Aligning health care policy with evidence-based medicine : When guidelines and policy conflict, what's a doc to do?

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Conflicts of Interest

Canadian Cardiovascular Society — SMD Role AHS

Practicing Physician

Grants from BI

Funding Landscape for New Drugs in Canada

- It has become more difficult for new drugs to be approved for sale or for pharmacare coverage in Canada
  - Eplerenone (Pfizer)
  - Dabigatran (Boehringer)
  - Rivaroxaban (Bayer)
  - Apixaban (BMS)

Canadians wait longer and have less publicly funded access to new drugs

Studies in
HEALTH POLICY

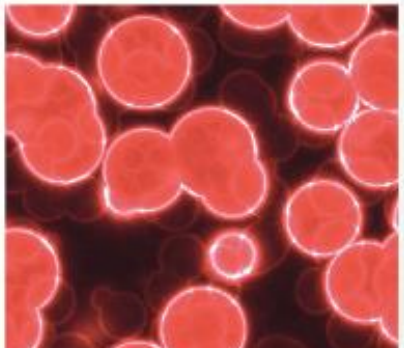
FRASER INSTITUTE

April 2012

Access Delayed, Access Denied 2012

Waiting for New Medicines in Canada

by Mark Rovere and Brett J. Skinner

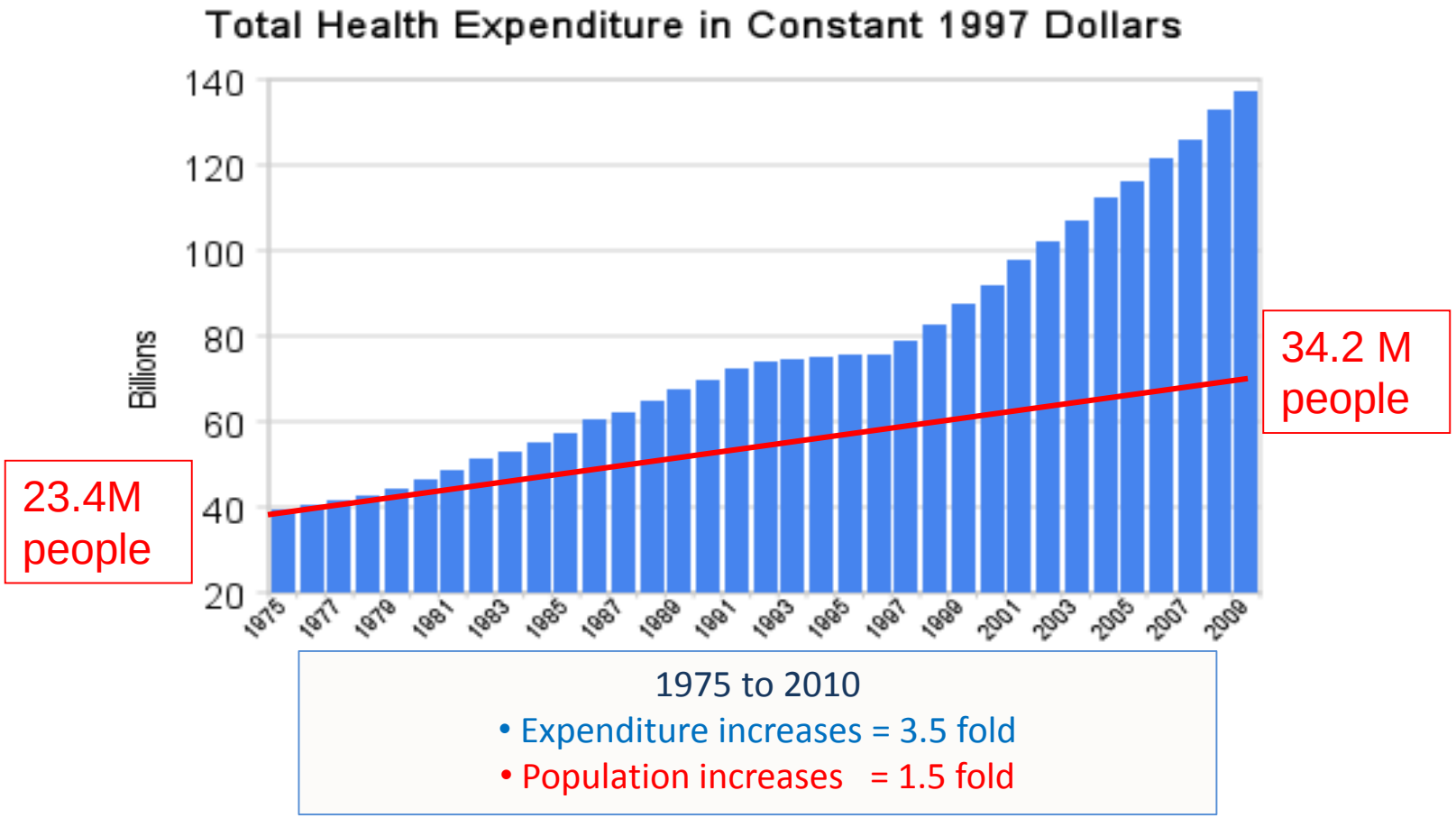


Key findings

- On average, Canadians wait over two years for access to new drugs because of federal delays in approving them and provincial delays in authorizing reimbursement.

Evidence = Non-sustainable cost increases in Canada

December 2011: Alberta 2nd highest (not getting value for $$)



Fraser Study

- Canadians wait an average of 2 years longer
- Health Canada takes longer than EMA and FDA
- Only 23% of approved new drugs are eligible for public drug program reimbursement as of January 2012
- Privately funded insurance plans covered 84% of drugs over the same time frame

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Training/Practice
Training/Health Policy and Promotion

Aligning Health Care Policy With Evidence-Based Medicine: The Case for Funding Direct Oral Anticoagulants in Atrial Fibrillation

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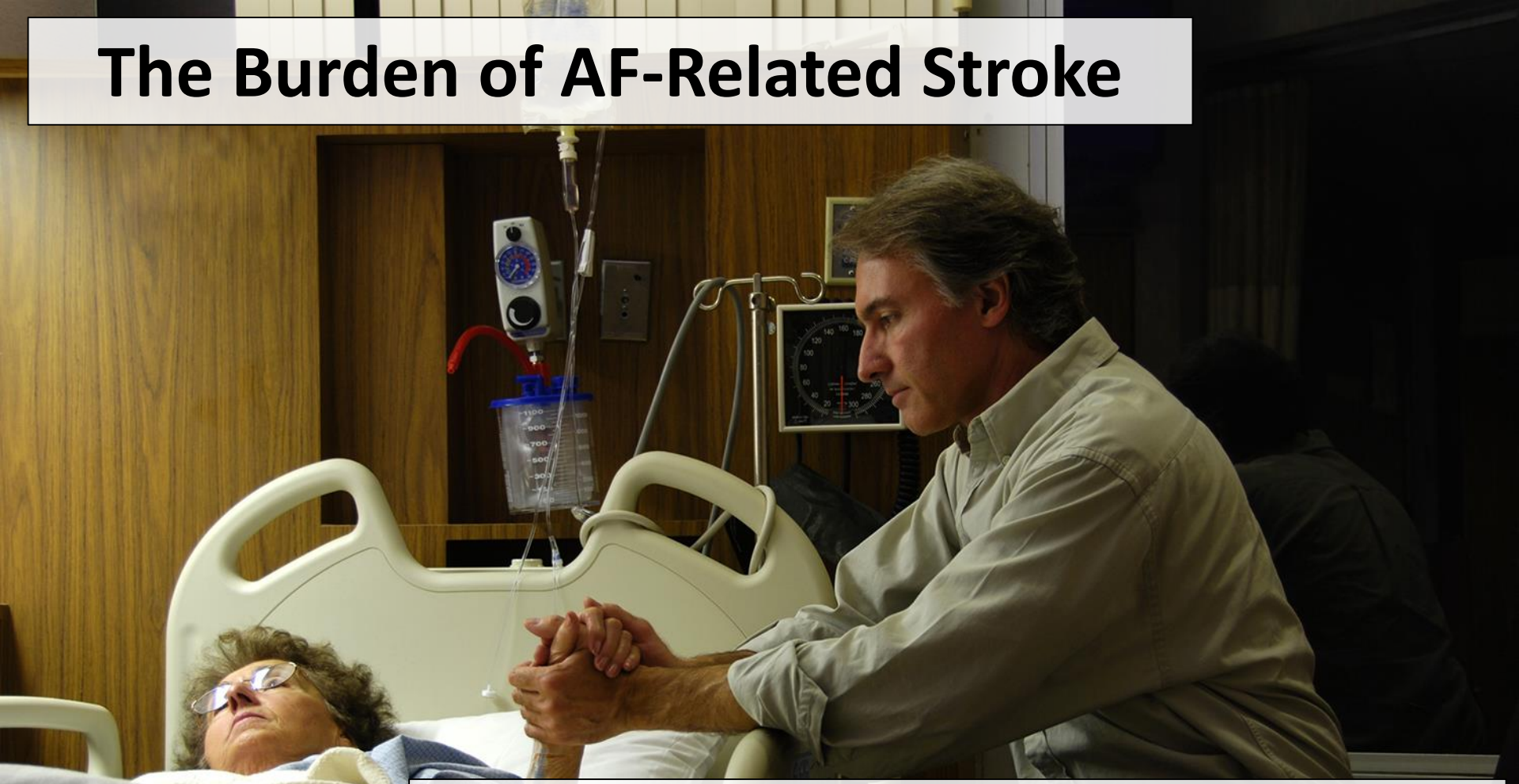
ABSTRACT

Misalignment between evidence-informed clinical care guideline recommendations and reimbursement policy has created care gaps that lead to suboptimal outcomes for patients denied access to guideline-based therapies. The purpose of this article is to make the case for addressing this growing access barrier to optimal care. Stroke prevention in atrial fibrillation (AF) is discussed as an example. Stroke is an extremely costly disease, imposing a significant human, societal, and economic burden. Stroke in the setting of AF carries an 80% probability of death or disability. Although two-thirds of these strokes

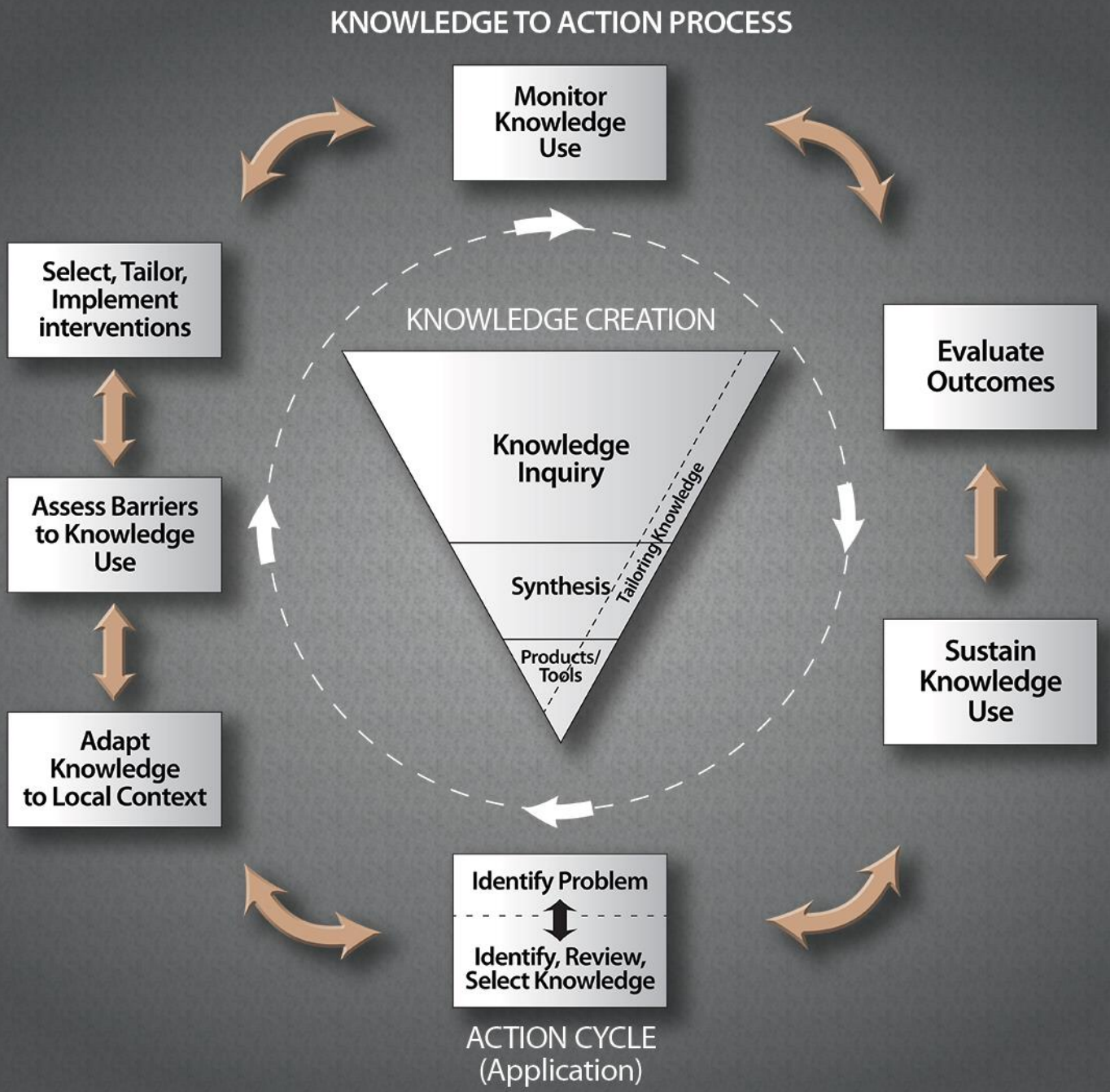
RÉSUMÉ

Le manque de concordance entre les recommandations formulées dans les lignes directrices des soins cliniques fondées sur des données probantes et les politiques de remboursement a créé des lacunes en matière de soins qui entraînent des résultats sous-optimaux chez les patients dont l'accès aux traitements basés sur les lignes directrices est refusé. Le but de cet article est de faire en sorte que ces obstacles à l'accès aux soins optimaux qui se font de plus en plus nombreux soient surmontés. À titre d'exemple, nous traitons de la prévention de l'accident vasculaire cérébral (AVC) associée à la fibrillation auriculaire

The Burden of AF-Related Stroke

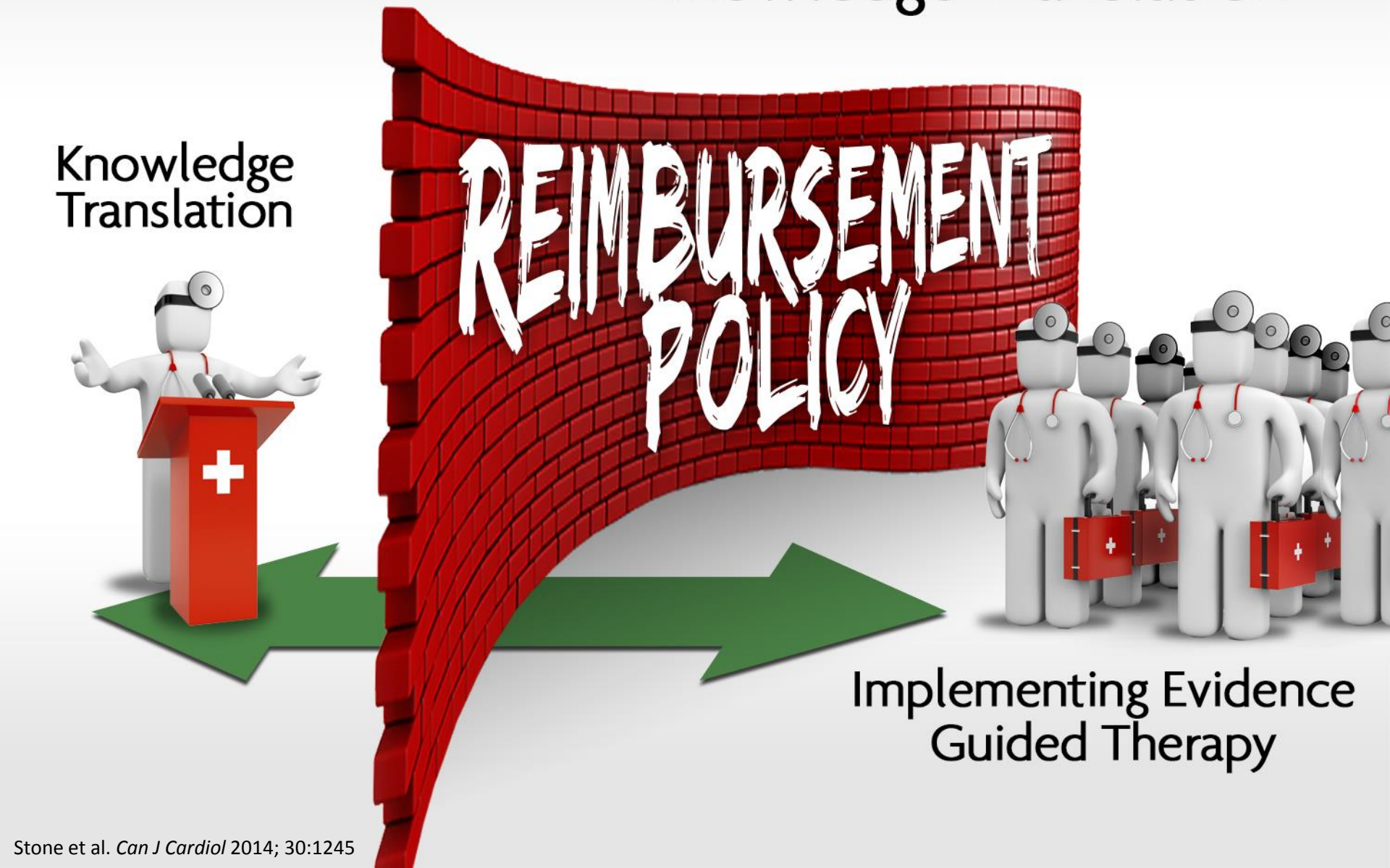


- AF: affects **1 in 10** people over 75 years and increases risk of stroke **fivefold**
- AF-related stroke: **80% probability of death / disability**
- **2 of 3** AF-related strokes are **preventable** with appropriate anticoagulation – but this is still under-prescribed and poorly managed, despite considerable effort



Canadian Institutes of Health Research www.cihr-irsc.gc.ca/e/39033.html#Knowledge-Users

Obstacles to Knowledge Translation



Stone et al. *Can J Cardiol* 2014; 30:1245


EVIDENCE
COST CONTAINMENT
CCS Recommendations:
Direct Oral Anticoagulants Preferred Over Warfarin
Pressure on Government:
Contain Healthcare Spend

Non universality of universal health care

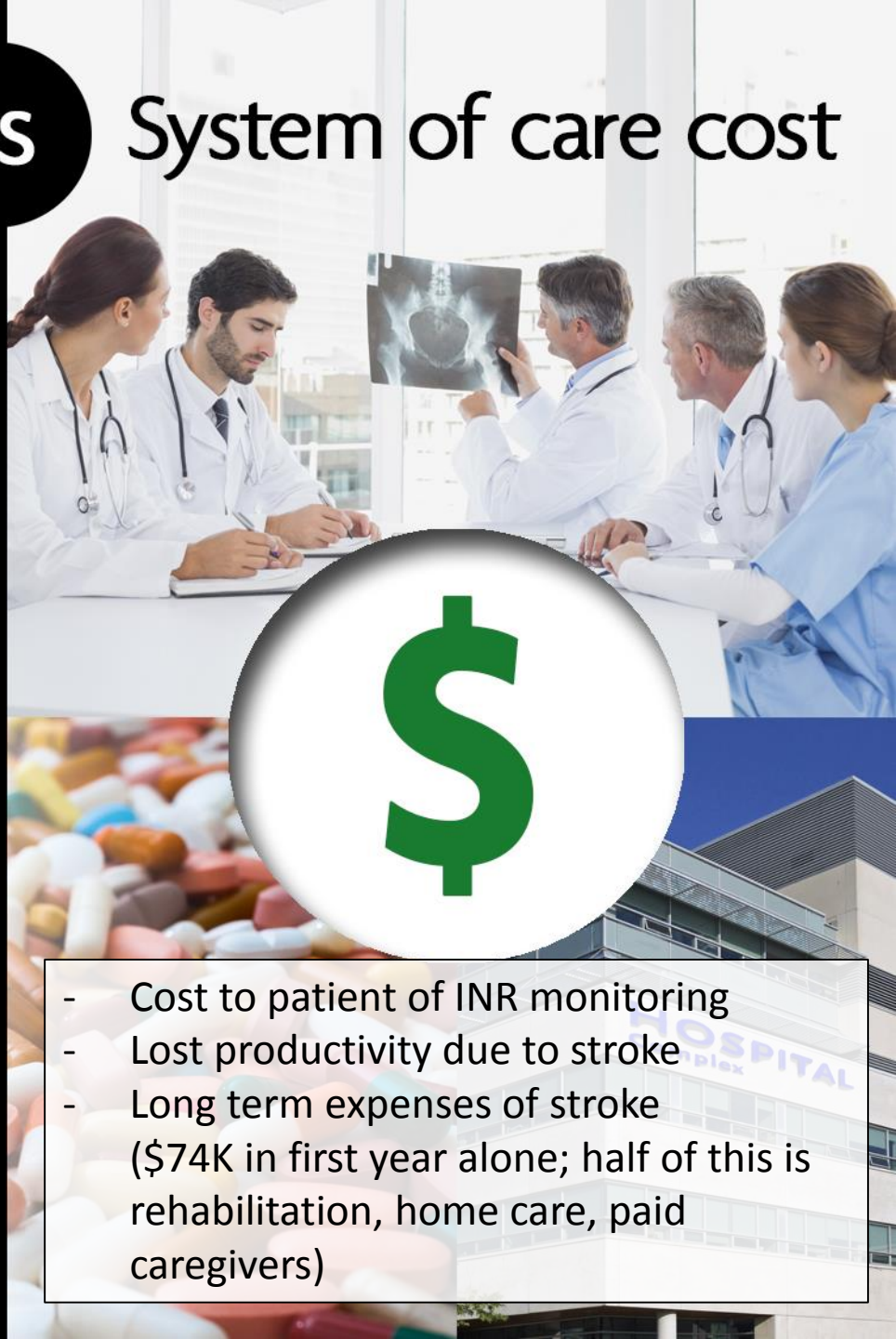
Disparity of care

Silo based cost

vs

System of care cost

- Acquisition cost: NOACs vs. warfarin
- Cost of INR management system
- Treatment costs for bleeding



- Cost to patient of INR monitoring
- Lost productivity due to stroke
- Long term expenses of stroke ($74K in first year alone; half of this is rehabilitation, home care, paid caregivers)

CanMEDS: Advocacy Role

Healthcare Practitioners as advocates for evidence based policy

CanMEDS: Other Roles

- Efforts to change specific practices or policies on behalf of patients
- Expressed by both individual and collective actions of healthcare practitioners in influencing public health and policy

- Allocate finite healthcare resources appropriately
- Balance effectiveness, efficiency, and access with optimal care by applying evidence and management processes for cost-appropriate care

Engaging with policy-makers to replace **silo-based** cost assessments with **system-based** cost assessments is necessary to effectively fulfill both roles.

What is a Doc to do?

- Need to work together
- Need to be responsible stewards helping to improve and ensure sustainability of our system
- Need to advocate for an end to silo based thinking
- Better approval and funding for evidence-based drugs and devices