Dialogue Summary

Achieving Greater Impact from Investments in Medicine in Canada

17 September 2019

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McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

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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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Dialogue

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SUMMARY OF THE DIALOGUE

Participants mostly agreed with the evidence brief's framing of the issue in terms of the key contextual factors that are important (e.g., several pushes over the years for national pharmacare, and recent initiatives that have made debates related to prescription medicines more visible to Canadians) and the three dimensions of the problem, namely that the appropriate use of medicines is not supported, prescription medicines are not accessible or affordable for all, and reforms are not pursued in a way that supports rapid learning or improvement. There was general agreement that discussions about prescription medicines in Canada focus on access and affordability challenges with comparatively little attention given to appropriateness or rapid learning. Participants raised six additional challenges that weren't focal points of the evidence brief, but that were also important: 1) failure to integrate efforts to improve prescribing when opportunities exist (which was flagged as a particularly important challenge by a number of participants); 2) few governance mechanisms to hold providers or organizations to account and facilitate the appropriate use of medicines in Canada; 3) data challenges (e.g., data are available to help frame access and affordability challenges, but not appropriateness challenges, and data are often controlled by private industry); 4) lack of information supports for citizens and patients; 5) lack of informational supports for providers and in organizations); and 6) lack of awareness of, and emphasis placed on, adopting a 'rapid learning and improvement' approach to achieving greater impacts from medicines.

Participants generally voiced support for the elements as framed in the evidence brief, but raised additional considerations for each that were considered particularly important. For element 1 (establish prescriber and patient supports to achieve greater impacts from appropriate medicines), these included the need to determine who is best positioned to 'lead the charge,' defining the unit of intervention for prescriber and patient supports, and the need to take advantage of existing national conversations that could provide logical 'ways in' for discussions about supporting the appropriate use of medicines. For element 2 (make sure the right medicines are accessible and affordable), additional considerations included the need to ensure the concept of an essential medicines list was clearly communicated with the citizens, patients and providers, the need to determine whether a single national body or a network should be tasked with making decisions and communicating them with Canadians, the need to ensure the private and public sector were working together, and the need to consider any coverage choices carefully. For element 3 (adopt a rapid-learning orientation focused on connecting existing assets and filling gaps across the seven characteristics), the two important considerations raised by participants were the need to engage more players in conversations about rapid-learning health systems, and the need to engage well-positioned organizations that can support a push for this approach. Participants also expressed a number of implementation concerns related to each element, given there are barriers at the level of citizens and patients, providers, organizations and systems.

In discussing next steps, there was relative consensus that despite the uncertainty created by the October 2019 federal election, each participant could commit to:

- expanding conversations beyond access and affordability to include the full range of issues required to make the most of investments in medicines (i.e., support for appropriate use and establishing a rapid-learning health system);
- taking opportunities to highlight how the approaches discussed (including pushing forward an essential medicines list) provide value to systems, rather than incur additional costs, and develop persuasive messaging that can be used to gain momentum as windows of opportunity open in the near future;
- taking advantage of existing initiatives that could help accelerate progress toward establishing rapid-learning systems, which could help achieve meaningful engagement of patients and providers, support for data and research infrastructure, and supportive system arrangements that can contribute to all of the elements considered; and
- facilitating dialogue among a more diverse range of stakeholders with 'skin in the game' (e.g., regulatory bodies, unions).

DELIBERATION ABOUT THE PROBLEM

Participants agreed with the evidence brief's framing of the issue in terms of the key contextual factors that need to be kept in mind while pursuing efforts to achieve greater impacts from investments in prescription medicines in Canada. In particular, most participants acknowledged that:

- there are recurring questions raised across the country about why – unlike many developed countries – Canada doesn't provide its citizens with universal coverage of prescription medicines, with most Canadians relying on a patchwork of private and public mechanisms to cover some, but not all, of the cost of the prescription medicines they need;
- there is a long history of high-profile calls for the inclusion of prescription medicines as part of the universal health system that ensures first-dollar coverage for all medically necessary hospital-based and physician-provided care (with the most recent being the release of the final report of the Advisory Council on the Implementation of National Pharmacare in June 2019); and
- there are initiatives and events currently unfolding in the country that will help to inform and ultimately shape the prospects for moving forward with efforts to achieve greater impacts from investments in medicines, including the Carefully Selected and Easily Accessible at No Charge Medications (Clean Meds) trial, the results of which were slated to be published soon after the dialogue, with early analyses suggesting there is promise in making a smaller list of essential medicines universally accessible to Canadians (see www.cleanmeds.ca), and the October 21, 2019 federal election, which will determine whether an issue like national pharmacare aligns with the priorities of the next federal government.

When considering how the problem was framed in the evidence brief, participants generally agreed with the three aspects highlighted: 1) appropriate prescribing, adherence and deprescribing are not currently optimally supported; 2) prescription medicines aren't accessible or affordable for all; and 3) reforms in medicines are not being pursued in a manner to optimally support rapid learning and improvement. The following dimensions of the problem (also highlighted in the evidence brief) were also discussed by participants:

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 approach elements, 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 elements of an approach to 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 about 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.

- there is a recurring focus on the access and affordability dimensions of the issue, with comparatively little attention given to the importance of ensuring the appropriate use of prescription medicines by patients and providers across the entire continuum of care (e.g., from when diagnoses are made and medicines prescribed, to ensuring patients adhere to their prescriptions, and on determining when patients should be taken off medicines prescribed to them through deprescription); and
- there is little to no emphasis on how to facilitate continuous cycles of rapid learning and improvement, which could ultimately support health systems in 'moving the needle' in high-priority areas that matter the most to patients and their families.

While many participants noted that this framing was in line with their understanding of the key aspects of the problem, there were six additional challenges that weren't focal points of the evidence brief, but that were raised by participants as being important as well. The first additional challenge was the one that most participants suggested was the most important to address: the failure across Canada to integrate efforts to improve prescribing when opportunities exist for broader system transformation. One participant noted that existing initiatives that seek to improve systems through 'rapid incrementalism' across the country (such as Alberta's strategic clinical networks) have a 'blind spot' with respect to improvements in prescribing. Many participants agreed with this point, and some added that there is still a lot of work to do to engage prescribers – and most notably physicians – in serious conversations about poor prescribing and how it can be addressed within efforts to improve patient care and experiences. A number of participants suggested that initiating open and honest conversations about the role that physicians play in contributing to the inappropriate use of medicines is essential, but being a sensitive topic for many means doing so will require a thoughtful approach.

The second additional challenge raised by participants was related to the first, and centred on their observations that there are few governance mechanisms in place in health systems across Canada that are designed to hold providers or organizations to account for the inappropriate use of medicines, and that health-system financial arrangements (e.g., how prescribers are paid) and delivery arrangements (e.g., how decision supports have been designed) are not optimized to ensure appropriate prescribing practices. Furthermore, a number of participants raised the point that efforts to overcome poor prescribing behaviours through targeted implementation strategies such as 'academic detailing' and 'audit and feedback' are often viewed as expensive, with their value downplayed by policymakers, compared to investments in front-line care (despite the net positive benefits associated with them). This point also raised additional concerns among other participants that even if there was buy-in among health-system planners, the challenge of convincing providers that their behaviours may need to be adjusted to improve patient care is a difficult one to overcome. There were also some participants who suggested that the influence of private industry on the behaviour of prescribers (e.g., pushing new drugs coming to market regardless of their actual benefit to patients) is also a driver of inappropriate use of prescription medicines, and would complicate any efforts to target the behaviour of individual providers.

The third additional challenge raised by participants was related to the availability of data that can be used to support an understanding of the problem, with some stating that statistics to help identify and frame gaps in access and affordability (particularly in the context of equity and social justice) were more readily available than data about appropriateness. Some participants suggested this could at least partially explain the dominant narrative around access to and affordability of prescription medicines, as well as the lack of emphasis on inappropriate use, or about the assets and gaps that exist in systems to support rapid learning and improvement. Furthermore, some participants raised the point that the private sector (e.g., insurance companies) owns a lot of data related to prescribing and use of medicines in Canada, which has made it a challenge to get a full understanding and raise awareness about some of the challenges associated with ensuring patients and providers are using prescription medicines appropriately.

The fourth additional challenge raised by participants was that there is a lack of informational supports available to citizens and patients that can help them be fully informed about the full scope of problems underpinning the challenges related to appropriate use, accessibility and affordability of prescription

medicines in Canada. For example, some participants suggested that many citizens and patients continue to assume that Canada "has the best health system in the world" despite a number of evaluations suggesting it performs poorly compared to many other high-income countries, particularly with respect to key indicators related to access and affordability. Participants who raised this point noted that citizens and patients may require additional informational supports to raise their awareness and enable them to meaningfully engage in realistic conversations about the key challenges and feasible solutions for improving the situation across the country. Furthermore, a number of participants raised the issue that, at the level of clinical decisions, patients often don't have access to information about the most appropriate prescription medicines for their conditions. Some participants also noted that, even when there is information available to citizens and patients, it can be biased by the interests of the pharmaceutical industry, and can do more harm than good. Overall, most participants agreed with the fact that the gap in knowledge may contribute to uncertainty among patients (or their caregivers) and, ultimately, to inappropriate use of the medicines prescribed to them.

The fifth additional challenge discussed by participants was the lack of informational supports in place for providers and in organizations more generally (e.g., in hospitals and long-term care homes). Participants who raised this issue focused on how individual providers and organizations rarely have consistent access to the most up-to-date, integrated and comprehensive patient information that outlines details about their full scope of diagnoses and medication history. During discussions about the issue, some participants suggested that the lack of information may hamper individual clinicians' efforts to prescribe the right medicines or deprescribe those that are no longer needed. The lack of comprehensive patient information was also raised as something that could make it difficult for organizations to establish mechanisms that help to ensure clinicians are prescribing medicines appropriately and monitoring their use (e.g., reminder systems based on up-to-date patient information). Some participants also noted that there are few efforts by organizations (or systems more generally) in Canada to develop and utilize patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs), which is indicative of the gap between the need for patient-related information and its availability.

The sixth and final additional challenge raised by participants was the lack of awareness of, and emphasis placed on, adopting a 'rapid-learning and improvement approach' to achieving greater impacts from medicines. While most participants voiced their support for such an approach in the context of trying to get the most from the investments made in prescription medicines, several suggested that many policymakers, stakeholders and researchers – not to mention citizens and patients – still have a long way to go before they fully understand the value of rapid-learning health systems. One participant summarized these views by suggesting that "everybody wants [a rapid-learning system] but nobody knows what one looks like." Furthermore, there were some participants who suggested that there could be political challenges associated with adopting such an approach, as it may be taken to imply decision-makers aren't 100% certain that their decisions will work as intended, and therefore need to monitor them and change course.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

Element 1 - Establish prescriber and patient supports to achieve greater impacts from appropriate medicines

Nearly all participants agreed that as much emphasis should be placed on element 1 as is currently being placed on ensuring access and affordability. While some participants flagged that efforts to improve the appropriate use of prescription medicines are mentioned in some of the key documents currently driving national conversations (e.g., the report of the Advisory Council on the Implementation of National Pharmacare), many participants acknowledged that the emphasis given to appropriateness in such documents was not commensurate with its actual importance. While participants stated they were largely receptive to the sub-elements included in element 1 (e.g., choosing the right mix of patient- and provider-targeted strategies, ensuring patients are aware of the right medicines for them), they suggested that three main considerations should drive efforts to introduce this element.

First, participants identified the need to determine who, at provincial and national levels, is best positioned to 'lead the charge,' particularly with initiatives that seek to change prescriber behaviour (e.g., academic detailing and audit and feedback). Additionally, participants discussed the need for any group or organization leading the charge to engage a broader range of stakeholders in the conversation than is currently the case, including regulatory colleges and industry. Furthermore, a number of participants emphasized that part of their responsibility would be to develop and articulate a clear business case that frames the conversation around the value of investments in behaviour change, rather than their cost.

Second, participants suggested that there was a need to define the unit of intervention for these initiatives. For example, targeting citizens or patients could involve developing succinct educational materials and finding better ways to communicate with them about the use of medicines, particularly in instances where they may need to change their behaviour. Some participants noted that this would contrast with the usual approach of targeting interventions at individual clinicians or groups of providers (with most of the emphasis during the deliberation placed on academic detailing and audit and feedback as interventions). They also noted how organizational processes and structures could support such initiatives. Finally, a number of participants also noted that all of these efforts would require targeted interventions at the level of entire systems to ensure the right arrangements are in place to support them (e.g., prescribing rules, scopes of practice and reimbursement approaches, as well as data and information and communication technology tools). One participant suggested that it is likely that a 'bucket' of complementary interventions needs to be defined, with all of them collectively influencing several units of intervention as part of a comprehensive and synergistic strategy.

Third, a number of participants stated that there was a clear need to take advantage of existing national conversations that could provide logical 'ways in' for discussions about supporting the appropriate use of medicines as a priority area. Two examples provided by participants were:

- the build up to the release of the Institute for Health Systems and Policy Research's (IHSPR) new strategic plan in 2020, which is now focused on pharmaceutical policy and may shift to include more emphasis on rapid-learning health systems (with conversation about appropriate prescribing nested in broader conversations about priority areas where the needle needs to move); and
- ongoing efforts (through initiatives like Choosing Wisely) to ensure patients and providers are collectively making the right decisions about tests, treatments and procedures.

Element 2 - Make sure the right medicines are accessible and affordable

Participants agreed with the framing of element 2 in the evidence brief, and particularly with the statement that there has already been extensive conversation (and debate) about how to ensure prescription medicines are accessible and affordable to Canadians. However, all participants noted that it was still important to work through how accessibility and affordability can be achieved by expanding coverage and determining what should be covered. Four key points related to these approaches were raised by participants during deliberations about element 2, particularly in the context of establishing an essential medicines list for universal public coverage.

First, a number of participants suggested that there was a need to ensure the concept of an essential medicines list is clearly communicated to all relevant stakeholders (including citizens and patients, as well as providers) in order to allay any concerns that they may have. For example, one participant noted that it would be important to clarify that such a list would be designed in ways that ensure it won't impede patient choice, and that it wouldn't crowd out the private-insurance market. Another participant clarified that these would likely be easy to explain since the included medicines would be those most frequently used by many patients (i.e., they are already the standard choice for many individuals) and that many of those on the list are already covered by the patchwork of provincial public programs (i.e., they wouldn't influence the role of private insurers).

Second, given the somewhat contentious nature of the issue, a few participants stated that it would be important to determine whether a central (i.e., national) body is established to make the tough decisions and communicate with the public, or whether the approach could be pursued through a more distributed and collaborative approach (i.e., through the establishment of a federal/provincial/territorial authority).

Third, several participants raised the point that there is a need to ensure that any initiatives pursued are underpinned by open conversations between the public and private sectors about how an essential medicines list would be established. One participant suggested that the private sector – inclusive of insurance and pharmaceutical companies – needed to be routinely engaged in conversations about how their products and services can be aligned to complement governmental initiatives. For example, in the case of insurance companies, conversations could focus on how their products could be used to fill gaps in coverage or supplement governmental insurance programs, and in the case of pharmaceutical companies conversations could focus on the prospects for developing new products that could be paid for by government. Furthermore, a number of participants noted that unions also need to be involved in these conversations given changes to how prescription medicines are paid for and who pays for them have implications for employee benefits (a domain where the private-insurance industry plays a large role).

The fourth point raised by participants in the context of discussions related to an essential medicines list was that it was important to pursue any coverage decisions very carefully. In particular, some participants warned that once decisions are made to expand who and what is covered, it can be very challenging politically to change in future (particularly if decisions could be made to take things away in future, even if warranted).

Element 3 - Adopt a rapid-learning orientation focused on connecting assets and filling gaps across the seven characteristics

As outlined above, most participants voiced their support for adopting a rapid-learning and improvement approach in order to achieve greater impacts from investments in medicines. When considering the approach in deliberations about element 3, four main points of emphasis were raised by participants.

The first point of emphasis raised by participants was that the conversation about rapid-learning health systems should be expanded beyond the usual players at the organizational and system levels, to include individual providers and physicians in particular. A number of participants suggested this was important since, to date, physicians have been a source of opposition to pursuing quality-improvement initiatives (including appropriate prescribing behaviours), and having them engaged early is one way to have them own the cause rather than oppose it. With this point in mind, some participants stated that there are parallel conversations happening now that focus on appropriate test ordering, and these could be viewed as an appropriate bridge to open up these broader conversations about prescribing behaviours in the context of rapid learning and improvement.

The second point raised by participants was that it is essential to engage well-positioned organizations and groups that can support a push (e.g., Canadian Health Services and Policy Research Alliance, Canadian Foundation for Healthcare Improvement, Choosing Wisely) and ensure systems are increasingly working to strengthen assets that are vital to supporting rapid learning and improvement (e.g., data systems and analytic capacity).

The third point raised by participants in the deliberation about element 3 was that there was a need to secure commitment and 'buy-in' from players at all levels of the system to ensure it can be done with a view to strengthening all of the characteristics needed for a rapid-learning health system (e.g., engaged patients, digital capture, linkage and timely sharing of data, timely production of research evidence, appropriate decision supports, aligned health-system arrangements, and a culture of and competencies for rapid learning and improvement). Finally, the fourth point raised by participants was the need to consider how the concept of a rapid-learning health system could be used to strengthen elements 1 and 2, and particularly element 2 (focused on establishing an essential medicines list). In particular, some participants noted that the establishment of such a list would require continual learning from all levels of the system to inform iterative improvements that ensure the approach is regularly optimized over time. In support of this point, one participant noted that the continuously changing landscape of disease burden, treatment options and patient preferences in Canada mean that it is likely an essential medicines list would need to be revisited and adjusted over time, which created a clear link between it and the rapid-learning health-system approach.

Considering the full array of approach elements

Taken together, the deliberations about the elements indicated that most participants agreed with how they were framed in the evidence brief, with a number expressing that it was important to pursue all in tandem, rather than in isolation from each other. Some participants also stated that, given the emphasis has traditionally been on element 2 (ensuring access to and affordability of prescription medicines), there should be efforts to raise the profile of element 1 (ensuring appropriate use of prescription medicines) and element 3 (adopting a rapid-learning orientation). However, some participants also emphasized that awareness-raising for elements 1 and 3 should not be done at the expense of pushing forward efforts related to access and affordability, such as establishing an essential medicines list. There were also a number of important implementation considerations (and in particular barriers) identified by participants with respect to each of the elements, which are detailed in the section below.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

During deliberations about implementation considerations for moving forward with each of the elements, a number of important challenges were raised by participants. For element 1, participants expressed concerns about four potential barriers to moving forward with efforts to support prescribers and patients:

1) citizens and patients may not support investments in behaviour-change strategies such as audit and feedback, as there is a perception that this will come at the expense of patient care (even though it can often save money and deliver value in terms of improving patient care and experiences);
2) demand may be lacking among providers for support to improve how they prescribe medicines;
3) powerful countervailing forces from those with business interests may interfere in efforts to change provider behaviour (e.g., pharmaceutical companies may pressure providers to prescribe particular medicines even if not appropriate for patients); and
4) systems lack accountability for outcomes that would be improved by investments of this type (e.g., more appropriate prescribing).

For element 2, while participants expressed their support for introducing universal access to an essential medicines list, they identified five barriers to doing so:

1) citizens and patients may have concerns that those with good coverage now will lose under the new system (unless a very effective communication plan can help them see the benefits of a switch, and unless transparency requirements and/or funding for patient groups can alleviate some of the 'hidden' efforts of those with business interests);
2) physicians may have concerns that key medicines will be missed (unless they can be engaged in processes that reassures them that their usual 'go-to' medicines are covered);
3) employers and trade unions may have concerns that a key employment benefit will be lost (unless the money can be re-channelled into incomes or alternative benefits);
4) insurers may have concerns that they will lose a business line (and the individual insurance market and small-business insurance market at least are likely to be subject to adverse selection and hence could fail); and
5) policymakers may have concerns about the politics of the transition for those covered under existing public plans, the short-term politics in provinces that are led by a different political party than the one that introduces it at the federal level, and the long-term politics related to a possible federal reduction in transfers.

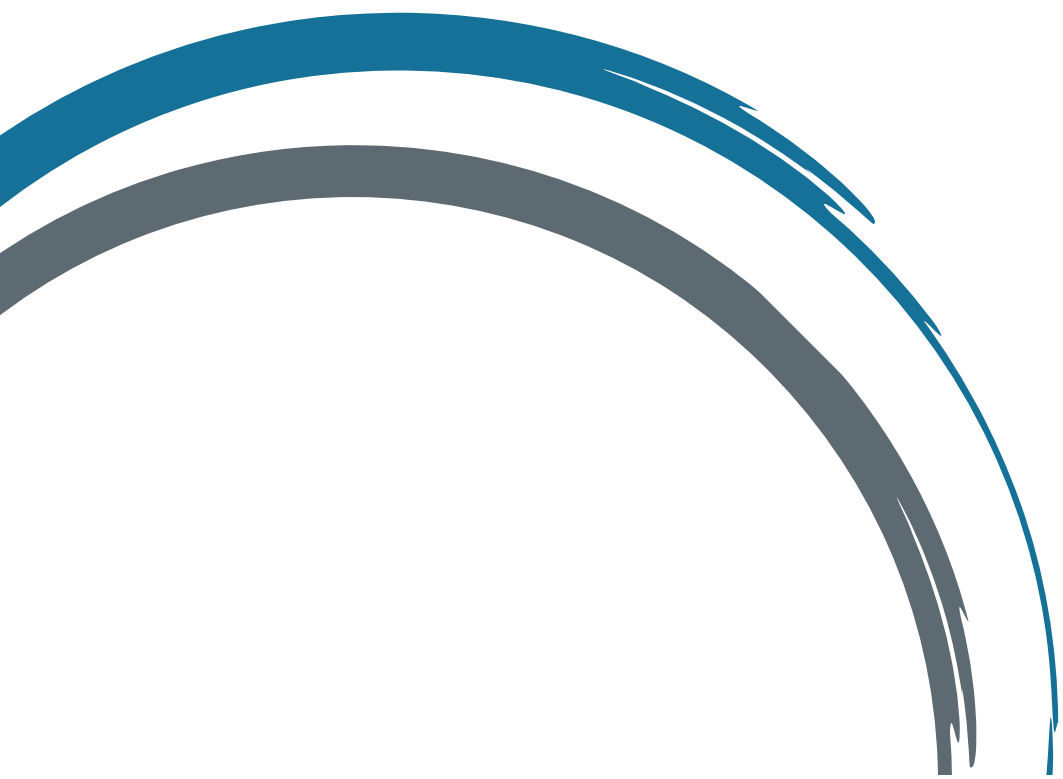
Finally, for element 3, participants noted that, while rapid-learning health systems is a trendy concept, there are three potential barriers that need to be considered:

1) incomplete data infrastructure to support audit and feedback, prompts and reminders, and measurement of impacts on important targets such as patient-reported experiences and patient-reported outcomes;
2) many governments' unwillingness to invest in research; and
3) historical lack of prioritization of rapid learning and improvement in medicines (compared to conditions like cancer).

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

In discussing next steps, there was general agreement that despite the uncertainty created by the forthcoming October 2019 federal election, each participant could commit to:

- expanding conversations beyond access and affordability to include the full range of issues required to make the most of investments in medicines (i.e., supporting appropriate use and establishing a rapid-learning health system);
- taking opportunities to highlight how the approaches discussed (including pushing forward an essential medicines list) provide value to systems, rather than incur additional costs, and develop persuasive messaging that can be used to gain momentum as windows of opportunity open in the near future;
- taking advantage of existing initiatives that could help accelerate progress toward establishing rapid-learning systems, which could help achieve meaningful engagement of patients and providers, support for data and research infrastructure, and supportive system arrangements that can contribute to all of the elements considered; and
- facilitating dialogue among a more diverse range of stakeholders with 'skin in the game' (e.g., regulatory bodies and unions).



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