creation of a regulatory pathway for SEBs that incorporates processes and requirements that protect the safety of patients. Its members have developed a set of principles that they believe should guide the introduction and regulation of SEBs in the country.

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**INTERNATIONAL COMPARISONS OF BIO-BASED ECONOMIES**


Source: www.pmlive.com/europe

Pharmaceutical Market Europe September 2011
MARKETING & PROMOTION

Canadian pharmaceutical companies spend almost US$1bn annually promoting their products, but spend is falling. Marketing challenges in the region mirror those faced elsewhere in the world, with phama companies slashing promotional budgets. Clients expect to get more from their marketing dollars, while others are looking at taking a purely in-house approach to marketing.

Increasingly, companies are being far more strategic and stream-lined in the way they market their products. Rather than having big campaigns, they are very focused on specific healthcare providers. In contrast to many other developed markets, companies in Canada still favour personal selling, with most companies allocating more than half of their promotional budget to sales reps.

Unlike the US, direct-to-consumer (DTC) advertising is illegal despite pressure to remove the legal restrictions common among the majority of industrialised nations. Advertising is regulated by the Pharmaceutical Advertising Advisory Board (PAAB), which was established in 1976. The board of directors represents a cross-section of the medical and medical advertising associations and organisations, as well as representatives from pharma and pharmacy associations, including Canada’s Research-Based Pharmaceutical Companies (Rx&D) and Canadian Pharmacists Association (CPhA).

As well as adhering to the Food and Drugs Act, pharma companies abide by the Pharmaceutical Manufacturers Association of Canada voluntary code of practice.

Making the most of digital

The use of digital channels in creating increased engagement either with HCP in an educational setting or disease awareness campaigns aimed at the public and patients, is a priority for pharma. However, the industry remains reticent about its ability to monitor engagement, in particular in social media channels. Cassandra Sinclair, managing director, Sudler & Hennessey Canada, to monitor engagement, in particular in social media channels. pharma. However, the industry remains reticent about its ability campaigns aimed at the public and patients, is a priority for either with HCP in an educational setting or disease awareness

The use of digital channels in creating increased engagement either with HCP in an educational setting or disease awareness campaigns aimed at the public and patients, is a priority for pharma. However, the industry remains reticent about its ability to monitor engagement, in particular in social media channels. Cassandra Sinclair, managing director, Sudler & Hennessey Canada, says: “Companies know that consumers are looking for information online, but they believe that putting generic information about a therapy area on the internet, in line with marketing regulations, only supports their competitors’ products.”

Companies are using much of the technology at their disposal to good effect, developing online detail aids and apps. There are a number of companies that have created websites that include password protected portals to cater to physician needs but uptake of, and engagement with, newfangled technology remains erratic.

“We know that specialists are more gadget- and technology-focused and have been early adopters of iPads and EMRs to their practice. However, family doctors in Canada are still rather reluctant and slow to adopt an overall ehealth practice. On the other hand, there are growing numbers of health care providers going online to look up information – clinical trials, diagnostic pathways and treatment algorithms as well as general Rx information. This increasing demand is resulting in a growing market in Canada but we must keep in mind that health care providers are still consuming information through traditional media, such as journals. Online medical education is proving popular too. However, they still like interacting with their peers in person and online has not yet replaced that.

“Canadian patients would love the opportunity to interact with their doctors online, according to statistics, but doctors don’t want to do that, particularly because they are not compensated for it. The incidence of patients using social media varies from therapy area to therapy area. Patients with diabetes do not blog or share details to the same extent as those with or caring for people with cancer, for example. In oncology there are a lot of chat rooms and a lot of people interacting online,” she adds.

The Canadian government is debating whether to place restrictions on Canadian citizens, preventing them from looking at US websites. Similar restrictions are already in place for websites farther afield.

The Authors

The PME editorial team.