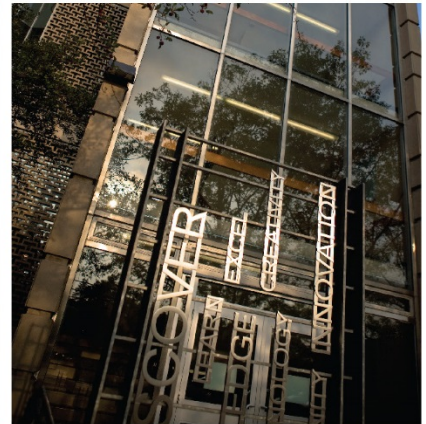




ADDRESSING OVERUSE OF HEALTH SERVICES IN CANADA



EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Addressing Overuse of Health Services in Canada**

18 November 2015

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

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SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed with the features of the problem described in the evidence brief, which included the overuse of health services leading to unneeded and potentially harmful care for patients, a range of system-level factors, a culture of ‘more is better’ combined with competing priorities between patients and providers, and fragmented approaches to address overuse with a lack of evaluations of them. Dialogue participants identified several additional features of the problem and its causes, including: 1) the language and framing used in discussing the overuse of health services (e.g., not considering the full spectrum of services, including harmful, marginally effective and low-value services); 2) a broader array of complex and interrelated causes of overuse (e.g., patient-level heterogeneity, provider remuneration and incentives, the role of industry in overuse, the lack of role clarity, and the lack of integrated approaches to addressing the issue); and 3) implications of provincial contexts for the problem (e.g., political and economic commitments, and variability in the availability of data, evidence, groups and processes that are needed to address the problem).

Overall, participants emphasized that in order to make a concerted effort towards addressing overuse of health services in Canada, there is a need for system leaders who will take ownership of the issue, and who can lead a process to develop a coherent framework and approach that everyone can use (instead of a fragmented approach across different groups). Participants generally agreed that identifying and prioritizing the services that need attention (element 1) could be strengthened by making better use of practice-variation data, technology reassessment and engagement of patients and stakeholders in identifying priorities to address. However, participants indicated that this needs to be coupled with efforts to diagnose the drivers of the problem, and determine the right level at which action is needed and the nature of that action. Participants also indicated that stakeholder-led action (element 2), particularly education coupled with meaningful clinician and patient engagement, is needed to support long-term cultural shifts, including stewardship roles for clinicians and appropriate expectations among patients. Lastly, for government-led actions, participants indicated that the focus should be on what governments are uniquely positioned to do to discourage the use of some services over others, including the development of strategic directions and accountability frameworks, stakeholder engagement, data integration, changing remuneration mechanisms, and behaviour-change supports.

Participants identified three type of activities for initially addressing overuse of health services in Canada. The first related to implementing processes to better harness and share data, developing a common framework with which to identify, diagnose and address overuse, and packaging evidence for use by policymakers when needed. Second, participants emphasized the need to develop role clarity among and synergy between system actors in diagnosing and addressing the problem using a common framework, and that that this needs to be combined with concerted efforts for building commitment and accountability for inter-provincial work to foster national action. Lastly, many participants indicated that both of these activities will require the implementation of approaches to get traction with different groups, including engaging at a grassroots level with the public, finding ‘early wins’ to garner political support, and positioning the issue within existing health-system priorities.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed with the features of the problem described in the evidence brief:

- overuse of health services leads to unneeded and potentially harmful care for patients, and places strain on already overstretched health systems;
- overuse of health services is driven by a range of system-level factors;
- addressing overuse is complicated by a culture of ‘more is better,’ patient and provider characteristics, and competing priorities between patients and providers; and
- numerous initiatives have been developed to address overuse of health services, but they are fragmented and not well evaluated.

However, dialogue participants also identified several additional components of the problem that were seen as important but not fully covered in the evidence brief. The additional components broadly related to the:

- 1) language and framing used in discussing the overuse of health services;
- 2) array of complex and interrelated causes of overuse of health services; and
- 3) implications of provincial contexts for the problem.

We describe the key themes that emerged related to these three additional components of the problem below.

Language and framing used in discussing the overuse of health services

Many dialogue participants struggled with the term ‘overuse of health services’ given that it leaves out important considerations. However, most acknowledged that terminology in this area is generally confusing, with many terms (e.g., disinvestment, low-value care and inappropriate care) used to refer to the same or similar concept. Given this, participants agreed with the suggestion of one dialogue participant who indicated that the issue should be considered across the full spectrum from harmful services, to marginally effective services, to low-value services, and of another participant who indicated that this should also include services with uncertain benefits or harms. Adding to this, the latter participant indicated that “then we are left only with high-value services, which is what we want to focus on providing.”

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Canada;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three elements of a potentially comprehensive approach for addressing the policy issue;
- 4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of a comprehensive approach for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

Agreeing with this overall framing, several other participants pointed out that the language used to discuss overuse will need to differ depending on the target audience. For example, one participant indicated that unnecessary care is most likely to resonate with patients. In contrast, another participant suggested that using the language of supporting appropriate care will be most likely to garner interest and support from clinicians given their focus on the specific needs of a patient (for whom some services will be appropriate and others not, depending on the patient's needs). As pointed out by another participant, it was this framing rather than cost saving that has been able to generate enthusiasm among physicians about the Choosing Wisely campaign. However, language that suggests cost saving was highlighted by some as being more likely to resonate at the level of organizations and governments. For example, one participant suggested that the language of disinvestment (a term often viewed negatively by patients as well as clinicians) would be more likely to capture the attention of those making decisions in organizations and governments given their focus on keeping budgets in check.

In addition to the language used to describe the issue in general and for particular target audiences, several participants emphasized the importance of considering alternative framings that further highlight the broad implications of the issue. For example, some participants noted that the issues of overuse, misuse and underuse can and should be considered together given important interdependencies among them. For example, one participant indicated that while the term overuse is helpful, it seems difficult not to talk about underuse as well. Specifically, the participant indicated that there is a tension in talking about ensuring appropriate use of services, but not including within that discussion the lack of access to important services (with palliative care and mental health and addictions being two examples given). Another participant further emphasized this in relation to the concept of opportunity cost, according to which not addressing overuse means an inability to use existing resources to invest in services that are currently lacking. Building on this point, this participant cautioned that the “reality is that the individuals who bear the gravest consequences of any decisions are often the members of vulnerable groups.”

Array of complex and interrelated causes of overuse of health services

Throughout the deliberations, participants consistently emphasized that the problem is complex with many causes, of which most causes, but not all, were identified in the evidence brief. Participants particularly emphasized issues related to: 1) patient-level heterogeneity; 2) remuneration and incentives for providers; 3) competing priorities among citizens/patients, clinicians and policymakers in the context of a culture of ‘more is better;’ 4) the role of industry in promoting the overuse of health services; and 5) lack of role clarity and integrated approaches to addressing the issue. First, as noted in the brief, patient heterogeneity makes it rare that a service can be fully withdrawn, since a given service may offer little or no benefit to many patients with certain risk factors, while being extremely beneficial to a small number of other patients. Highlighting this point, one participant indicated that “it’s not that technology should never be used, but that it should only be used in certain circumstances for specific people.” Similarly, another participant indicated that overuse “implies that there is a threshold, but it’s difficult to reconcile that with the inherent variation among patients.”

Second, in relation to the challenge of remuneration systems often providing incentives for physicians to provide more services, but not necessarily more appropriate services, one participant indicated that this is particularly challenging to address “unless physicians are willing to engage in the role-sharing needed to address overuse.” Another participant indicated that another consideration related to payment that was not covered in the brief was the lack of awareness among clinicians and patients about the true cost of services, especially in relation to the expected benefits.

Third, participants pointed in several ways to the issue of competing priorities among citizens/patients, clinicians and policymakers in the context of a culture of ‘more is better.’ For example, one participant indicated agreement with the evidence brief about the culture of ‘more is better.’ However, this individual

added that an additional underlying cause of this culture is that “our system always seems to have an inferiority complex as compared to other jurisdictions” and the “competition between [provincial] neighbours for having access to the newest and best” is also an important driver of this culture. A second participant further emphasized the point from the evidence brief about physicians being caught between the priorities of patients who often want more, and the system that is telling them to reduce the services provided. However, adding a critical perspective to this tension, a third participant indicated that respecting clinician autonomy is in conflict with addressing overuse, and that “in respecting the autonomy of the most powerful people in the system, we ignore the needs of those most in need.” The participant further noted that this is something that often gets lost in discussions about addressing overuse, and needs to be emphasized more in policy deliberation and policy development.

Fourth, the role of industry was identified as an important contributor to overuse of health services. One participant indicated that fundamental to the problem is “aggressive marketing about the latest and greatest technologies.” The participant noted that this marketing comes in many forms, such as workshops from industry about how to implant a new valve that costs significantly more than one that provides the same or similar benefits. Marketing directly to patients was identified as being particularly problematic given that patients are seeking out more and more information by themselves on the internet where marketing regulations are much less effective. Following this, patients then bring this information to their physician, who may be inclined to provide the service ‘just in case.’

Lastly, participants identified a lack of role clarity for, and integrated approaches to, addressing the issue as key components of the problem. One participant raised this in the context of the restructuring of health authorities in their province, which resulted in a lack of clarity about whose role it is to make changes (let alone about what needs to be done to address the issue of overuse). However, this participant also indicated that despite this challenge, the province still has strong leadership capacity, so that if capacity can be better organized and harnessed through greater role clarity and accountability agreements, then the issue could be addressed. Emphasizing the lack of integrated approaches among stakeholders to address the issue in different provinces, another participant indicated that it is “very difficult to do this in isolation, and there really has to be a larger programmatic plan and framework in place.”

Implications of provincial contexts for the problem

Dialogue participants also emphasized two ways in which provincial contexts have important implications for understanding the problem and engaging in coordinated cross-provincial action. First, the current economic situation and the political commitments that have been made by current political leaders shapes the range of what can be done in any given province. Second, the availability of data, evidence, groups and processes needed to address the problem further shapes this range. Combined, participants indicated that these contextual factors significantly contribute to the difficulty in coordinating action across the country. For example:

- some provinces may have new political leaders with a strong political commitment to address overuse in a particular way and over a tight timeline, whereas others may not have such political commitment or have prioritized different longer-term approaches;
- some provinces may have hospital-based health-technology assessment groups, whereas others may have more accessible data; and
- some provinces may have robust approaches to clinician engagement and strong connections to the Choosing Wisely campaign, where others may have neither.

DELIBERATION ABOUT POLICY AND PROGRAMMATIC ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH TO ADDRESSING THE PROBLEM

Participants generally agreed that a comprehensive approach to addressing the problem needs to include actions to identify services that are overused (element 1) and to address the identified priority areas through a mix of stakeholder- and government-led initiatives (elements 2 and 3). However, participants also indicated that the proposed approach to addressing the problem lacked an element focused on diagnosing the drivers of overuse, and determining the right level at which action is needed and the nature of that action. Participants indicated that this type of activity would most logically follow efforts to identify and prioritize health services that are overused (element 1). We summarize deliberations about this proposed new element as part of element 1 below.

Element 1 - Implementing transdisciplinary approaches to identify health services that are overused

Identifying and prioritizing the services that need attention

Of the range of approaches profiled in the evidence brief that have been used to identify and prioritize services that are overused and need attention, participants emphasized the importance of focusing efforts on making better use of data to identify practice variation, as well as to prioritize technology for reassessment in Canada. While participants indicated that variation analyses are important, they also indicated that there is relatively little systematic use of practice-variation data to draw attention to areas requiring reassessment. Some noted that this is due to insufficient data in their province (but some indicated that their province has dedicated capacity for standardizing and understanding data), and others indicated that the analyses are conducted but not used. For example, one participant stated that variation analyses “produce interesting and colourful maps, but they don’t have an impact on changing practice.” For technology reassessment, participants indicated that there is an increasing focus on the reassessment of widely used drugs and, to a lesser extent, other technologies, which can be built upon going forward. However, participants noted inconsistent capacity across the country for conducting such analyses and suggested that the prioritization of technologies for reassessment is not yet systematic, transparent or both.

Given this state of affairs, participants identified important components of what needs to be done to better identify and prioritize services for reassessment. First, some participants highlighted that in order to make the best use of practice-variation data, the data needs to be accompanied by quality standards that indicate what services are needed, and by standards for timely access to appropriate and high-quality care. Second, several participants indicated the need for meaningful consultation with citizens and stakeholders to identify priorities from among the many areas of high practice variation, and to inform stakeholder- and/or government-led action to address the variation. Third, one participant pitched the idea for provinces with strong health-technology-assessment capacity to share capacity with other provinces to identify priorities for reassessment across the country. Lastly, several participants emphasized the need to build close connections between the re-assessors and key stakeholders and government officials, as a mechanism to increase the prospect for usable reassessments and for action based on these reassessments.

Diagnosing the drivers of overuse and determining the right level at which action is needed and the nature of that action

One participant raised the issue that identifying health services that are overused is insufficient and it needs to be accompanied by processes to diagnose the drivers of overuse in order to then determine where action is needed and the nature of that action. Participants all agreed that this is an essential additional step that was not included in the original description of the elements, and shared several ideas for how this could be done. One participant suggested that turning the diagnosis of the drivers of overuse into actions to address it will only work if receptors are in place at the system level that can be used to spur change. Another participant outlined that strategic clinical networks are emerging in some provinces as the natural group to take on significant aspects of this role, given that such networks work across all sectors in the health system and could

offer the ability to generate system-wide action. These networks typically champion efforts to provide appropriate care across the continuum of care for a particular disease, which can include the identification of projects for reassessment and using their leadership role to support practice change in their community of practice. Several participants supported this idea, indicating that the diagnosis of the drivers of overuse needs to happen closer to the front-lines of care, and that such networks could also address the need to shift expectations for system-level stewardship away from individual clinicians to clinical communities.

However, some participants cautioned that for a model like strategic clinical networks to do this in a systematic and coordinated way, several considerations need to be addressed. For example, several participants emphasized the need for a commitment to engage a broader spectrum of participants in activities to diagnose the drivers of overuse, and to determine the level and nature of action required. Other participants noted that leaders in their province have expressed interest in such a model if physicians are brought into the process and commit to remain engaged in the tough decisions that need to be made. Others indicated that a broad array of physicians (particularly family physicians), as well as home and community care providers, need to be engaged. In addition, other participants stressed the need to engage representatives from other sectors to be able to address the issue from a broader societal perspective. However, while the engagement of these groups was seen by some as essential, participants emphasized that action also requires political will, and that system leaders will need to continue to act as a steward for the health system.

Element 2 - Implementing health-system stakeholder-led initiatives to address overuse

Participants indicated that stakeholder-led action is essential to support long-term cultural shifts required to support stewardship roles for clinicians and appropriate expectations among patients. Several participants emphasized that an important part of supporting such a long-term cultural shift is prioritizing education for, and engagement with, clinicians and patients. For clinicians, participants indicated that education needs to include interactive and continuous learning that focuses on building leadership capacity, supporting a culture change, and building of communities of practice that can take leadership roles within the system. One participant placed particular emphasis on the need for building leadership capacity in the system, and indicated that “we can’t underestimate the need to build this type of capacity in the system.” Turning to clinician engagement, several participants highlighted that engaging a range of stakeholders is essential for allowing groups to take ownership of the issue. For example, one participant outlined how meaningful changes to address overuse in a major hospital through the Choosing Wisely campaign were achieved by engaging a range of stakeholders in the process and, as a result of this engagement, those stakeholders taking ownership of implementing changes in their respective areas.

The provision of information and education to patients and engaging them in efforts to address overuse was similarly highlighted as essential with one participant indicating that “we have a generation who expects to be part of decision-making and be empowered by information.” One participant indicated that an approach that should be prioritized to address this goal is doing a better or more consistent job of engaging in shared decision-making with patients. Acknowledging that this is not a new idea, the participant highlighted that it has not been taken up despite strong evidence about the benefits of providing information to patients and engaging them in shared decision-making through decision aids.

Element 3 - Implementing government-led initiatives to address overuse

Participants highlighted that while de-listing services is one approach that governments are uniquely positioned to implement, it is very rare for a service to be completely de-listed. Instead, participants indicated that the focus should be on what governments are uniquely positioned to do to discourage the use of some services over others, particularly where “governments can do things at scale that can achieve efficiency.” Key areas identified by participants for government leadership included:

- developing strategic priorities, as well as accountability frameworks and agreements related to those priorities, that could support collaboration and consistency among provinces (e.g., in prices for drugs and technologies);
- engagement of a broad array of stakeholders, including patients, and supporting a process to bring together stakeholders with competing interests in an interdisciplinary working group to work towards common goals;
- integrating data and ensuring access to and use of it (e.g., through audit and feedback to support the provision of appropriate care) given that the government has the powerful and unique ability to strengthen the collection, dissemination and use of data;
- changing remuneration mechanisms to place conditions on how and when services can be used (e.g., modifying fee codes, establishing prior approval mechanisms or moving away from ineffective financial bonuses to penalties); and
- implementing other strategies that can support behaviour change at the system level (e.g., changes to test-ordering forms, standardization of order sets in electronic medical records, and/or other decision-support systems).

One participant also raised the option of value-based insurance, which was mentioned in the evidence brief. This participant indicated that value-based insurance is essentially a synonym for cost-sharing and highlighted that there is strong evidence that this type of approach is not good at achieving desired outcomes. Given this, the same participant emphasized that this type of approach should be resisted, with the rest of the participants generally agreeing.

Considering the full array of options

Overall, participants emphasized that in order to make a concerted effort towards addressing the overuse of health services in Canada, there is a need for system leaders who will take ownership of the issue and who can lead a process to develop a coherent framework and approach that everyone can use (instead of a fragmented approach across different groups). Participants generally agreed that identifying and prioritizing the services that need attention (element 1) could be strengthened by making better use of practice-variation data, technology reassessment, and the engagement of patients and stakeholders in identifying priorities to address. However, participants indicated that this needs to be coupled with efforts to diagnose the drivers of overuse, and determine the right level at which action is needed and the nature of that action. Participants also indicated that stakeholder-led action (element 2), particularly education coupled with meaningful clinician and patient engagement, is most needed to facilitate long-term cultural shifts that support stewardship roles for clinicians and appropriate expectations among patients. Lastly, for government-led actions (element 3), participants indicated that the focus should be on what governments are uniquely positioned to do to discourage the use of some services over others, including developing strategic directions and accountability frameworks, engaging stakeholders, integrating data, changing remuneration mechanisms, and supporting behaviour change.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Four themes emerged from the deliberations about implementation considerations. First, some participants indicated that a key part of any implementation plan will be avoiding duplication of effort, which requires the ability to share successes across the country so they can be used by others. These participants indicated that there are several players that are well positioned to help make this happen across the country, including those with a national scope (e.g., Canadian Agency for Drugs and Technologies in Health) as well as provincial and local initiatives. Second, two participants focused on the lack of system capacity to design and implement behaviour-change programs as the main implementation challenge. One participant indicated that quite often decisions are made about the type of things that need to be done, but not how it's going to be done or the types of supports that are needed to make change happen. The same participant noted that real change can be

made through relatively small behavioural changes, which may be more politically palatable than pursuing larger-scale change across provincial and territorial health systems. Another participant indicated that there is a need to learn from other systems that have been able to overcome the challenge of supporting behaviour change in professional groups. Third, one participant raised the concern that in the current fiscal climate it can be enticing to focus on cost instead of quality and equity. Agreeing with this, another participant said that a lack of focus on equity would be worrying given that, as outlined in the problem section of the evidence brief, the tendency to react to those with the loudest voices means that the quieter voices of those most in need are often ignored. Lastly, one participant indicated that an important barrier underlying all of these considerations is what they see as a general “lack of courage both to implement new and promising approaches, [and] to stop those things that we are doing but that don’t add value.”

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Participants identified three type of activities for moving forward with addressing overuse of health services in Canada. The first activity related to implementing processes to better harness and share data. Several participants indicated that using data, information and evidence to set priorities and develop plans is critical, with one participant noting that “having the data is an immensely powerful tool.” Others noted that while there are big data gaps, understanding where the gaps lie is important for being able to set priorities to fill them over time. Moving forward, participants indicated that developing a common framework, checklist and/or targets that could be used to identify, diagnose and address overuse would be extremely helpful, with some noting that the Canadian Agency for Drugs and Technologies in Health or other national organizations might be best positioned to lead this. One participant indicated that a national approach to developing a common framework, checklist and targets could be developed, and that the costs for such efforts should be minimal, yet the benefits significant. In addition, one participant noted that the ability to package this information to inform policy platforms with the best available data and evidence needs to be improved and done more proactively. Another participant suggested that one such deliverable to address this could be a toolkit to educate those new on the scene to the issue of overuse of health services and how to address it.

Second, participants emphasized the need to develop role clarity and synergy among system actors for identifying, diagnosing and addressing overuse using a common framework. Participants indicated that this needs to be combined with concerted efforts to build commitment and accountability for inter-provincial work and national action where feasible. One participant indicated that building role clarity among different system actors, such as policymakers, health regions and stakeholders, will help ensure they are working together toward common goals. One participant specifically noted their interest in forging ahead with more collaborative decision-making and co-design of policy. This participant indicated that governments tend to inherit all of the risk in addressing complex issues and therefore what’s needed is a collective sense of ownership to enhance transparency among policymakers and communities. Moreover, the same participant indicated that they would like to contribute to a pan-Canadian approach that goes beyond just sharing ‘lessons learned’ and includes some sort of federal mandate to deliver on big objectives, because otherwise it will just be another roundtable for discussion that does not spur action.

Lastly, many participants indicated that both of the aforementioned activities will require the implementation of approaches to get traction with different groups. Several participants indicated that an important component of this is to foster grassroots engagement through social media for the public and other stakeholders. For example, in emphasizing the need to identify where national action might be appropriate, one participant indicated that “key levers like social media exist across borders and these need to be harnessed for the greater benefit of the country as a whole.” Another participant indicated that social media needs to be used well, which requires engaging key influencers in Canada who can have an impact on the views of Canadians and not cast doctors and governments in a bad light.

Other participants indicated that “we need to start now” and build momentum to address the issue. Several participants indicated that one action on which provinces could collaborate would be to create a list of “low-hanging fruit” to show early success in reducing harms and costs, and to build momentum for addressing more complex services over the medium to long term. Responding to this point, and again emphasizing the need to identify where national action is logical, one participant indicated that “instead of working with provincial medical societies to develop lists, they need to work with national bodies given the chaos of doing this across multiple bodies in each province.” While agreeing on the need for action, one participant stated that “we just need to start and go beyond lists and checklists. We need to act.” This participant indicated that there is a large amount of evidence about how to effectively change behaviour and that this needs to be used to make change happen now, with the most logical starting point being to change what tests are allowed to be ordered given that reductions in test ordering can have a significant impact on eliminating unnecessary services. Building on this, one participant also indicated that progress in addressing the issue could initially be made by positioning it within existing priorities. For example, the participant described how their province has training programs in place for promoting physician leadership and quality improvement, which could be leveraged towards the bigger goal of addressing the overuse of health services, and likely be replicated in other provinces. Lastly, one participant indicated that critical to all of this is “engaging champions because they have a lot of influence on the prescribing practices of others working in their community of practice.”

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