

Impacts of Incontinence in Canada

A briefing document from the the Canadian Continenence Foundation

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EXECUTIVE SUMMARY

The following policy brief has been commissioned by The Canadian Continence Foundation (TCCF) to help government address the unmet needs of Canadians living with incontinence. Incontinence is a chronic condition that continues to carry an enormous stigma. Incontinence can impact all parts of a persons' life: social interactions, sex life, ability to work, travel, play sports, and participate in community life.

An extremely conservative estimate of the prevalence of incontinence in Canada indicates that 7% of Canadian women and 3.5% of Canadian men experience moderate to severe incontinence on a daily basis. Many studies suggest that the prevalence is significantly higher. Incontinence takes a serious emotional toll on those living with the condition. Women living with incontinence are more likely to suffer from depression than their continent peers. In one study, urinary incontinence, Alzheimer's disease and stroke were the three chronic conditions found to most adversely affect an individuals' health-related quality of life.

Incontinence is not only costly to individuals, but also to employers and the health care system. An individual with incontinence will spend \$1,500 per year on products. Furthermore, incontinence costs Canadian employers over 11 million days of lost work, and over \$1.5 billion in lost productivity. Incontinence will also add \$1.9 billion in health care costs to the Canadian system on a yearly basis. In total, incontinence will cost Canadians nearly \$5.6 billion annually.

Incontinence Costs in Canada	
Costs to the Individual	\$2,070,990,000
Costs to the employer	\$1,580,733,217
Costs to the health care system	\$1,947,420,930
Total	\$5,599,144,147

The Canadian Continence Foundation proposes the following to policy makers:

- Increase education about incontinence to both the public and health professionals.
- Include access to urinary incontinence treatments in the wait times strategy.
- Increase funding to allow for more treatment to be provided to people with stress incontinence, such as surgical correction of stress incontinence with slings. As a first step, the Canadian Continence Foundation urges the Ontario government to provide \$16 million in dedicated funding for mid urethral sling procedures to ensure that incontinent individuals are treated in a timely manner.
- Fund the creation of community-based continence care clinics.
- Increased funding to allow access to conservative treatments and therapies.
- Include all drugs to treat urinary incontinence on provincial formularies.
- Increase the daily funding allotment for absorbent products in long term care facilities to allow the use of a new diaper as required.
- Increase funding for the purchase of absorbent products for those individuals living on fixed incomes.
- Increase funding for the purchase of catheters for individuals living in the community and in institutions.

INTRODUCTION

This paper is a briefing document from The Canadian Continence Foundation (TCCF) to help government formulate better policies to meet the unmet needs of Canadians living with incontinence. Incontinence is a chronic condition that carries an enormous stigma. According to Dr. Kevin Baker, “This condition is far too often unreported, in part because patients are too embarrassed to discuss it with their physicians. It has been reported that in Ontario there are over 300,000 women who suffer from incontinence...”¹

Incontinence can impact all parts of a persons’ life: social interactions, sex life, ability to work, travel, play sports and participate in community life. In the words of one gynecologist working in Ontario:

“I am a Gynecologist that specializes in urinary incontinence in women. This is a common and distressing problem for women after childbirth. Many of my patients tell me that they can no longer exercise or play with their children because of the urinary leakage. Some patients claim that the no longer have relations with their spouse because they leak urine whenever they have relations. Other patients tell me they are on antidepressants for this problem.”²

The problem is further compounded by a lack of family physician knowledge of the condition and of current available treatments and products. This combination of stigma and lack of knowledge has led to the overall under-reporting of the condition. There are few accurate Canadian statistics of the overall prevalence of the condition – with studies reporting wide ranges of prevalence from 2% to 20% of the overall population.

This paper will bring together the most up-to-date information related to incontinence in order to provide policy makers with a more accurate view of this chronic condition in Canada. The paper will delve into the stigma and emotional consequences of incontinence, provide an overview of the various types of incontinence, describe the financial implications of the condition for both the individual and society, and will conclude with a discussion of a variety of solutions for decision makers in Canada to consider.

This brief will highlight to policy makers the needs of a large and growing population, and shed light on the many complex issues that those living with incontinence face on a daily basis. The Canadian Continence Foundation’s recommendations for positive action and policy change are included at the end of the paper.

¹ Baker, K. Letter, Marie Fortier, Champlain LHIN, October 16, 2008

² Kalbfleisch, R Letter, Ministry of Health and Long Term Care, Ontario, November 10, 2008

PREVALENCE

Determining the true prevalence of incontinence in Canada is difficult. Estimates in studies (see Table 1) vary from 2% to 50% of the population, depending upon the study, the research method and the questions posed. For example, asking the question “Are you incontinent?” will garner a dramatically different number of positive responses than the question “Do you suffer from occasional leakage of urine?”

This problem is further compounded by the stigma and embarrassment associated with the condition. Very few (25%)³ women and men living with incontinence seek professional help as they either assume that it is a normal aspect of aging, or because they are simply too embarrassed to bring their condition to the attention of their health care professional. As stated by Contreras Ortiz, “Clearly there is still a long way to go in making patients and society aware of the fact that UI is a disorder, which can and should be treated. Consequently, patients must be encouraged to report their problem, while health care providers should raise the issue on routine exams in risk groups.”⁴

Finally, there are many levels of incontinence, from mild to moderate to severe and very severe. Individuals who have one episode of urine leakage a week may be considered incontinent, but individuals who experience several episodes a day will require different coping strategies, must spend more money on products, and will experience more profound emotional consequences. However, people experiencing any level of incontinence share some of the same emotional consequences.

Viktrup et. al. performed a comprehensive review of SUI in active elderly women. The author finds: “UI may be transient in up to one third of community-dwelling elderly and up to 50% of inpatients, depending on a variety of risk factors.”⁵ The surveys and studies that are reviewed report findings as low as 16% of women reporting monthly incontinence, and as high as 65% of women reporting weekly incontinence.

Thom reviewed the literature to investigate the reported prevalence of incontinence in community dwelling women. Thom found that among middle-aged and younger adults, prevalence for incontinence ranged from 12 to 42% for women. Among older adults, prevalence ranged from 17 to 55%. Stress incontinence predominated in younger women, whereas urge and mixed incontinence predominated in older women.⁶ He concludes that an accurate estimation of the prevalence of UI depends on specifying the definition of incontinence and the age and gender groups of interest.

Table 1 provides a non-exhaustive overview of some of the studies that report prevalence of incontinence. The data suggests that a range of prevalence values exist, depending on how incontinence is defined, as well as the age and gender of the study group.

A conservative estimate of the prevalence of incontinence suggests that **7% of Canadian women experience some form of moderate to severe incontinence** on a daily basis. Some studies indicate that the prevalence could be significantly higher.

The stigma and embarrassment often associated with the condition make it difficult to accurately assess the true prevalence.

³ Reymert J, Hunskaar S *Why do only a minority of perimenopausal women with urinary incontinence consult a doctor?* Scandinavian Journal of Public Health, 1994, September 12(3):180-183.

⁴ Contreras Ortiz O *Stress Urinary Incontinence in the gynecological practice* Int. J Gynaecol Obstet 2004 Jul;86 Suppl 1:S6-16

⁵ Viktrup L, Koke S, Burgio KL, Ouslander JG *Stress urinary incontinence in active elderly women* South Med J 2005 Jan.98(1):79-89

⁶ Thom, D. *Variation in estimates of urinary incontinence prevalence in community: effects of differences in definition, population characteristics, and study type* J Am Geriatr Soc 1998 Apr;46(4):473-80.

Table 1: Reported prevalence of Incontinence

Citation	Conclusion/statement
Herschorn S, Corcos J, Gajewski J, Schulz J, Ciu E <i>Canadian Urinary Bladder Survey: Population-Based Study of Symptoms and Incontinence</i> Neurology and Urodynamics, 2003, Vol 22, Part 5.	The Canadian Bladder survey provided the following age-stratified data (% of men and women with any degree of incontinence): <ul style="list-style-type: none"> • 18-40 yrs: 10% men, 16% women • 41-64 yrs: 16% men, 33% women • 65+ yrs: 30% men, 55% women
McDowell, I <i>Analysis of urinary and faecal incontinence in the Canadian population using data from the Canadian Study of Health and Aging</i> , Health Canada, 1998 [Available at http://www.phac-aspc.gc.ca/seniors-aines/pubs/info_exchange/incontinence/exch6_e.htm , last accessed Dec. 4, 2008]	<ul style="list-style-type: none"> • Slightly more than five percent of the men in the study and seven percent of the women experienced daily urinary incontinence. • After age 84, daily urinary incontinence noticeably increased (men 14.8% and women 23.5%) • For seniors in institutions, daily urinary incontinence was nine to ten times higher (men 36.8% and women 36.9%) than among seniors residing in the community.
Fedorkow DM. <i>Prevalence of urinary incontinence, pelvic organ prolapse and anal incontinence in women</i> . In: Drutz HP, Herschorn S, Diamant NE, eds. <i>Female pelvic medicine and reconstructive pelvic surgery</i> . London: Springer, 2003; 11–24	Nearly 9% of all respondents reported urinary incontinence, 56% of whom were below 55 years of age. Over half of the respondents had never consulted a physician about their incontinence,
Miller, D <i>Office management of stress incontinence: current and future role</i> Clin Obstet Gynecol 2007 Jun;50(2):376-82.	Approximately 11 million women in the United States may be regularly incontinent. (3.6% of US population based on Census figures of 305 million US residents, accessed Dec. 2, 2008 at http://www.census.gov/)
Fultz N, Girts T, Kinchen K, Nygaard I, Pohl G, Sternfeld B <i>Prevalence, Management and Impact of Urinary Incontinence in the Workplace</i> Occupational Medicine 2205;55:552-557.	37% of respondents (women aged 18-60 years) reported urine loss during the last 30 days. Of these: <ul style="list-style-type: none"> • 44% lost urine at least monthly while at work; • 21% at least weekly; • 8% daily • Remaining reported less than monthly, but did experience urine loss in the previous month.
Milne JL, Moore KN <i>An exploratory study of continence care services worldwide</i> Int J Nurs Stud 2003 Mar;40(3):235-47.	UI is a complex symptom of underlying disorders that affects over one and a half million Canadians. (4.7% based on 2006 Canada Census Data; population of 31.6 million Canadians.)
Milsom I <i>The prevalence of urinary incontinence</i> Acta Obstet Gynecol Scand 2000 Dec;79(12):1056-9.	Urinary incontinence is one of the most important health problems confronting modern society. More than 50 million men and women throughout the world are afflicted. Population studies have demonstrated that approximately 10% of all women suffer from urinary incontinence.

<p>Thom, D. <i>Variation in estimates of urinary incontinence prevalence in community: effects of differences in definition, population characteristics, and study type</i> J Am Geriatr Soc 1998 Apr;46(4):473-80.</p>	<p>“Estimates of urinary stress incontinence vary in the literature from 4% to 50%.”</p>
<p>Farage MA, Miller KW, Berardesca E, Maibach HI, <i>Psychosocial and societal burden of incontinence in the aged population: a review</i> Arch Gynecol Obstet. 2008 Apr;277(4):285-90</p>	<p>Most adults past the age of 65 suffer incontinence on some level. (100% in adults 65+ years).</p>

While it is clear that prevalence is difficult to determine, there can be no doubt that there is a large number of Canadians living with incontinence. Incontinence ranges from mild cases, where women and men experience some urine leakage each month, to very severe cases where the individual experiences leakage on many occasions each day. Furthermore, the prevalence of incontinence increases significantly with age.

For the purposes of economic and cost calculations that will be performed in later sections of the brief, we will use the general - and fairly modest - estimate that 7% of women in Canada experience some form of moderate to severe leakage of urine on a daily basis. Furthermore, “although the epidemiology of urinary incontinence has not been investigated in men as thoroughly as in women, most studies show that the male-to-female ratio is about 1:2”⁷ Therefore, we will use the general prevalence estimate of 3.5% of men in Canada experience some form of moderate to severe leakage of urine on a daily basis.

EMOTIONAL AND PSYCHOLOGICAL CONSEQUENCES OF INCONTINENCE

Incontinence takes a serious emotional toll on those living with the condition. Women living with incontinence are more likely to suffer from depression than their continent peers. The results of one study revealed that urinary incontinence, Alzheimer’s disease and stroke were the three chronic conditions that most adversely affected an individuals’ health-related quality of life.

Many studies have outlined the emotional and psychological consequences of incontinence. A non-exhaustive summary is provided in Table 2 below:

⁷ Strothers L, Thom D, Calhoun E *Urinary incontinence in men* In: Litwin MS, Saigal CS editors. *Urologic Diseases in America*. US Department of Health and Human Services, Public Health Service, NIH, National Institute of Diabetes and Digestive and Kidney Diseases. Washington DC, US Government Publishing Office, 2004;NIH Publication No 04-5512.

Table 2: Emotional, Psychological & Social Impacts of Incontinence

Citation	Findings/Conclusion
Farage MA, Miller KW, Berardesca E, Maibach HI, <i>Psychosocial and societal burden of incontinence in the aged population: a review</i> Arch Gynecol Obstet. 2008 Apr;277(4):285-90	“... significant and often devastating impact on the physical and emotional health of the patient. Incontinence in the older adult is a humiliating and disabling disorder, which causes substantial stress, depression, and limitation. It can impede interpersonal relationships, decrease sexual function, and increase the risk of debilitating falls, institutionalization and even increase mortality.”
Fultz N, Girts T, Kinchen K, Nygaard I, Pohl G, Sternfeld B <i>Prevalence, Management and Impact of Urinary Incontinence in the Workplace</i> Occupational Medicine 2205;55:552-557	Of women with severe or very severe symptoms: <ul style="list-style-type: none"> • 45% reported a negative impact on concentration; • 64% on physical activity; • 77% on self confidence; • 74% on completion of tasks • 88% reported negative impact in at least one of the four areas above • 4% indicated that UI had affected personal decisions about employment; • 2% changed the type of work they do; • 0.9% decreased the number of hours worked; and • 0.8% indicated they no longer work outside the home.
Subak LL, Brown JS, Kraus SR, Brubaker L, Lin F, Richter HE, Bradley CS, Grady D, and Diagnostic Aspects of Incontinence Study (DAISy) Group <i>The “costs” of urinary incontinence for women</i> Obstet Gynecol. 2006 April; 107(4): 908–916.	The health related quality of life impact of incontinence is similar to that observed with other chronic medical conditions like osteoarthritis, chronic obstructive pulmonary disease, and stroke. Our study confirms findings of others that women with incontinence perceive substantial benefits from a reduction in the number of incontinence episodes...Women are willing to pay up to \$900 per year for 100% improvement in incontinence, which is similar to the willingness to pay for improvement of migraine headaches or gastroesophageal reflux.
Herbruck LF, <i>Stress Urinary incontinence: prevention, management, and provider education</i> Urol Nurs. 2008 Jun;28(3):200-6.	The costs of urinary incontinence are financially and socially substantial to those who are living with its effects...prevention of these disorders or management at the earliest possible level is indicated.
Hägglund D, Ahlström G <i>The meaning of women’s experience of living with long-term urinary incontinence is powerlessness</i> J Clin Nurs. 2007 Oct;16(10):1946-54.	The meaning of women’s experience of living with UI is powerlessness.
Contreras Ortiz O <i>Stress Urinary Incontinence in the gynecological practice</i> Int. J Gynaecol Obstet 2004 Jul;86 Suppl 1:S6-16	UI is a common problem, affecting women in all age groups, and has devastating effects on their social, professional and family life.

<p>Viktrup L, Koke S, Burgio KL, Ouslander JG <i>Stress urinary incontinence in active elderly women</i> South Med J 2005 Jan;98(1):79-89</p>	<p>Urinary incontinence in the elderly is a significant health problem fraught with isolation, depression, and an increased risk of institutionalization and medical complications...</p>
<p>Monz B, Pons ME, Hampel C, Hunskaar S, Quail D, Samsioe G, Sykes D, Wagg A, Papanicolaou S <i>Patient-reported impact of urinary incontinence – results from treatment seeking women in 14 European countries</i> Maturitas 2005 Nov. 30;52 Suppl 2:S24-34</p>	<p>The greatest patient-reported impact of UI symptoms on activities was on exercise, with more than 45% of patients (with moderate to severe incontinence) moderately to totally limited in this activity. In most countries, more than 60% of the women reported that they were moderately to extremely bothered by their UI symptoms.</p>
<p>Subak LL, Brubaker L, Chai TC, Creasman JM, Diokno AC, Goode PS, Kraus SR, Kusek JW, Leng WW, Lukacz ES, Norton P, Tennstedt S, Urinary INcotnience Treatment Network <i>High costs of urinary incontinence among women electing surgery to treat stress incontinence</i> Obstet Gynecol 2008 Apr;111(4):899-907.</p>	<p>Urinary incontinence is associated with substantial costs. Women spent nearly USD750 per year out of pocket for incontinence management, had a significant decrement in quality of life, and were willing to pay nearly USD1,400 per year for cure.</p>
<p>Vigod, S, Steward DE <i>Major Depression in Female Urinary Incontinence</i> Psychosomatics, 47:147-151, April 2006.</p>	<p>The prevalence of depression was 15.5% in women with urinary incontinence (30% in women ages 18–44) and only 9.2% in women without urinary incontinence.</p>

One of the main reasons that women and men with incontinence suffer in silence – fearing even to discuss the issue with their physician – is the great embarrassment and shame that the condition engenders. The internet, with its myriad of chat rooms and anonymous forums devoted to discussing the experiences of people living with incontinence provides a window into the suffering that incontinence produces. Common themes that from these groups include:

- Questions about embarrassment, and the stigma associated with being incontinent;
- Use of diapers
- Fear that family members, work colleagues, and friends will discover that a person is experiencing incontinence.
- Ways to make plastic pants last longer
- Questions about how to deal with the sudden leakage of urine

Many sites encourage members to share their stories so that they can help each other with their incontinence. A few of these stories are reproduced below, to help the continent understand to a small degree what these individuals deal with:

“I was diagnosed with rectal cancer at age 47. It’s been almost nine years since finding that tumor which completely changed my life. I had radiation, chemo and surgery where I received a temporary colostomy. After that was reversed, I was left with no control of my bowels. I know I should be happy that I’m beating the cancer but there are times I wish I didn’t. For the first year and a half I was almost a virtual shut-in, only venturing out of the house when I absolutely had to. Then there was the constant fear of having an accident. I was going to the bathroom some thirty times a day and I had to get to one fast ”

“I am a 45 year old mother of 3, and have had incontinence for over 20 years now. It controls me. I so wish it didn’t... but it does. I have suffered from depression over this. I used to teach Sunday school and sing in church, but I don’t even go there very much any more – after singing one day and having an accident while behind the pulpit. I very ashamedly walked home and while in the shower begged God for a reason why. I don’t expect an answer, however, I do believe that everything happens for a reason and we have to try to live life to its fullest in whatever capacity that is.”

“My doctors have been great but they are at a loss as well. I don’t know where to turn anymore but I try to keep on going in life. I know I am not alone but sometimes I feel like no one understands. Thanks for this website, I cried when I read these stories. I don’t feel as alone anymore.”

TYPES OF INCONTINENCE AND ASSOCIATED TREATMENTS

Incontinence has been defined by the International Continence Society as the “complaint of any involuntary leakage of urine”⁸.

The following are the main types of incontinence:

- *Stress Urinary Incontinence (SUI)*, which is the leaking of urine associated with coughing, sneezing, straining, exercise or any other type of exertion. Fifty percent of individuals with incontinence have SUI.
- *Urge Incontinence (UI)* is leaking of urine associated with the sudden uncontrollable urge to empty the bladder and leakage occurs. UI is a key symptom of the overactive bladder syndrome.
- *Overflow incontinence (OI)* is constant leaking or dribbling from a full bladder.
- *Mixed incontinence (MI)* is a combination of stress and urge incontinence.

Other types of incontinence include:

- *Functional incontinence* denotes incontinence related to causes outside of the urinary system. A person may have trouble controlling urine, but this problem is exacerbated by functional factors, such as physical barriers to the toilet, a lack of mobility, a degree of unwillingness to comply, medication issues, etc. This type of incontinence may be managed by addressing the functional factor, such as improving the patient’s mobility, motivating the patient, improving access to the toilet, modifying meds, etc.
- *Nocturnal enuresis* is used to describe nighttime incontinence, also known as bedwetting.

INCONTINENCE TERMS

Bladder – the urine storage reservoir

Urethra – a passage through which the bladder is emptied.

Supportive structures and sphincters – these are responsible for preventing leakage.

⁸ Abrams P, Cardozo L, Fall M, et al. *The standardisation of terminology of lower urinary tract function: report from the standardisation sub-committee of the International Continence Society.* Neurourol Urodyn 2002;21:167-78

TREATMENTS

A number of treatment options are available for individuals with incontinence, and descriptions of these treatments are provided in detail in other briefs and papers (Canadian Continence Foundation, 2007, Miller, 2007). They are described briefly below:

Behavioral Treatments

Behavioral treatments are conservative measures and are the first treatment option for patients with stress and urge incontinence. Behavioral treatments include bladder retraining, education, and dietary modifications.

Physical Therapy

Includes pelvic floor muscle exercises, biofeedback, and electrical stimulation.

Intermittent Self-Catheterization

Intermittent self-catheterization involves passing a small disposable catheter through the urethra and into the bladder to empty it.

Injectable Treatments

Injecting bulking agents, such as collagen, to narrow the urethral walls has been shown to be successful for SUI and is minimally invasive. Botulinum toxin therapy (Botox) injections have also been used to treat urge incontinence.

Drug Therapies

The general classes of drugs used are: anticholinergic drugs, tricyclic antidepressants, and combined anticholinergics and smooth muscle relaxants. These drugs are used for treating overactive bladder.

Surgical Treatments

There are two main surgical treatments for SUI used in Canada: Retropubic suspension and sling insertion (mid-urethral sling). The Burch procedure (retropubic suspension technique) has been shown to be successful for the treatment of SUI and has good long term efficacy. Slings provide support under the bladder neck and/or urethra, and can be made from a number of different materials. The harvesting of a patient's own tissue (fascia) over the abdominal muscles is still commonly performed; however, this newer, minimally invasive outpatient technique is the insertion of a mesh sling to help support the bladder neck. Short term data indicates that this technique is as effective as the Burch procedure, but long term data is lacking.

A technique that uses the pelvic bone or transobturator area to support the tape rather than using the abdominal wall is called the transobturator sling. This procedure is a minimally invasive outpatient procedure that is expected to be equivalent to other mid-urethral sling techniques.

Another surgical procedure reserved mostly for men, is the insertion of an artificial urinary sphincter (AUS). An AUS is a device made of silicone rubber that has an inflatable cuff that fits around the urethra close to the point where it joins the bladder. The cuff is inflated to keep urine from leaking and when the individual wishes to urinate, he deflates the cuff, allowing the urine to drain out.

Sacral Nerve Stimulation (SNS)

During SNS, a pacemaker-type device is implanted to electrically stimulate the sacral (lower spinal) nerves in an attempt to improve bladder function and manage incontinence.

PRODUCTS AND DEVICES FOR THE MANAGEMENT OF INCONTINENCE

Absorbent Products

Absorbent products (diapers, panty liners and pads) are the most commonly used incontinence product, and can be used to help manage any type of incontinence.

Collection Devices

Internal devices such as indwelling urethral catheters and suprapubic catheters, as well as external devices, such as condom catheters, can be used to manage severe incontinence.

Mechanical Devices

Insertion of a pessary is a nonsurgical method of treating certain problems caused by weak pelvic muscle. A pessary is a rubber device that is inserted into the upper vagina, which presses on the urethra and holds up the bladder neck and uterus. In men, soft external penile clamps (such as the Cunningham clamp) can be used to protect against severe leakage.

FINANCIAL AND ECONOMIC IMPACT OF INCONTINENCE

Incontinence costs Canadians over \$7.5 billion annually.

Incontinence is costly to individuals, employers and the health care system. An individual with incontinence will spend \$1,500 per year on products. Furthermore, incontinence costs Canadian employers almost 9 million days of lost work, and over \$1 billion. Incontinence will also add \$1.95 billion in health care costs to the Canadian system on a yearly basis.

A number of studies have attempted to determine the overall economic implications of incontinence. The Canadian Urinary Bladder Survey (CUBS 2003) showed that 21.8% of Canadians 18 or older have bladder problems, with a cost to Canadians of \$1.5 billion per year.⁹ In the review article of Urinary Incontinence, Viktrup et. al. suggest that: "In 2003, the estimated total economic cost of incontinence in the United States was \$12.02 billion...Costs for elderly women and men with incontinence living in the community totaled \$7.36 and \$1.79 billion respectively."¹⁰

Keeping in mind that Canada's population is ageing, coupled with the fact that the prevalence of incontinence increases with age, costs associated with incontinence will rise and incontinence will become an increasing burden on society.

The following section will determine more specific cost breakdowns to the individual, the employer and society, and the health care system.

⁹International Continence Society <http://www.icsoffice.org/publications/2003/pdf/049.pdf>

¹⁰ Viktrup L, Koke S, Burgio KL, Ouslander JG *Stress urinary incontinence in active elderly women* South Med J 2005 Jan.98(1):79-89

Costs to the Individual

Each year, a senior with incontinence living at home will spend an average of \$1,000 to \$1,500 on incontinence supplies¹¹. These costs, which are paid for by individuals with Urinary Incontinence, include:

- Absorbent Products;
- Additional laundry expenses;
- Additional dry cleaning expenses;
- Additional toilet paper and paper towels;
- Homecare services; and
- Medications not covered by healthcare plans.

According to the 2006 Census, the number of women living in Canada was 16,136,925. The number of women over the age of 15 was 13,414,410. As 7% of women over the age of 15 years experience moderate to severe incontinence, the number of Canadian women living with incontinence in Canada is nearly 1 million (939,008). Therefore on a yearly basis, Canadian women spend nearly \$1.5 billion on products to manage their incontinence.

According to the 2006 Census, the number of men living in Canada over the age of 15 years was 12,618,650. As 3.5% of men over the age of 15 years experience moderate to severe incontinence, the number of Canadian men living with incontinence in Canada is close to half a million (441,652). Therefore, on a yearly basis Canadian men spend over \$600 million on incontinence supplies. In total, Canadian men and women spend over \$2 billion on incontinence products each year.

Table 3: Costs of Incontinence to the Individual	
Women age 15+ years in Canada	13,414,410
Women aged 15+ years with incontinence (*7%)	939,008
Cost of incontinence per year	\$1,500
Out of pocket costs to Canadian women	\$1,408,512,000
Men age 15+ years in Canada	12,618,650
Men aged 15+ years with incontinence (*3.5%)	441,652
Costs of incontinence per year	\$1,500
Out of pocket costs to Canadian men	\$662,478,000
Total out of pocket Costs to Canadians due to incontinence	\$2,070,990,000

Costs of Lost Productivity

People living with incontinence who remain in the workforce find it stressful to manage their incontinence while at work. Some manage by using frequent bathroom breaks, others make extensive use of absorbent products. Still others chose to work from home, or will change their job in order to find a career that will allow them to work around their condition.

Presenteeism is defined as “The problem of workers being on the job but, because of medical conditions, not fully functioning... An example of presenteeism might be an employee who suffers from depression and so is less able to work effectively. And another example might be the employee

¹¹ Subak LL, Brubaker L, Chai TC, Creasman JM, Diokno AC, Goode PS, Kraus SR, Kusek JW, Leng WW, Lukacz ES, Norton P, Tennstedt S, Urinary Incontinence Treatment Network *High costs of urinary incontinence among women electing surgery to treat stress incontinence* Obstet Gynecol 2008 Apr;111(4):899-907

with a migraine headache who may have difficulty looking at a computer screen.”¹² For incontinent individuals who remain at work, the issue of presenteeism is important as it may lead to a decrease in concentration, performance of physical activities, self confidence and ability to complete tasks without interruption¹³. “Leakage or loss of urine is a bothersome symptom that can diminish quality of life and disrupt daily routines. Mounting evidence suggests that employees cannot do their best work when distracted by relatively benign health concerns like allergies, migraines or back pain...”¹⁴

“Co workers may not be aware of the prevalence and impact of involuntary urine loss because it is not freely discussed and can often be concealed. Behaviors such as frequent trips to the toilet or lapses in concentration might be misattributed to poor work habits or insufficient commitment to the organization. From the employee’s perspective, this could limit opportunities for advancement and diminish job satisfaction. From the employer’s perspective, ‘presenteeism’..may be a greater drain on productivity than is absenteeism.”

It is difficult to accurately determine the exact amount of lost productivity that can be attributed to incontinence. However, some studies can shed some light on the issue:

Wu et. al. found that employees with over active bladder (OAB) had 2.2 excess work loss days as the result of medically related absenteeism and 3.4 excess days as the result of disability compared with employees without OAB¹⁵. In a study of workers with chronic conditions at Dow chemical, Collins et.al. found “the associated absenteeism by chronic condition ranged from 0.9 to 5.9 hours in a 4-week period, and on-the-job work impairment ranged from a 17.8% to 36.4% decrement in ability to function at work.”¹⁶

“Chronically ill workers take sick days, reducing the supply of labour – and, in the process, GDP [Gross Domestic Product]. When they do show up for work to avoid losing wages, they perform far below par – a circumstance known as ‘presenteeism’... Output loss (indirect impacts) due to presenteeism (lower productivity) is immense – several times greater than losses associated with absenteeism.”¹⁷

To quantify the cost of incontinence to employers, in terms of absenteeism and presenteeism, the following assumptions were made:

- *7% of the Canadian working female population suffers from incontinence on a daily basis.*
- *As the ratio of women-to-men with incontinence is generally 2:1, 3.5% of the Canadian working male population suffers from incontinence on a daily basis.*
- *Incontinence is a chronic condition that affects individuals in their work life to a similar degree as other chronic conditions.*

¹² Medicinenet.com <http://www.medterms.com/script/main/art.asp?articlekey=40516>

¹³ Fultz N, Girts T, Kinchen K, Nygaard I, Pohl G, Sternfeld B *Prevalence, Management and Impact of Urinary Incontinence in the Workplace* Occupational Medicine 2205;55:552-557.

¹⁴ Quoted by Fultz N, Girts T, Kinchen K, Nygaard I, Pohl G, Sternfeld B *Prevalence, Management and Impact of Urinary Incontinence in the Workplace* Occupational Medicine 2205;55:552-557.

¹⁵ Wu E, Birbaum H, Marynchenko M, Mareva M, Williamson T, Mallett D *Employees with overactive bladder: work loss burden* Journal of Occupational and Environmental Medicine, 2005 47(5)439-446.

¹⁶ Collins JJ, Baase CM, Sharda CE, Ozminkowski RJ, Nicholson S, Billotti GM, Turpin RS, Olson M, Berger ML, *The assessment of chronic health conditions on work performance, absence and total economic impact for employers* J Occup Environ Med 2005 Jun;47(6):547-557

¹⁷ Partnership to Fight Chronic Disease, Milken Institute, *The 2008 Almanac of Chronic Diseases* [Available at <http://www.fightchronicdisease.org/resources/almanac.cfm>]

- According to Statistics Canada, the number of days lost due to illness or disability in 2006 was 7.6 days per worker.
- Individuals with incontinence are affected in a similar manner as those with other chronic conditions, therefore one can extrapolate that these individuals were absent 7.6 days each year.
- According to the Milken Institute, presenteeism represents 4/5th of all indirect costs of chronic conditions. Extrapolating therefore would indicate that presenteeism would account for another 30.4 days of lost productivity per year. In order to remain conservative in estimates, we will attribute only an additional 5 days of lost work to presenteeism due to incontinence.
- Incontinence therefore costs employers at total of 12.6 days of lost work for each person with incontinence.
- According to Statistics Canada, the number of women employed in the labour force in 2007 was 8,453,000.
- According to Statistics Canada, the number of men employed in the labour force in 2007 was 17,945,800
- According to Statistics Canada, the average weekly earnings in 2006 were \$678.91.

Table 4: Labour Force and Participation Rates, Sex & Gender	
Labour Force	2007
Total	17,945,800
Men	9,492,800
Women	8,453,000

Table 5: Calculation of days lost productivity due to Incontinence	
Women in Work Force	8,453,000 women
Women with Incontinence in work force	591,710 women
Men in Work Force	9,492,800 men
Men with Incontinence in work force	332,248 men
Total employees with incontinence	923,958
Absenteeism due to incontinence	7,022,081 days (*7.6 days)
Presenteeism due to incontinence	4,619,790 days (*5 days)
Total Days lost due to incontinence	11,641,871 days

Table 6: Calculation of Cost of Incontinence to employers	
Total Days lost due to incontinence	11,641,871 days
Cost of 1 day of labour	\$135.78 (678.91/5)
Total Cost of Incontinence to Employers	\$1,580,733,217

In summary, incontinence costs Canadian employers over 11 million days of lost work, and over \$1.5 billion. Bringing the condition out of the closet, enhancing access to treatments, providing more treatment options, and encouraging individuals to talk about the condition with their health care providers will help alleviate some of these costs and improve productivity.

Costs of Health Care

Individuals living with incontinence will require increased access to health care services. They will require increased numbers of visits to nurse continence advisors, physicians and specialists; those with overactive bladder may require medications, those with stress urinary incontinence may require surgery, and the elderly may require earlier admittance to long-term care facilities.

Physician visits will be required to diagnose the condition, to develop management strategies, and, if necessary, to refer to specialists. If a patient is referred to a specialist, then increased physician costs will also include time spent by the specialist on assessment of the patient, evaluation for treatment, implementation of treatment and follow up. Wagner et. al. found that individuals with overactive bladder (OAB) reported 20% more visits to the physician than those without OAB¹⁸. Many of the costs associated with Overactive Bladder – both direct and indirect – are comparable to those of Urinary Incontinence. In 1998, a US managed care claims study¹⁹ of the direct medical care resources and costs associated with OAB treatment found an average cost of \$462 per patient per month (\$5,544/year).

A recent report released by the Medical Advisory Secretariat of the Ministry of Health in Ontario concluded “Urinary incontinence...was identified as 1 of the key predictors in a senior’s transition from independent community living to admission to a long-term care (LTC) home For caregivers, UI is often a major driver in the decision to institutionalize elderly family members and is often cited as the “tipping point.”²⁰ Citing studies by Morrison et. al. and Thom et. al, “the authors determined that 10% of all admissions for men and 6% of all admissions for women were attributable solely to UI.”²¹ Incontinence increases the risk of hospitalization by more than 30% and is believed to be a significant factor for institutionalization among the elderly; about half of patient admissions to nursing facilities in the US have listed a diagnosis of incontinence. One study has reported that incontinence doubled the risk of admissions to nursing homes, independent of age and the presence of other diseases.²²

A study examined the incremental costs associated with caring for individuals with incontinence in long term care facilities versus those without incontinence. Shih, et. al. found that the incremental labour costs (per shift) of caring for those patients with occasional incontinence was \$3.31 (2002 US dollars) and \$5.16 for those with frequent UI. “Combining patients with frequent UI (more than 70% of

¹⁸ Wagner TH, Hu TW, Bentkover J, LeBlanc K, Steward W, Corey R, Zhou Z, Hunt T *Health-related consequences of overactive bladder* 2002, Dec:8(19 Suppl);598-607.

¹⁹ Hall J. Direct medical care resources and costs associated with the treatment of overactive bladder using retrospective medical care claims data. JMCP In press.

²⁰ Medical Advisory Secretariat. *Behavioural interventions for urinary incontinence in community-dwelling seniors: an evidence-based analysis*. Ontario Health Technology Assessment Series 2008;8(3).

²¹ Ibid

²² Viktrup L, Koke S, Burgio KL, Ouslander JG *Stress urinary incontinence in active elderly women* South Med J 2005 Jan.98(1):79-89

all UI patients) and occasional UI, the weighted average incremental costs per shift were 4.52 dollars. With incremental labor costs of 4.52 dollars per patient per shift, UI costs an additional 13.57 dollars to treat per day, or 4957 dollars annually.²³

Table 7 provides an outline of health care costs associated with urinary incontinence:

Table 7: Direct Costs Associated with Incontinence	
Average Direct Medical Costs/person	\$5,642 ²⁴
Increased visits to family physician	\$56.10/visit ²⁵
Increased nursing home costs	\$4,957 annually ²⁶
Daily LTC Facility rate (basic)	\$133.75/resident/day ²⁷
<ul style="list-style-type: none"> • Nursing & Personal Care: \$73.69 • Program & Support Services: \$7.12 • Raw Food: \$7.00 • Other Accommodation: \$ 45.94 	

In order to calculate the increased costs of incontinence to the health care system, and in an attempt to remain as conservative as possible, we used the Birnbaum claims data. Similarly, we have not attempted to calculate the increased costs related to early admission to long term care facilities, nor have we calculated increased costs to the LTC facilities due to caring for those with incontinence. Incontinence therefore costs the health care system a *minimum* of \$1.9 billion/year.

²³ Shih YC, Hartzema AG, Tolleson-Rinehart S *Labor costs associated with incontinence in long term care facilities* Urology 2003, Sept;62(3):442-6.

²⁴ Birnbaum H, Leong S, Oster E, Kinchen K, Sun P *Cost of Stress Urinary Incontinence: A Claims Data Analysis.* *Pharmacoeconomics.* 22(2):95-105, 2004. - assuming a Canadian dollar at par

²⁵ Ministry of Health and Long Term Care, *Schedule of Benefits for Physician Services under the Health Insurance Act* accessed December 5, 2007
http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/a_consul.pdf

²⁶ Shih YC, Hartzema AG, Tolleson-Rinehart S *Labor costs associated with incontinence in long term care facilities* Urology 2003, Sept;62(3):442-6.

²⁷ Personal Communication, Carolyn Verleyen, RN BScN MBA, President & CEO, Lutheran Homes, Kitchener Waterloo

Table 8: Calculation of Costs to the Health Care system	
Women aged 15+years in Canada	13,414,410
Women aged 15+ years with incontinence (*7%)	939,008
Women with incontinence who consult their physician (*25%)	234,752
Men aged 15+ years in Canada	12,618,650
Men aged 15+ years with incontinence	441,652
Men with incontinence who consult their physician (*25%)	110,413
Total number of individuals with incontinence who consult their physicians	345,165
Average direct medical costs/person	\$5,642
Increased health care costs due to incontinence	\$1,947,420,930

Cost Summary

Table 9 outlines increased costs to Canadians due to incontinence. Readers should be assured that the costs outlined in this brief are conservative estimates, and have not been inflated. Other costs could also be taken into account, for example; *“Opportunity costs incurred through early retirement may be an important aspect of the indirect costs of urinary incontinence”*²⁸ Furthermore, it has been found that women with incontinence are more likely to also suffer from depression²⁹ which will also increase costs to the individual and the health care system. These additional costs to the individual, society and the health care system due to this fact have not been included in the above estimates.

Table 9: Summary table of increased costs due to incontinence	
Costs to the Individual	\$2,070,990,000
Costs to the employer	\$1,254,550,172
Costs to the health care system	\$1,947,420,930
Total	\$5,272,961,102

In total, incontinence will cost Canadians over \$5.5 billion annually. Many of these costs can be avoided if policy makers put a greater emphasis on helping to increase awareness of the condition among Canadians, on reducing the stigma, and on increasing access to appropriate care and treatments. More detailed solutions follow.

RECOMMENDATIONS

Incontinence is a serious and problematic issue for millions of Canadian women and men. Individuals with incontinence live in embarrassment and fear of discovery about their condition. Significant

²⁸ Fultz N, Girts T, Kinchen K, Nygaard I, Pohl G, Sternfeld B *Prevalence, Management and Impact of Urinary Incontinence in the Workplace* Occupational Medicine 2205;55:552-557

²⁹ Zorn BH, Montgomery H, Pieper K, Gray M, Steers WD. Urinary incontinence and depression. *J Urol* 1999;102:82-84.

advances must be made in order to help people living with incontinence cope with their condition. An important first step is to increase knowledge and education of the condition, which will help reduce the stigma of the condition and encourage individuals to seek help.

Education

The Canadian Continence Foundation urges the government to implement programs to educate the medical community and public at large about incontinence.

It has been suggested in the body of work that has studied incontinence that education about urinary incontinence should be directed at *all* organizational levels to reduce embarrassment, promote communication and provide women with information about prevention and treatment.³⁰

The education of physicians is a vital step in helping Canadians who live with incontinence, as research has found that there are wide variations in knowledge, attitudes and comfort levels among family physicians when dealing with incontinence.³¹ Herbruck suggests that education should begin in medical schools: “Educating future health care providers to approach these topics with sensitivity will positively impact the care patients receive.”³²

Further, “Beyond ensuring that employees are given the knowledge, time and facilities for managing urinary (in)continence, occupational health professionals are in a unique position to provide insight relating urinary incontinence to the nature of work³³.”

Education should also be directed at nurses who are often the front line contact for patients. Nurse continence advisors should also be provided with training to aid those living with incontinence. Finally, an emphasis must be placed on providing more education for individuals living with incontinence as patients with greater knowledge of their condition feel more empowered, feel more confident asking questions, take a more active role in their treatment, and are more compliant with treatment. Funding should be provided to the Canadian Continence Foundation and other appropriate organizations to aid in providing more widespread education to patients.

Wait Times Strategy

The Canadian Continence Foundation urges the government to include urinary incontinence in the Wait Times Strategy.

It is important that urinary incontinence, and stress urinary incontinence in particular, be included in the National Wait Times Strategy. The Strategy is a 10 year plan created by the Federal Government which outlines strategic investments directed towards reducing wait times for access to care, particularly for certain conditions (cancer, heart, diagnostic imaging, joint replacement and sight restoration services.)

If a Canadian with incontinence finally overcomes his or her reticence and discusses the condition with his or her physician, he or she will often have to wait 6-9 months before an appointment with a

³⁰ Fultz N, Girts T, Kinchen K, Nygaard I, Pohl G, Sternfeld B *Prevalence, Management and Impact of Urinary Incontinence in the Workplace* Occupational Medicine 2205;55:552-557

³¹ Swanson JG, Skelly J, Hutchison B, Kaczorowski J *Urinary incontinence in Canada. National survey of family physicians' knowledge, attitudes and practices.* Can Fam Physician. 2002 January 48:86-92.

³² Herbruck LF, *Stress Urinary incontinence: prevention, management, and provider education* Urol Nurs. 2008 Jun;28(3):200-6.

³³ Fultz N, Girts T, Kinchen K, Nygaard I, Pohl G, Sternfeld B *Prevalence, Management and Impact of Urinary Incontinence in the Workplace* Occupational Medicine 2205;55:552-557

specialist is available. Another 4-6 month wait is generally required to assess the incontinence, and if surgery is an option, patients can wait up to two years to receive the surgical treatment that they require³⁴.

Dr. Richard Baker, a surgeon in Ottawa describes the problem in the following manner:

“In some of our major Canadian cities right now there are waiting lists of at least one year to see a specialist in incontinence and waiting times for surgery to address incontinence are as long as two years. Women are left without access to physiotherapists. In many, physiotherapy could be useful and even prevent the need for surgery. However, where surgery is required, those who suffer from SUI are too often denied access to the care they need.”³⁵

The Canadian Continence Foundation urges the government to include urinary incontinence in the Wait Times Strategy to help Canadians living with incontinence obtain *timely* access to appropriate treatments.

Performing more Cost Effective Surgical Procedures

The Canadian Continence Foundation urges the Government to increase funding to allow for more treatment to be provided to people with stress incontinence, such as surgical correction of stress incontinence with slings. As a first step, the Canadian Continence Foundation urges the Ontario government to provide \$16 million in dedicated funding to ensure that incontinent individuals are treated in a timely manner. It is anticipated that similar initiatives will be undertaken in other provinces.

As discussed in a previous section (types of incontinence and their treatment), there now exist excellent surgical options for the treatment of stress urinary incontinence (if all other more conservative methods of treatment fail.) Sling insertion and retropubic suspension procedures have both been found to be effective methods of treating Stress Urinary Incontinence, which is the most common form of incontinence.

Until recently, the ‘gold standard’ for SUI surgery was the retropubic suspension (also called “Burch”) procedure, as it is effective and has good long-term viability. However, the newer sling procedures are rapidly taking over from this method. Sling insertion (of which TVT is the only brand supported by significant clinical research) was first introduced 10 – 15 years ago. There have been many patients treated with this technique but it was with the publication of the first prospective randomized trial of the sling versus retropubic suspension that it became much more widely accepted³⁶. The study compared the two techniques at 6 months and again at 2 years in the same groups of patients and found the durability and effect on SUI was equivalent. However, the overall patient morbidity and quality of life was better with the sling compared to the retropubic suspension procedure.

When comparing costs, one must take overall costs into account; not simply the unit cost of the materials. Table 10 provides an outline of costs for the two procedures:

³⁴ Carr L, Urologist, Sunnybrook Health Sciences, presentation, *Shedding light on a neglected women’s health issue stress urinary incontinence*, September 22, 2006

³⁵ Baker, K. Letter, Marie Fortier, Champlain LHIN, October 16, 2008

³⁶ Ward K, Hilton P. *Prospective multi-centre randomized trial of tension-free vaginal tape and colposuspension as primary treatment for stress incontinence*. *BMJ* 2002; **325**: 67–73

Table 10: Costs of sling insertion versus retropubic suspension		
Economic Comparison	Sling Insertion	Retropubic Suspension
Average Total Cost	\$3,032	\$6,047
Device Cost	\$730	0
Average length of hospital stay	0 days	5 days
Surgery Time	30-45 minutes	60-90 minutes
Procedure performed at Ambulatory Centers?	YES	NO
<i>Table source: Ministry of Health and Long Term Care, Ontario</i>		

Dr. Richard Kalbfleisch, a surgeon working in Hamilton provides an outline of the issues with funding for sling procedures:

“Prior to 2001 I could do as many of the traditional Burch procedures a year as necessary to meet my patients needs. With the new TVT procedure I am limited to 96 procedures a year...Up until the hard cap was put in place, I was doing 178 TVT procedures per year. In 2007 the OR manager at the McMaster site of Hamilton Health Sciences actually cancelled several of my patients booked for the TVT a week before their surgery because of the cap. I am told by management that the cap is in place because lack of government funding. Currently I am booking this type of surgery in December 2011. That works out to 384 of my patients waiting for their incontinence surgery. Do you think this is reasonable? Why doesn't the wait time to services apply to urinary incontinence? In Hamilton Health Sciences we need funding for at least 600 TVT procedures a year collectively for all surgeons at our site.”³⁷

The Ontario Health Technology Advisory Committee (OHTAC) report concluded that “Midurethral slings are highly effective in treating stress urinary incontinence in women who have failed conservative treatments. Midurethral slings are as effective as colposuspension and are less invasive.”³⁸ The Committee recommends increased access to midurethral slings through development of an appropriate fee code, as well as the development of guidelines and training for surgeons in the use of midurethral slings.

The Canadian Continence Foundation urges provincial governments to follow the recommendations of the Ontario Health Technology Advisory Committee.

Creation of Community Clinics

The Canadian Continence Foundation urges the Government to set aside funding for the creation of Community-based Continence Care Clinics.

³⁷ Kalbfleisch, R Letter, Ministry of Health and Long Term Care, Ontario, November 10, 2008

³⁸ Ontario Health Technology Advisory Committee *Advancing Health Evidence-Based Advice on Health Technology* 2003-2008 [Available at: http://www.health.gov.on.ca/english/providers/program/ohtac/pdf/progress/full_report_2008.pdf last accessed May 11, 2009]

Numerous studies have found that those individuals living with incontinence in the community are underserved, and that continence services should be “community focused, multi-disciplinary, and generalist in nature.”³⁹

There is a clear need for Continence Care Clinics to be established within communities across Canada. These clinics would provide access to GPs and specialists for diagnosis, to physiotherapists and nurse continence advisors for treatment, and to others for access to a range of continence-related information. Community-based Continence Care Clinics will:

- Improve access to continence care;
- Provide awareness, support and education about incontinence in the community;
- Maximize access to effective non-surgical therapies;
- Triage patients to appropriate continence care providers to optimize patient flow within the health care system; and
- Collaborate for the purpose of education, research, and professional development.

Access to Conservative Treatments

The Canadian Continence Foundation urges the Government to increase funding for conservative treatments for people with incontinence.

Conservative treatments such as physiotherapy and behavioral treatments are often the most effective and least invasive of all incontinence treatment solutions. Increased information about, and access to these types of therapies is necessary in Canada (i.e. some hospitals and private therapy clinics).

Increased access to a choice of medications

The Canadian Continence Foundation urges the provincial governments to include all drugs to treat urinary incontinence on provincial formularies.

The Canadian Continence Foundation also urges the Committee to Review Drugs (Ontario formulary) to perform an extensive review of the OAB drug class to ensure that the most effective medications are uniformly and fairly covered.

There are a number of medications available for the treatment of overactive bladder. Some of the older medications are available on provincial formularies. However many of the newer medications have not been included and some of these drugs are easier to take and have less unpleasant side effects.

Increased Funding for Absorbent Products

The Canadian Continence Foundation urges the government to increase its daily funding allotment for absorbent products in long-term care facilities.

The Canadian Continence Foundation urges the government to increase funding for the purchase of absorbent products for those individuals living on fixed incomes.

³⁹ St John W, Wallis M, James H, McKenzie S, Guyatt S *Targetting community-dwelling urinary incontinence sufferers: A multi-disciplinary model community-based model for conservative continence services* Contemporary Nurse October 2004 17(3) 211-222.

Current funding for paper products in long-term-care facilities is minimal at best. Given that funding levels are so low, nurses are allowed to change diapers a limited number of times each day. Residents are therefore often forced to sit in a wet diaper for hours at a time. Barrier creams and other 'diaper rash' remedies are often required. This is an indignity that should not be tolerated.

Similarly, Canadians living on fixed incomes often cannot afford to buy enough absorbent products. Increased funding for the purchase of absorbent products is required both for individuals living in the community and in long term care facilities.

Increased Funding for Catheters

The Canadian Continence Foundation urges provincial governments to increase their funding for catheters for individuals living in the community and in institutions.

Access to catheters varies greatly across the country and provincial reimbursement for catheters is different in each province. In order to avoid urinary tract infections, it is suggested that individuals using catheters use them only once (single use). This would require that the catheter be changed five to six times each day. There is also a wide variety in quality of catheters, ranging in price from \$0.75 for a lower quality catheter, to \$5.25 for higher quality catheters. If each catheter is used only once, this indicates a yearly cost of \$1,370.00 – \$8,200.00 per year. This represents a significant investment and most affected individuals have difficulty absorbing this cost without aid from the government.

Of all provinces, Saskatchewan has the most generous subsidies for catheters, and it is suggested that other provinces look to Saskatchewan as a potential model for emulation.

Inequality in access to treatment between provinces

The Canadian Continence Foundation urges provincial governments to provide equal access to continence care and treatment.

Canadian men and women who need treatment for incontinence face widely varying levels of access to care across the country. It is unacceptable that whether someone with incontinence receives treatment in a timely manner is often dependant upon where the individual lives. This wide variation applies to access to pelvic floor surgery, drug coverage and access to surgical materials.

ACKNOWLEDGEMENTS

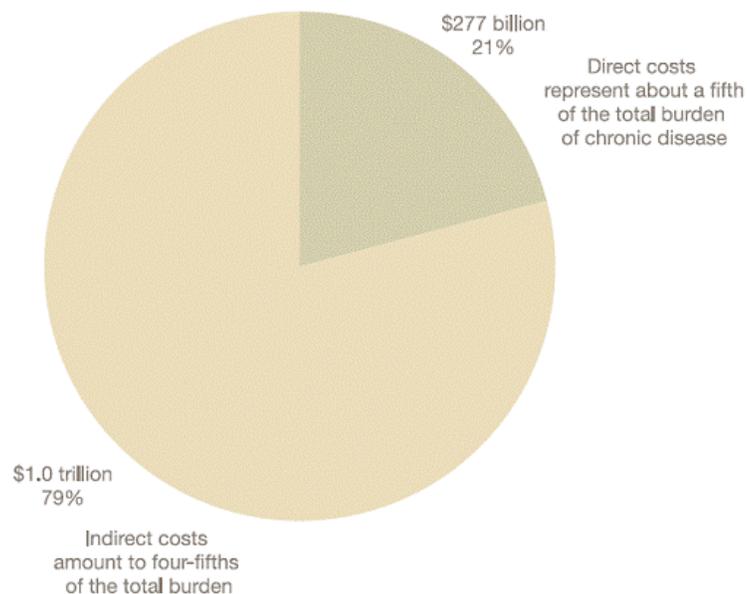
Thanks to the Astellas Foundation for their generous support of the Canadian Continence Foundation and this project.

The Impacts of Incontinence in Canada report was researched and written by Elisabeth Fowler, World Health Advocacy.

APPENDIX I: HEALTH CARE SPENDING, CHRONIC DISEASES

HEALTH CARE SPENDING RELATED TO CHRONIC DISEASES IS DWARFED BY THE INDIRECT COSTS OF THESE HEALTH PROBLEMS

Total cost burden in 2003 for seven common chronic diseases*



- Direct costs = Health care costs associated with treatment of chronic disease
- Indirect costs = Productivity losses such as absenteeism and presenteeism associated with people with chronic diseases

*This study evaluated the burden of seven of the most common chronic diseases/conditions (cancers, diabetes, heart disease, hypertension, mental disorders, pulmonary conditions, and stroke).

Source: DeVoi R, Bedroussian A, et al. An Unhealthy America: The Economic Burden of Chronic Disease. The Milken Institute. October 2007. Full report and methodology available at: www.chronicdiseaseimpact.com.

APPENDIX II: INCONTINENCE WEB SITES & CHAT ROOMS/FORUMS

International Foundation for Functional Gastrointestinal Disorders

<http://www.aboutincontinence.org/site/about-incontinence/courageous-profiles/>

Incontinence Support Center

<http://www.incontinencesupport.org/>

I am Incontinent

<http://www.experienceproject.com/groups/Am-Incontinent/2090>

Incontinence Resource Center

<http://www.incontinencesupport.org/>

Canadian Continence Foundation

<http://www.continence-fdn.ca/>

InContact

<http://www.incontact.org/chat.html>

Depend Message Board

www.Depend.com

Bladder and Bowel Foundation

<http://www.bladderandbowelfoundation.org/>

The Simon Foundation for Continence

<http://www.simonfoundation.org/>

National Association for Continence

<http://www.nafc.org/>

International Continence Society

http://www.icsoffice.org/ASPNET_Membership/Membership/Home.aspx

SeekWellness

<http://www.seekwellness.com/incontinence/>

National Urologic and Kidney Diseases Information Clearinghouse

<http://kidney.niddk.nih.gov/kudiseases/topics/incontinence.asp>

Mayo Clinic, Incontinence Section

<http://www.mayoclinic.com/health/urinary-incontinence/DS00404>

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