Evaluation of Drug Substitution Policy's Impact on Seniors and Seniors' Impact on Drug Policy (Seniors Drug Focus Project)
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We conclude that direct evidence of consumer attitudes and beliefs toward policy change is a valuable contribution to the field of policymaking, in its ability to provide feedback on the impact of a policy from groups directly affected by it. This differs considerably from the options offered through central database monitoring as it allows for recording of individual experience with the policy, including quality of life and economic impact. Direct consumer evidence can also capture side effects which are not serious enough to trigger medical services plan (physician or hospital services) intervention, but significant enough to trouble seniors.

We believe that the use of direct consumer evidence to inform policy making is both cost-effective and contributes to better policy. Researchers will be challenged to adapt their methods and processes to fit in with the fast-moving political cycle.
Seniors and the Drug Information Age
Chappell, N., Maclure, M.
Accepted for publication, Journal of Applied Gerontology

Health reform in the 1990’s has been largely cost-driven, with attention focused on cost efficiency and some, albeit less, emphasis on intervention effectiveness. While a large part of the ongoing health care crisis is an information crisis little research attention has focused on the explosion of knowledge and its impact on health care. Our research draws attention to the information crisis in health care, notably in the area of prescription medications. In the course of researching changes in drug benefits policy on seniors, it became increasingly clear that medication use is enveloped in volumes of frequently inconsistent data relevant to consumers, clinicians and payers. Each of the three stakeholders frequently disagreed in their interpretation of the data and in their beliefs about the role of the other in decision-making about the use of specific medications. As governments enact policies to control the rapid escalation of prescription drug costs senior consumers, clinicians and policymakers are all impacted by the explosion of available information, and the challenge of using this information to inform decisions.

The Effect of Government and Industry Media Campaigns on Seniors’ Perceptions of Reference Based Pricing
Brunt, JH, Chappell, N, Maclure, M, Cassels, A.
Accepted for publication, Journal of Applied Gerontology

Little is known about the complex process of introducing government health policies that affect seniors. The introduction of a cost-containment program, Reference based pricing (RBP), to British Columbia’s Pharmacare system had helped illuminate the competing perspectives and agendas of government and the pharmaceutical industry when health care funding policy affecting seniors is implemented. In this paper we examine the intensive public relations campaigns and media messages used by these stakeholders and explore the resonance and impact they had on seniors’ views about RBP. While Pharmacare stressed the fiscal merits of RBP, industry focused on the threat the policy posed to the public’s health and attempted to rally seniors and health care providers to stop its implementation. A province-wide survey of seniors conducted shortly after the policy’s introduction indicates that there was a high degree of skepticism about the anti-RBP information received from industry and moderate support for the policy as it was seen as an example of good stewardship of tax dollars. We conclude that the pharmaceutical industry’s campaign was unsuccessful because Pharmacare’s messages resonated more effectively with seniors’ views on public health policy.

our research methodology to augment traditional academic research with targeted interviews and small sample focus groups. The rapid response arm of the project demonstrated that policy specifics could be influenced by research if it was tailored to specific questions and was timely. Researchers who aim to influence policy should recognize the existence of a spectrum of evidence quality. At one extreme is quickly accessible unrepresentative opinion, which is how the policymaker receives most information. At the other extreme is the large slow representative study, which is how many researchers see the world. Three is need for innovation between these two extremes. In the information age researchers should be striving to use information technologies to improve the quality of rapid data collection and analysis nearer the policymaker’s end of the spectrum.

Camouflaged Sampling: how use health databases to reach individual patients without violating their privacy.
M Maclure, Pharmacare, BC Ministry of Health, Victoria BC Canada

Camouflaged sampling enables drug claims and other health databases to be used for contacting people for epidemiological studies and therapeutic advice, without violating privacy. A list of targeted people (e.g. seniors on multiple medications, or patients using over 30 canisters of beta-agonist per year) is camouflaged by adding a random sample of non-targeted people (e.g. all seniors). The mixture has a known percentage of targeted people, yet staff handling letters of invitation and telephone interviewers remain ignorant of each patient’s health status (e.g. medications) until he or she has agreed to participate. For camouflage to work, people must be able to decline without indirectly indicating they have or do not have the targeted health status. The percentage of camouflage is equivalent to one minus the positive predictive value of a positive test in a screen for disease. To choose an optimal percentage, balancing privacy versus inefficiency and intrusion, relative costs (possible harm multiplied by risk of occurrence) of alternative adverse events are weighed. Risk varies with the camouflage percentage. The privacy of targeted patients greatly increases in going from 0 to 5 percent camouflage, but gains from 5 to 10, or 10 to 15 percent camouflage, are much smaller. However, more than 50 percent camouflage may be needed to assure patients and defenders of privacy. Then the majority on the list are free of the targeted health status, and the list can be described as a random sample of the general population, enriched with a certain percentage of targeted individuals.
Policy/Program Implications Associated with major Finding #3
5 Funding of research on a prospective trial of drug policy, which includes feasibility and process information to inform future such activities.

Recommendations for future policy/programs:
1 Evidence-based research unit within government.
1 Prospective randomized controlled trial of drug benefits policy.
2 Funding of “alternative to physician” information sources for common health issues, which are easily accessed by and acceptable to consumers.
LIST OF PUBLICATIONS, PRESENTATIONS AND PRODUCTS ARISING FROM RESEARCH

Publications


Chappell, N., Maclure, M. Seniors and the Drug Information Age. Accepted for publication, Journal of Applied Gerontology.


Mullett, J, and Coughlan, R. Clinicians’ And Seniors’ Views of Reference Based Pricing: Two Sides of A Coin. Accepted for publication, Journal of Applied Gerontology.


Presentations

Chappell 1996. Presentation of interim research findings to Victoria seniors. Silver Threads Seniors Centre, Victoria BC.

Maclure 1997. Select Findings from the Seniors Drug Focus Project. CAG Poster session, Calgary, Alta.

Cassels 1997. “Senior Physician Communications: Findings from the Seniors Drug Focus Project.” Monterey Seniors Centre, Victoria, B.C.
Body of the Report

EVALUATION OF DRUG SUBSTITUTION POLICY'S IMPACT ON SENIORS AND SENIORS' IMPACT ON DRUG POLICY

Across Canada, prescription drug reimbursement policies have been adopted by provincial and federal governments as a means of providing extended health care coverage to specific groups within society, for the greater public good. Increasingly, drug benefits plan managers are called upon to exercise fiscal restraint in the face of rapidly rising prescription drug costs and increased demand for newer, more costly medications. Accordingly, administrators are expanding the range of policy options, to place greater emphasis on those which support optimum coverage coupled with greater cost effectiveness.

It is often the case that no one policy emerges as the clearly superior option, in which case administrators are called upon to make judgments as to which best meets the combined health, social, political and economic goals of the program. These decisions are influenced by the beliefs and values of policymakers, as well as those of their elected leaders. Additional factors, such as ease of implementation, administrative burden and perceived support or opposition from consumers and stakeholders also play an important role in the ultimate policy decision. In recent years, consumer preference has gained legitimacy as an additional criterion upon which to base policy choices.

The Context of Drug Policymaking in British Columbia

Cost increases for prescription medications over the past two decades have been alarming. In BC, the budget for the prescription medication reimbursement program (Pharmacare) has increased more than 2200% over 20 years (1974-1994), approximately a 17.5% per annum increase, amounting to a doubling of costs in five years. Most of this cost increase is due to escalating drug prices, in particular the cost of new drugs. This poses a serious challenge for government decision makers who, certainly in recent years, are confronted with the need to balance limited economic resources against growing demand for health programs.

In British Columbia, Pharmacare responded to budgetary pressures by increasing their reliance on evidence to inform decision-making, and by increasing their capacity to generate evidence of prescription drug effectiveness. Two arms-length organizations were established with mandates to provide specific types of evidence. The Therapeutics Initiative was created to provide Pharmacare with reviews of evidence of comparative clinical effectiveness of drugs, and to provide prescription drug education to clinicians. The Pharmaco-economics Initiative was formed to provide evidence of the relative cost-effectiveness of medications. Pharmacare was also strongly supportive of suggestions for bringing direct evidence from drug benefits plan beneficiaries to the policymaking table, and thus a natural partner for this project, hereafter referred to as the Seniors Drug Focus Project (SDFP).

Utilization of Research in Policymaking
A small body of literature on the utilization of research in policymaking has established that this is a difficult process. However, the literature provides limited evidence of why linking research with policy is so often difficult. The findings of such studies - factors that impede or enable research to influence decisions - has itself been challenging to utilize. ¹

The principal investigator of this project had previously concluded that: “If researchers want decision makers to use their products, they need to do market research, i.e. understand the decision makers’ culture, consider the timing and content of users’ decisions, promote demand for the research, understand the emotions of the users, help them to use the products after they have bought them, involve the users in the design, and solicit continual feedback from the user (Maclure, 1992).”

More recently, Soumerai (1997) found that, despite the availability of relevant research on the effects of cost-sharing policies, less than a quarter of the states which made changes to Medicaid cost-sharing policies used this research to guide policy development. He concluded that research results must be actively disseminated in a form tailored to the needs of managers and policymakers. In addition, he recommended replacing crisis-oriented budget confrontations with an on-going structured advisory process that includes researchers, policymakers and patient advocates. The Seniors Drug Focus Project afforded government, university and clinical researchers an opportunity to work closely with drug benefits policymakers in designing research to meet policymakers needs, and to assess the impact of this evidence on decision-making. This report outlines our observations on three and a half years of using direct evidence from seniors to influence policy.

¹ For discussion, see Maclure (1992).

*Evaluation of Drug Substitution Policy’s Impact on Seniors and Seniors’ Impact on Drug Policy, NHRDP Proj. No. 6610-2120-602*
FINDINGS

Objective 1  Impact of Drug Policy Change on seniors
A. Seniors Beliefs and Attitudes
The high premium seniors placed on the preservation of Medicare and Pharmacare was generally underestimated by clinicians and policymakers. Seniors expressed support for policy changes that give equivalent outcomes for fewer tax dollars, and expressed a willingness to try a switch to the reference medication. Seniors displayed a sophisticated knowledge of federal policy concerning prescription drug marketing and sales, and strongly perceived that pharmaceutical companies enjoyed excess profits as a result of these. They were also aware and disapproved of the industry’s widespread marketing of products to physicians and consumers. Seniors preferred to get information on drug policy changes from their doctors, and wanted to be able to discuss the implications for their care at that time.

B. Experiences and opinions of consumers
Seniors experiences and opinions can differ markedly from the views espoused by stakeholders, consumer interest groups and advocacy organizations. Where drug reimbursement policy is concerned, powerful lobby groups such as the medical, pharmacists and pharmaceutical manufacturers associations have considerable access to and influence on Canadian policymakers and politicians. In the case of the Reference Pricing policy, we found that these groups appealed to the public and to government to have the policy stopped, citing the interests of seniors. The difficulty in engaging individual seniors in dialogue around policy issues makes it difficult for policymakers to assess the degree of truth in the statements put forward by these powerful lobby groups. Through our research, we discovered that physicians and pharmacists- at the individual level as well as when speaking through their professional organizations - were considerably out-of-touch with the values and beliefs of seniors regarding drug reimbursement policy. In addition, seniors professed a deep distrust of the pharmaceutical industry, labeling their campaigns to stop the policy as “fear mongering” and an attempt “to scare seniors into taking drugs.”

While seniors want to learn about drug benefit policy changes from their physicians and pharmacists, we found that they do not necessarily share the clinicians’ views regarding the ultimate benefit or desirability of the policy. Our research offered a number of important insights leading to possible explanations for this important finding. Our research showed that physicians tend to view restrictions on prescribing options as an unnecessary infringement on their ability to practice medicine, and thus may oppose such polices on an ideological basis. Seniors are much less concerned in this regard, and tend to base their judgements on their knowledge and experience with the policy. Another possible contributing factor is that many seniors believe physicians are unduly influenced by the pharmaceutical industry, and may share the industry’s opposition to a ban on policies that would affect their profitability.

Taken together, these communication difficulties pose a serious impediment to seniors' independence and health outcomes. They may result in seniors receiving inappropriate care (due to not being able to express their needs or symptoms properly), making less than optimal treatment choices due to lack of information or comprehension, or not following through on physician advice due to incomprehension. These situations lead to an over reliance on physicians in maintenance of the senior’s health, and pose a barrier to the senior assuming a more active partnership in co-managing their health.

**Objective 3 - Assessment of the Feasibility of Randomized Controlled Trials (RCT’s) of Health Care Policy**

**A. Seniors’ views on use of policy trials**

In general terms, seniors support for the concept of a randomized, controlled trial of a new policy was based more on their support for the policy than on their concerns regarding a trial. There was strong support for evaluation of policy and prudent fiscal management of resources. We presented seniors with a scenario involving a phased-in implementation of a new drug policy, where a proportion of seniors would be immediately affected by the change, while another group would be delayed by a time period of 3 to 12 months. Allocation to the immediate or delayed impact group would be random, and would allow researchers to determine the effects of the new policy against the old.

The majority of seniors interviewed said they understood and would accept randomized policy trials, but needed reassurance on how the trial would affect them. Prime concerns were differential access to “better care”, and a concern that the government, not the patient and physician, would be determining what care the patient received. Options such as physician-triggered exemptions (Special Authority) were important safeguards, as ultimately seniors wanted assurance that their physician, not government, was choosing the best treatment for them. Seniors were also concerned that a staggered implementation could result in a perception of different standards of care being offered to those in two policy trial groups, and that this could lead to abuse of the system.

**B. Physician attitudes toward policy trials**

Physician attitudes toward use of RCT’s in policy evaluation were elicited through telephone interviews with BC general practitioners (n=50) and two focus groups with Vancouver physicians. We gauged support for randomized controlled trials of five potential policies:
- remunerated mandatory telephone care of patients by physicians, as practiced in Denmark;
- telephone care of patients by a nurse, through a 1-800 line (Telecare);
- use of nurse practitioners;
- independent drug therapy review; and
- reference pricing of one category of prescription medication.
A. Policy choice and development
Theoretically this is the stage of the policy cycle where options can be examined, potential impacts considered, and strengths and benefits of competing models assessed. Direct consumer evidence can contribute to policymakers understanding of consumer values, beliefs and attitudes as they pertain to policy options. This is also theoretically a time when policymakers can reflect on the policy questions and issues which will influence the choice of policy, and work with researchers to ensure capture of in-depth, academic quality, policy relevant data.

Our experience was that the time period leading up to the choice of policy was quite volatile, with considerable sensitivity around public acknowledgment that policy options were being considered, and a reluctance to engage stakeholders or consumers for fear of “derailing” the process. We were not successful in using direct consumer research to influence this stage of policymaking, and in fact were asked to refrain from doing active field work in the months during which the policy was being developed.

B. Policy implementation/ communication
We found policymakers to be strongly interested in evidence that would assist them in communicating policy change to seniors - how do seniors get their information, what sources do they trust, what do they want to know and in what depth. In addition, there was interest in feedback from individual clinicians regarding their prescribing choices under drug substitution policy and their overall attitudes to the policy change. The feedback from the physician and pharmacy professional associations had been quite polar and quite negative, and policymakers were interested in knowing if this feedback reflected the views of individual clinicians, or if resistance was limited to the professional associations.

We discovered that the traditional pace and rigor associated with academic research was exceedingly difficult to reconcile with the policymakers’ need for rapid answers to specific questions. Brief interventions and evidence from rapid response research into specific issues were highly successful in influencing policy, primarily through refutation or reinforcement of previously held ideas that policymakers were considering in shaping the policy.

We used small samples of knowledgeable seniors to explore seniors’ qualitative response to policy issues, and were able to report back almost immediately outlining the findings. We also used targeted samples of seniors who would be affected by the proposed policy change to conduct in-depth telephone interviews regarding potential policy impacts. Targeted sampling allowed us to reach a higher proportion of individuals directly affected by the policy in a much shorter time and at a much reduced cost than had we employed population-based random sampling methods. This meant we were able to produce high-quality information on affected groups within a timeframe relevant to policymakers - approximately 1 month.

Our methodology was continually revised, based upon our growing understanding of the policymakers and the realm of policymaking. In the process, we discovered there were two markets for information from seniors. The first was met by the slow-paced rigorous academic methodology, which was able to provide insight into seniors' values and beliefs, and the basis for their support or disapproval of policy. The second audience was for quick answers to pressing day-to-day issues, largely related to implementation of a selected policy. In these cases, the window of opportunity to provide evidence to affect a decision was frequently as brief as a few weeks, and often less than a month. Our response was to develop a second "rapid response" arm to the research. Through this arm, we held small numbers of focus groups with seniors and clinicians to assess their response to specific policy questions, or to identify issues they found important in the implementation of a policy. In addition, we conducted small-sample targeted interviews of seniors who had been affected or would be affected by a particular policy.

The first audience was senior policymakers. We scheduled 1:1 or small group meetings regularly, to apprise them of the progress of the research, and to solicit further questions and areas of interest. These meetings were held frequently in the early stages of the project, when we and the policy change were new and exciting, however the policymakers were less available in the latter stages of the project/policy, as the immediate hurdles of the implementation had been overcome and attentions turned to other more pressing issues.

We also attempted to hold group meetings of senior policymakers to formally present findings and solicit feedback. These were generally rescheduled numerous times due to schedule conflicts, and poorly attended when they did occur. We concluded that, while group feedback was an important part of the “feedback to researcher” loop, it was not the way to influence policy.

The second audience for our research findings was a drug policy advisory committee, comprised of government and community experts, and charged with implementation of the policy. We were granted observer status at their monthly meetings, and were asked to provide feedback to the group on our research of seniors' and clinicians' beliefs, attitudes and wishes regarding drug benefits policy. We judge ourselves to have been quite successful in integrating research evidence into the implementation stage. We judged our success to be due in large part to the structured nature of the committee, which met regularly for the sole purpose of implementing and monitoring this policy, and whose members had a strong interest in “getting it right” for seniors, clinicians and most stakeholders.
Direct consumer research is a valuable tool for policymakers concerned with serving the public good. Ultimately, our research has shown that policymakers need better access to in-depth public opinion to enable them to create and implement policies which serve the needs of consumers and the public interest, rather than established interest groups.
**PURPOSE OF THE SURVEY**

As part of the Seniors Drug Focus Project, two general surveys have been conducted with seniors. The first survey was completed in March of 1996, the second in June 1997. Both surveys were conducted to obtain the views and opinions of seniors about new Pharmacare policies in relation to the impact of the policy and the way it was introduced. The goal of the second survey was to ascertain potential differences in opinions or ideas in the year following substantial policy introductions, in particular the Reference Drug Program (formerly called Reference Based Pricing). The general surveys are one component of a project that aims to consolidate the opinions and ideas of the professionals prescribing and dispensing medications (doctors and pharmacists) with those of policy makers and at least one affected population, seniors. The purpose of using this approach is to facilitate informed policy changes which reflect, as much as possible, the needs and concerns of those most affected.

This report provides a summary of the findings from the 1997 telephone survey of 601 seniors and includes a comparison with the 1996 survey of 1699 seniors where overlap of questions occurs. **Unless otherwise stated, the results are from the 1997 survey.** Eventually, these results will be compiled with additional data gathered from seniors, and the views and opinions gathered from clinicians and policy makers, about policy changes.

**METHODS**

**SAMPLE**

The sampling frame of the 1997 survey consisted of a random sample of seniors aged 65 and older from the Division of Vital Statistics, Ministry of Health (with a refusal rate of 33%). In total, 601 interviews were completed. The 1996 survey had a refusal rate of 28% and 1699 seniors were interviewed.

**SURVEY INSTRUMENT**

The construction of the 1997 interview schedule was based on information gathered from a number of sources: The first general survey of 1996, 21 focus group sessions (11 with seniors and 10 with clinicians), interviews with policymakers and researchers in Pharmacare, interviews with
DATA ANALYSIS

Data were entered into a SPSS data entry package. After all were entered, the data were cleaned and prepared for analysis in SPSS. The graphs were produced using Harvard Graphics.

RESULTS

DEMOGRAPHICS

Comparisons between the demographic distribution between the 1996 and 1997 surveyed respondents by sex, age, education and income are displayed in figures 1, 2, 3, and 4 below. The difference between the participants in each survey is significant for all these variables. A higher proportion of women participated in the second survey ($x^2=8.56$, $p=.003$), and participants in the second survey were older ($x^2=34.88$, $p=<.001$). The education level of the participants is lower for participants in the 1997 survey ($x^2=30.23$, $p=<.001$) and the income level is lower ($x^2=25.02$, $p=<.001$). We added five additional demographic questions to the second survey: marital status, number of people in their household, size of community, relative health and satisfaction with life (see Appendix I for distribution).

Figure 1: Sex
RDP DRUG USE IN THIS SAMPLE

Similar to the first general survey, a number of questions focussed on the Reference Drug Program. The percentage of participants who had experience with a reference drug from the initial three drug categories affected by RDP was the same, at 10%, in both surveys. Two more drug categories were added to the policy before the 1997 survey which increases the percentage of participants in this survey who have had experience with a reference drug to 13% (n=79). Gastric Acid Suppression Drugs was the first category to be affected on October 1st, 1995, followed by nitrates for angina on November 1st and non-steroidal anti-inflammatory drugs (NSAIDS) for treatment of rheumatism and osteoarthritis on November 27th. The most recent additions to the policy were one group of Calcium Channel Blockers (dihydropiridines) and ACE Inhibitors for the treatment of hypertension on January 1st, 1997. Of our sample for this survey, 58 (10%) were taking medication for stomach pain, 23 (4%) were taking nitrates, 65 (11%) were on NSAIDS for arthritis, 26 (4%) were taking dihydropiridines and 70 (12%) were using ACE inhibitors (see figure 5). Figure 6 displays how many respondents in the 1997 survey had experience with a reference drug group and/or a reference drug. Of those taking a drug in a reference category, 41% were on a reference. Of those taking a drug in a reference category, 41% were on a reference drug.

Figure 5: Percentage of respondents taking a medication in RDP affected drug categories
Once a standardized explanation of RDP was given to each participant, the overall impression of the policy was favourable with just 8% believing it was a bad policy in both surveys (figure 7).

![Figure 7: Opinion of RDP](chart)

There was significant difference however, in the distribution of the other options for the question ($x^2 = 35.91$, $p<.001$). Compared to the 1996 survey respondents, 12% fewer thought the policy was ‘good’ and 12% more were ‘unsure’ in the 1997 survey. Further, both surveys indicate that the more knowledgeable seniors are about RDP, the more support they have for the policy.

A high proportion of participants in the 1996 and 1997 surveys (22% and 54%, respectively), reported they had been affected by RDP, when in first they were not taking a drug in any of the RDP categories. These results are a further indicator of the lack of understanding seniors have about RDP. It is clear that methods of information transfer from policy makers to the stakeholders need to be improved.

Some of the anticipated concerns of seniors regarding RDP involved issues around the discontinuation of sustained release medications, ability to pay for a required medication, and how exceptions would be dealt with. Discontinuing sustained release medications appears to be of minimal concern. In the 1996 survey 70% ($n=1183$) of the participants believed they would probably not forget to take a pill 2 or 3 times a day if they had to; This was similar in the 1997 survey 66%. There was concern about ability to pay as 64% ($n=1081$) of the participants in the 1996 survey and 68% ($n=400$) in the 1997 survey anticipate that most seniors will be unable to pay for more expensive medications not covered by Pharmacare. Further, just over half of the survey respondents (1996 54%, $n=913$; 1997 58%, $n=342$) agreed that many exceptions will have to be made for people who have legitimate medical reasons to be on a more expensive drug. Between 1996 and 1997 was a significant increase ($x^2 = 34.54$, $p<.001$) in agreement that with RDP some people may not get the medication they need (1997 40%, $n=671$; 1997 49%, $n=290$). However, 58% ($n=974$) of the 1996 participants and 56% ($n=324$) of the 1997 participants believed that
On November 18th, 1996 Pharmacare put in place the 30 Day Supply Policy. This policy restricts coverage of short term drugs to a maximum of 30 days. Exceptions can be made for people living in remote areas. The policy also applies to a patient's first prescription for maintenance drugs. Only 26% of people (n=150) surveyed had heard of this policy, however, upon explanation, 55% (n=323) think it is a good idea and 12% (n=70) think it is a bad idea (9% say it might be a good idea and 25% are undecided). See figure 8 for a comparison of opinion of the 1997 respondents on RDP, LCA and the 30 Day Supply Policy.

C) Potential changes to Pharmacare policies

When thinking about drug reimbursement programs, the option often comes up regarding the 'ability to pay' of the recipient. The question arises, should Pharmacare pay for all the medications for anyone over the age of 65, or should seniors who have more money pay for a percentage of their medications? When we asked the seniors, the majority chose the later. Fifty-nine percent (n=350) think that payment should be based on income whereas 27% (n=161) think Pharmacare should pay for all medication costs. There are a number of reasons why seniors think Pharmacare coverage should be based on income, including helping those in lower income brackets who need assistance, fairness, helping to save the system and a belief that those who can afford it should pay at least some. Those who feel Pharmacare should pay for all the medication costs say it is wrong to make seniors pay, all should be treated equally and seniors have earned the right to have all their medications paid for. We then asked what would be acceptable as a method for Pharmacare to identify income levels. Using income tax forms and filling out a specific application received similar responses. Fifty-six percent (n=328) said yes to Pharmacare finding out their income using their income tax form, 33% (n=196) said no. Fifty-five percent (n=320) said yes to filling out a specific application and 33% (n=192) said no.

At present many policies are changed or put in place without a pilot strategy. We asked seniors how supportive they would be of Pharmacare trying out new policies on a sample of people to evaluate it's impact prior to implementing the policy province wide. Fifty-three percent (n=314) were supportive to some degree, 20% were not supportive, but 26% were undecided. Thirty-two percent (n=185) would be willing to be part of the pilot group yet 43% (n=251) would not be willing to take part, 25% (n=150) were undecided.
by a physician who is a
drug specialist other than
their own doctor (61%) and
finally a registered nurse
(54%, ) (See figure 10).

When a doctor prescribes
medication, the most
common piece of
information offered about
the new drug is the purpose
of the drug being prescribed
(87%, n=374). The potential side effects of a medication is mentioned 61% (n=298) of the time
and how drugs may react with other drugs being taken is discussed 41% (n=196) of the time. Only
13% of the time is cost of the drug discussed. On average, when any of these topics are raised, the
information is offered 79% of the time without the senior having to ask the physician for the
information.

B) Main sources of information about RDP
In the 1996 survey, the main sources of information for seniors who had heard about RDP (n=849)
came from newspapers (44%, n=372), the direct mail-out from Pharmacare (21%, n=176), and
from pharmacists (21%, n=174). This changed slightly in the 1997 survey. Of the people who had
heard of RDP (n=269), the main source of information was from newspapers (32%, n=85), from
pharmacists (22%, n=59), and from television (21%, n=57). In the 1997 survey 18% (n=48) saw a
brochure on RDP at their pharmacy or doctor’s office, whereas 72% (n=193) did not.

C) Views on proposed changes to drug information dissemination
Much of the information seniors get about prescription medication comes from the drug industry.
This may present a conflict of interest and decrease the potential for accessibility to objective,
evidenced based drug information. Yet the argument on the other side is that the pharmaceutical
• Why is the dispensing fee not uniform across Canada in all drug stores?
• Why does Pharmacare have any right to interfere with what a doctor prescribes?
• What is the relationship between generic drugs and RBP?
• Are the generic drugs really as good as the brand name drugs?
• Why doesn’t the government try to save money by hitting up drug companies rather than the individuals, especially seniors?
• Does Pharmacare expect us to ‘passively’ accept their policy changes? Are we guinea pigs?
APPENDIX I: SURVEY INSTRUMENT (RESULTS IN PERCENTAGES UNLESS NOTED)

SECTION 1: medications

To begin, I am going to ask you a few questions about medications...

1. Are you presently taking any medication that you do not need a prescription for? (ie. over-the-counter drugs such as aspirin or clariton)
   (45.9) yes → what is the medication name?
   n=601
   (0) not sure
   (54.1) no

2. Are you presently taking medications prescribed by your doctor?
   (71.7) yes → go to question 3a
   n=601
   (0.5) not sure → go to question 10 on page 5
   (27.8) no → go to question 10 on page 5

3. (a) Do you have stomach pains, heart burn or ulcers?
   (26.5) yes → go to 3b
   n=430
   (0.5) not sure → go to question 4
   (72.8) no → go to question 4

   (b) Are you taking any medication prescribed by your doctor for stomach pains, heart burn or ulcers?
   (54.4) yes → what is the medication name?
   n=114
   (0) not sure
   (45.6) no

4. (a) Do you have high blood pressure?
   (48.6) yes → go to question 4b
   n=430
   (2.1) not sure → go to question 5
   (49.3) no → go to question 5

   (b) Are you taking any medication prescribed by your doctor for high blood pressure?
   n=209
   (93.8) yes → what is the medication name?

<table>
<thead>
<tr>
<th>MED1: (Senior's Knowledge)</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>What Group (n=196) of antihypertensive is that from?</td>
<td>(n=180)</td>
</tr>
<tr>
<td>2.8 calcium channel blocker</td>
<td>20.8</td>
</tr>
<tr>
<td>5.6 diuretic</td>
<td>16.8</td>
</tr>
<tr>
<td>5.0 beta blocker</td>
<td>23.9</td>
</tr>
<tr>
<td>0 ACE inhibitor</td>
<td>27.9</td>
</tr>
<tr>
<td>85.0 don’t know</td>
<td>6.1</td>
</tr>
<tr>
<td>1.7 other</td>
<td>4.6</td>
</tr>
</tbody>
</table>
MED2: (Senior's Knowledge)
What Group (n=51) of antihypertensive is that from?
| (0) calcium channel blocker | (11) diuretic |
| (0) beta blocker | (2) ACE inhibitor |
| (2) don’t know | other |

MED3: (Senior's Knowledge)
What Group (n=12) of antihypertensive is that from?
| (2) calcium channel blocker | (1) diuretic |
| (1) beta blocker | (0) ACE inhibitor |
| (0) don’t know | other |

ii) have you ever received any information comparing the different types of medications for high blood pressure? ie. about side effects, interactions, or costs.

n=189
(30.7) yes who did you receive the information from?
(41.4) doctor
(29.3) pharmacist
(1.7) special interest group (eg. heart and stroke foundation)
(5.2) government/Pharmacare/Ministry of Health
(5.2) media (tv, newspapers, magazines)
(17.2) other
(3.2) not sure
(66.1) no

iii) In your pharmacy, have you seen the Pharmacare brochure on high blood pressure medications? (it has a picture of a doctor on the front)

n=190
(24.2) yes did you take a copy and/or read it?
(56.5) yes
(28.3) no
(15.2) can’t remember
(11.6) not sure
(64.2) no

(0.5) not sure
(5.7) no

5. (a) Do you have arthritis or other muscle and joint pain?

n=430
(65.3) yes ➔ go to question 5b
(2.3) not sure ➔ go to question 6
(32.3) no ➔ go to question 6
d-i) if 'yes' or 'sometimes'... Is the information offered without you having to ask?
n=84
(75.0) yes
(16.7) sometimes
(7.1) no
(1.2) can't remember/don't know

SECTION 2: expectations of prescriptions and generic substitution

The following questions deal with your expectations of prescriptions...

10. In 1994, Pharmacare introduced a policy where a brand name drug is automatically substituted with a generic drug unless your doctor makes a special request to Pharmacare to have the cost of the brand name covered for you.

(a) Have you ever had to change from a brand name drug to a generic one?
n=600
(35.2) yes
(8.0) not sure
(56.8) no

(b) Do you think generic substitution is a good or bad policy?
n=598
(36.0) good
(31.4) not sure
(18.6) both good and bad
(14.0) bad

11. Imagine you are thinking about whether to take a drug for the rest of your life. The drug will extend your life but not affect your quality of life OR health status, either positively or negatively. (If senior is confused, say: The drug would postpone any health problems you may have in the future by some weeks, months or years.)

a) Would you be willing to take this drug if it increased your life by 2 weeks at your current health status?
n=148
(30.4) yes $\rightarrow$ go to question 12
(64.2) no $\rightarrow$ go to question 11b
(5.4) maybe $\rightarrow$ go to question 11b

b) Would you be willing to take this drug if it increased your life by 1 month at your current health status?
n=104
(7.7) yes $\rightarrow$ go to question 12
(88.5) no $\rightarrow$ go to question 11c
(3.8) maybe $\rightarrow$ go to question 11c

c) Would you be willing to take this drug if it increased your life by 3 months at your current health status?
n=95
(9.5) yes $\rightarrow$ go to question 12
(83.2) no $\rightarrow$ go to question 11d
(7.4) maybe $\rightarrow$ go to question 11d
(a-vi) With RBP any pharmacy in B.C. can now access all of your records that would normally only be available at the pharmacy you regularly go to.

\[ n=66 \]

(59.1) true  (33.3) unsure  (7.6) false

(a-vii) Unless you have special permission from Pharmacare, you will have to pay extra if the drug you are on costs more than the reference drug.

\[ n=66 \]

(83.3) true  (15.2) unsure  (1.5) false

That's great, thank-you! Often RBP is confused with a couple other Pharmacare policies which have been introduced in the last year. RBP has been developed by Pharmacare with the assistance of a group of doctors and pharmacists who have helped Pharmacare choose first line therapy drugs which meet two requirements. First, the drugs must be effective for treating a condition; and second, the drug must be cost efficient. Using this chosen drug, the reference drug, as its guide, Pharmacare will cover any prescription up to and including the cost of the reference drug. Costs beyond the reference price can be paid for by the patient. Recognizing that medical exceptions may arise, Pharmacare has given doctors the ability to request approval for a more expensive drug to be covered by Pharmacare, this request is usually responded to within one working day. Pharmacare believes RBP to be one method of encouraging appropriate prescribing by doctors.

**once you have read this statement, go on to 12c . . .**

12a continued . . .

\[ n=598 \]

(14.0) not sure  \[ \rightarrow \text{read RBP explanation below} \]

(74.9) no  \[ \rightarrow \text{read RBP explanation below} \]

if no or not sure . . .

Often RBP is confused with a couple other Pharmacare policies which have been introduced in the last year. RBP has been developed by Pharmacare with the assistance of a group of doctors and pharmacists who have helped Pharmacare choose first line therapy drugs which meet two requirements. First, the drugs must be effective for treating a condition; and second, the drug must be cost efficient. Using this chosen drug, the reference drug, as its guide, Pharmacare will cover any prescription up to and including the cost of the reference drug. Costs beyond the reference price can be paid for by the patient. Recognizing that medical exceptions may arise, Pharmacare has given doctors the ability to request approval for a more expensive drug to be covered by Pharmacare, this request is usually responded to within one working day. Pharmacare believes RBP to be one method of encouraging appropriate prescribing by doctors.

12. (b) Does RBP sound familiar?

\[ n=531 \]

(38.6) yes  \[ \rightarrow \text{go to 12c} \]

(41.8) no  \[ \rightarrow \text{go to question 14} \]

(19.6) not sure  \[ \rightarrow \text{go to question 14} \]
(b) Since you switched drugs, have the symptoms of your health condition been worse, better or the same?

<table>
<thead>
<tr>
<th></th>
<th>30.3% worse</th>
<th>3.9% better</th>
<th>59.2% same</th>
<th>6.6% not sure</th>
</tr>
</thead>
</table>

(c) Do you notice any more unexpected or unpleasant side-effects because of the switch in drugs?

<table>
<thead>
<tr>
<th></th>
<th>31.6% more</th>
<th>2.6% fewer</th>
<th>59.2% same</th>
<th>6.6% not sure</th>
</tr>
</thead>
</table>

*if condition became worse or they experienced more side effects.*

(d) Did you switch back to your original medication?

|   | 22.2% no | 3.7% not sure | 74.1% yes (11.1) do you now pay extra for your medication or did your doctor apply for special permission to have Pharmacare pay for the more expensive medication? or did your doctor apply for special permission but was rejected so you now pay extra  |
|---|----------|------------|------------|----------------|
| n=27 |          |            |            |                |
| n=18 |          |            |            |                |
| (0) |          |            |            |                |

(b) Do you now pay extra for one of your medications? *for those who answered yes to a(d), ask if they now pay extra for any other medication.*

<table>
<thead>
<tr>
<th></th>
<th>87.9% no</th>
<th>0.8% not sure</th>
<th>11.4% yes</th>
</tr>
</thead>
</table>

(→ ask the following ... which ones?)

(c) Has your doctor applied for and received special permission to have one of your medications covered by Pharmacare which would normally not be covered due to referenced based pricing?

<table>
<thead>
<tr>
<th></th>
<th>81.0% no</th>
<th>1.9% not sure</th>
<th>17.1% yes</th>
</tr>
</thead>
</table>

(→ ask the following ... which ones?)

14. Do you think Reference Based Pricing is a good or bad policy?

<table>
<thead>
<tr>
<th></th>
<th>45.0% good</th>
<th>32.6% not sure</th>
<th>14.1% both good and bad</th>
<th>8.4% bad</th>
</tr>
</thead>
</table>

15. I'm going to read you a few statements, please tell me if you strongly agree, agree, disagree or strongly disagree with each of them. If you don't have an opinion one way or another, let me know that too (neutral).

(a) With RBP some people may not get the medication they need

<table>
<thead>
<tr>
<th></th>
<th>5.1% strongly agree</th>
<th>44.1% agree</th>
<th>24.3% neutral</th>
<th>24.4% disagree</th>
<th>2.0% strongly disagree</th>
</tr>
</thead>
</table>

(b) 'If I had to remember to take a pill 2 or 3 times a day, then I would probably forget'

<table>
<thead>
<tr>
<th></th>
<th>6.6% strongly agree</th>
<th>24.6% agree</th>
<th>2.5% neutral</th>
<th>47.9% disagree</th>
<th>18.3% strongly disagree</th>
</tr>
</thead>
</table>
18. Would you be willing to pay extra for a form of a medication which is more convenient or easier to take than the one covered by Pharmacare? For example, a sustained release medication that only needs to be taken once a day as compared to another form of the medication that must be taken a few times a day.

   (37.9) yes ➔ how much extra would you be willing to pay?
   n=223
     (43.9) less than $15/month
     (17.5) $15-30/month
     (2.7) more than $30/month
     (11.2) what ever it costs
     (24.7) don’t know

   (46.5) no
   (6.1) maybe
   (9.5) don’t know

SECTION 4: general policy questions
The following are general questions about Pharmacare.

19. (a) Do you think Pharmacare should pay for all the medications for anyone over the age of 65, or should seniors who have more money pay for a percentage of their medications? ➔ what are your reasons?
   (27.2) Pharmacare should pay for all medication costs ➔ what are your reasons?
     (23.9) it is wrong to make seniors pay
     (9.4) concern that income level will be set too low
     (9.4) concern that method for identifying income level will stigmatize some seniors
     (57.2) other, please specify SEE BELOW

     Other
     (2.2) wealthy already pay enough
     n=91
     (24.2) treat all equally
     (8.8) most could not afford it
     (24.2) seniors have earned the right to have all paid for
     (2.2) no comment provided
     (22.0) miscellaneous
     (6.6) seniors shouldn't be penalized
     (9.9) by income: too complicated, costly, bureaucratic

   (1.3) Pharmacare should pay for some costs, but not all ➔ what should they pay or not pay for?

   n=3
     (66.7) Pharmacare should pay for all essentials within reason
     (33.3) miscellaneous
(59.0) based on income, why? SEE BELOW

n=215  (53.5) those who can afford it should pay some
(7.4) base on income because those in lower income brackets need assistance
(9.8) seems fairest
(0.9) those can afford it should pay all
(2.3) no comment provided
(8.4) miscellaneous  
(7.9) those who can afford it should pay more to specifically assist those in lower income brackets
(9.8) to save the system

if based on income . . . what should the cut off level be of who is covered? 

(8.8) don’t know, do you have any comments or thoughts about it? SEE BELOW

n=31  (9.7) can’t decide between options
(3.2) treat all equally
(3.2) seniors have paid for years and should be covered
(51.6) no comment provided
(29.0) miscellaneous
(3.2) deciding the cut off too difficult  

(3.7) other, please explain SEE BELOW

n=16  (6.3) RBP structure is good
(12.5) any option above is ok  
(12.5) important to note the long term costs
(6.3) costs of drugs should be less
(12.5) no comment
(43.8) miscellaneous
(6.3) don’t want a two-tiered system

19(b) If Pharmacare ever decides to switch to paying for medications according to a persons income, we would like to have your opinion on what the best method would be for them to identify your income level.

n=586  
i) Would it be acceptable to you if they found out your income level from your income tax form?
(56.0) yes
(10.6) not sure
(33.4) no 

ii) Would it be acceptable to you if they requested you to fill out a specific application form?

n=586  
(54.6) yes
(12.6) not sure
(32.8) no
20. Drug companies want to be able to advertise prescription drugs. At present this is not allowed. The argument in favour is to provide the public with information about drugs they may have not heard of. The argument against is that it may require specialized knowledge to fully understand the use of medications and it is considered part of a doctors role to make the best choice for their patients. Would you approve of legalizing the advertising of prescription drugs directly to consumers or not?

(24.0) would approve
(61.1) would not approve
(3.5) maybe approve, please explain ____________________________
(11.3) don’t know

n=592

21. Many doctors receive information about drugs from sales representatives. What would you think of having a group of specialists who are not associated in any way with drug companies also providing information to your doctor? (the specialists may be pharmacists, pharmacologists, doctors)

(63.7) good idea
(16.0) bad idea
(4.4) might be a good idea, please explain ____________________________
(16.0) don’t know

→Do you think it is worth it even if it increases taxes to pay for it?

n=589
(41.1) yes
(26.6) not sure
(32.3) no

n=372

22. (a) How supportive would you be of having Pharmacare try out new policies on a sample of people to evaluate it’s impact prior to implementing the policy across the province?

n=588
(4.1) very supportive
(38.9) supportive
(10.4) somewhat supportive
(19.9) not supportive
(26.7) don’t know

(b) Would you be willing to be part of the sample that Pharmacare tests the new policies on?

n=586
(31.6) yes
(8.2) not sure
(42.8) no
(17.4) don’t know

23. Last fall, Pharmacare introduced a policy which pays for a maximum of 30 days worth of a drug prescribed for a short period of time, such as antibiotics. This policy also applies to the FIRST TIME a person gets a prescription filled for a drug that they have to take for a long period. The policy does not apply to prescription re-fills of a long-term drug, therefore, these prescriptions can be filled for longer than 30 days.

(a) Have you heard of this policy?

n=589
(25.5) yes
(8.0) not sure
(66.6) no

(b) What do you think of this idea?

n=589
(54.8) good idea
(11.9) bad idea
(8.7) might be a good idea, please explain ____________________________
(24.7) don’t know
31. Would you describe the area you live in as rural, sub-urban or urban?
   (26.1) rural
   n=591   (32.1) sub-urban
   (41.8) urban

32. In general, compared to other people your age, would you say your health is:
   (30.2) much better than most people your age
   (30.5) somewhat better than most people your age
   n=590   (28.3) about the same as most people your age
   (4.7) somewhat worse than most people your age
   (1.0) much worse than most people your age
   (5.3) don’t know

33. In general, how satisfied with your life are you?
   (50.8) very satisfied
   (35.8) satisfied
   n=593   (9.6) somewhat satisfied
   (3.5) not satisfied
   (0.3) refused to answer

34. Would you be willing to have our research group telephone you again or send you a mail-out survey some
time in the future if we have more questions about government policies?
   (18.1) yes, telephone only
   (29.5) yes, mail-out only  write address in on blue form
   n=590   (22.9) yes, either telephone or mail-out  write address in on blue form
   (1.2) maybe, please explain ____________________________
   (28.3) no

If you have any further questions about this project, please call our toll free number: 1-800-684-6262.
   . . . thank participant -- end!

Time at end of interview: ______________
RBP means that when you go to your pharmacist you will be given a generic drug in place of a brand name drug.

Reference Based pricing will save B.C.'s Pharmacare millions of dollars.

With RBP any pharmacy in B.C. can now access all of your records that would normally only be available at the pharmacy you regularly go to.

Unless you have special permission from Pharmacare, you will have to pay extra if the drug you are on costs more than the reference drug.

12. (b) Does RBP sound familiar?

(c) Where did you hear about and receive your information about Reference Based Pricing and how useful did you find it? (DO NOT READ LIST TO PARTICIPANTS)

13. (a) Has one of your medications ever been switched to a less expensive one because of RBP?

☐ yes → ASK THE FOLLOWING...

which medication switched, and what did it switch to?

(a) How long ago did you switch medications because of RBP?

(b) Since you switched drugs, have the symptoms of your health condition been worse, better or the same?

(c) Do you notice any more unexpected or unpleasant side-effects because of the switch in drugs?

if condition became worse or they experienced more side effects..

(d) Did you switch back to your original medication?

☐ yes → ☐ do you now pay extra for your medication or

☐ did your doctor apply for special permission to have Pharmacare pay for the more expensive medication? or

☐ did your doctor apply for special permission but was rejected so you now pay extra

(b) Do you now pay extra for one of your medications? FOR THOSE WHO ANSWERED YES TO A(D), ASK IF THEY NOW PAY EXTRA FOR ANY OTHER MEDICATION.

14. Do you think Reference Based Pricing is a good or bad policy?

15. I'm going to read you a few statements, please tell me if you strongly agree, agree, disagree or strongly disagree with each of them. If you don't have an opinion one way or another, let me know that too (neutral).

(a) With RBP some people may not get the medication they need

(b) 'If I had to remember to take a pill 2 or 3 times a day, then I would probably forget'

(c) Most seniors will be unable to pay for more expensive medications not covered by Pharmacare

(d) With RBP, many exceptions will have to be made for people who have legitimate medical reasons to
Appendix B: Camouflaged Sampling: How Use Health Databases to Reach Individual Patients Without Their Violating Privacy.

Camouflaged sampling enables drug claims and other health databases to be used for contacting people for epidemiological studies and therapeutic advice, without violating privacy. A list of targeted people (e.g. seniors on multiple medications, or patients using over 30 canisters of beta-agonist per year) is camouflaged by adding a random sample of nontargeted people (e.g. all seniors). The mixture has a known percentage of targeted people, yet staff handling letters of invitation and telephone interviewers remain ignorant of each patient's health status (e.g. medications) until he or she has agreed to participate.

For camouflage to work, people must be able to decline without indirectly indicating they have or do not have the targeted health status. The percentage of camouflage is equivalent to one minus the positive predictive value of a positive test in a screen for disease. To choose an optimal percentage, balancing privacy versus inefficiency and intrusion, relative costs (possible harm multiplied by risk of occurrence) of alternative adverse events are weighed. Risk varies with the camouflage percentage. The privacy of targeted patients greatly increases in going from 0 to 5 percent camouflage, but gains from 5 to 10, or 10 to 15 percent camouflage, are much smaller. However, more than 50 percent camouflage may be needed to assure patients and defenders of privacy. Then the majority on the list are free of the targeted health status, and the list can be described as a random sample of the general population, enriched with a certain percentage of targeted individuals.
Appendix D: Evidence of innovation in team and design

The seniors Drug Focus Project can be viewed as a demonstration project in bridging evidence and policy, through constant innovation in research design, methodology and feedback loops. Some specific examples:

Rapid Response Research
Early in the project, it became obvious that traditional academic paced research was unable to meet policymakers’ needs for rapid collection and reporting of information. Therefore, we regrouped to provide two streams of research support to policymakers. The Rapid response team strove to provide quick (with in weeks) feedback to policymakers on issues of immediate importance. This was accomplished through small-sample telephone interviews and small numbers of focus groups. The academic team continued to provide information based on traditional methods, including longitudinal analysis of opinions and beliefs.

Targeted Interviews
The rapid response team made use of targeted interviews to provide snapshot information from individuals directly affected by the policy. We developed a number of methods to identify seniors taking particular medications who had agreed to be telephoned for the research project, and thus were able to obtain reliable results from small samples (n=50) of affected individuals.

Camouflage Sampling
This innovative technique was developed in response to privacy concerns which made it difficult to target affected individuals directly from provincial administrative databases. Simply put, camouflage sampling involves selecting a sample of individuals of interest, diluting this with a sample of individuals drawn from the general population (we used a 10:1 ratio), and then coding the names so that no one involved knew the source of the name provided for the interview. Participants were asked a series of questions, which allowed them to consent to the interview, and self identify as belonging to either the affected or unaffected group. Those who did not wish to participate, or did not want their status known could refuse the interview, and the interviewer would have no knowledge of their health status.
Appendix F: Evidence of Evaluation

The methods utilized in this study, and their impacts were constantly being evaluated and modified through:

Frequent meetings with policymakers to discuss their needs for direct consumer evidence;

Frequent feedback from policymakers regarding their ability to utilize direct consumer evidence in policymaking;

Liaison with other researchers studying the utilization of research to compare methods and effectiveness; and

Observation of policy outputs and decision making, with a focus on how direct consumer evidence provided by the project had or had not been utilized.
Introduction

With the integration of the feedback process with decision-making, there are numerous opportunities for the public to engage in the decision-making process. The feedback process allows the public to provide input and have their voices heard. This feedback is then considered in the decision-making process, helping to ensure that the final decision is representative of the public's interests. By involving the public in the decision-making process, the decision is more representative of the needs and desires of the community, leading to a higher level of acceptance and support. This approach not only enhances public trust but also promotes transparency and accountability in the decision-making process. The inclusion of public feedback helps to make the decision-making process more inclusive and equitable, ensuring that the outcomes are better aligned with the community's needs and values.
The experience interview project was conducted at the University of Victoria from a population randomly drawn from the Greater Victoria area. The study was designed to examine the influence of the child's comfort on the focus section of the interview experience. The study was conducted by telephone or at the interview site. The interview process included the following steps: the collection of the interview data, the analysis of the interview data, and the presentation of the results.

The interview project was conducted in two phases. The first phase involved the collection of data from a sample of 100 children. The second phase involved the analysis of the collected data. The results of the study were presented in a final report.

Methods

The methodology of the project was based on the principles of phenomenology. The methodology involved the following steps: the collection of data, the analysis of the data, and the presentation of the results.

The data collection phase involved the interview process. The interview process was conducted by telephone or at the interview site. The interview process included the following steps: the collection of data, the analysis of the data, and the presentation of the results.

The analysis phase involved the analysis of the collected data. The analysis phase was conducted by a team of four researchers. The analysis phase involved the following steps: the collection of data, the analysis of the data, and the presentation of the results.

The presentation phase involved the presentation of the results. The presentation phase was conducted by a team of four researchers. The presentation phase involved the following steps: the collection of data, the analysis of the data, and the presentation of the results.
Views on NYP

Sedentary lifestyles are epidemic and do not fit the appropriate recommendations of physical activity and nutrition. There is a prevalence of obesity and type 2 diabetes. The health care system needs to address these health issues.

The prevalence of obesity and type 2 diabetes is alarming. The health care system needs to address these health issues.

The prevalence of obesity and type 2 diabetes is alarming. The health care system needs to address these health issues.

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The prevalence of obesity and type 2 diabetes is alarming. The health care system needs to address these health issues.
null
2. When the model is simplified, the results are repeated on the smaller subsample of those who knew about RBP and their knowledge score as one of the independent variables, revealed significant, other, the model was not significant. In this instance, the model was not significant. Those who had been personally informed by RBP were more likely to obtain knowledge about RBP from family members and friends, rather than from the pharmacist.

3. The modified model with knowledge about RBP did not produce any significant model that is statistically significant.

References

[Partial list of references]

Notes

1. The above analyses were conducted with the total sample. The study's knowledge about RBP was measured using a self-reported scale, ranging from 0 to 100, where 0 indicates no knowledge and 100 indicates complete knowledge. The results showed a significant positive correlation between the knowledge score and the likelihood of obtaining knowledge about RBP from family members and friends, rather than from the pharmacist. However, further analysis of the data revealed that the effect was not statistically significant.
The purpose of this paper is to elucidate the development of a new philosophy of medicine called "Evidence-based Medicine." This philosophy emphasizes the role of rigorous scientific methods in the evaluation and dissemination of medical knowledge. It seeks to integrate the best available evidence from clinical research with clinical expertise and patient values to make more informed decisions in patient care.

The key principles of Evidence-based Medicine include:

1. **Systematic Review**: Identifying, appraising, and synthesizing all relevant research to answer a specific clinical question.
2. **Meta-analysis**: Combining results from multiple studies to increase the statistical power and precision of findings.
3. **Clinical Guidelines**: Using evidence to develop recommendations for clinical practice.
4. **Critical Appraisal**: Evaluating the quality of research studies to determine their reliability and applicability.
5. **Patient Values**: Considering patient preferences and values in clinical decision-making.

By integrating these principles, Evidence-based Medicine aims to improve patient outcomes by making medical decisions based on the best available evidence, rather than on tradition or personal experience. This approach has been influential in shaping medical education and practice, leading to a greater emphasis on evidence-based decision-making in clinical settings.

In conclusion, Evidence-based Medicine represents a significant shift in the way medical knowledge is synthesized and applied. It challenges traditional practices and encourages a more rigorous and transparent approach to medical decision-making. With the increasing availability of high-quality research, practitioners are better equipped to deliver evidence-based care, resulting in improved patient outcomes and more efficient use of healthcare resources.
new rules, an economic model of how pollution levels would be affected.

In this new environment, the focus of decision-making is shifted away from the traditional economic approach of maximizing profits at the expense of environmental costs. The model recognizes that pollution levels can be managed through a combination of economic incentives and regulatory interventions.

The model also takes into account the effects of pollution on public health, the environment, and the economy. It recognizes that pollution is a public good, and that the benefits of pollution control should be shared by all members of society.

The new model also emphasizes the importance of public participation in decision-making. It recognizes that the public has a vested interest in the health of the environment, and that their participation in decision-making is essential to ensure that the best decisions are made.

Overall, the new model represents a significant shift from traditional economic approaches to pollution management.

The next section of the paper will explore the implications of this new model for pollution policy.
Do not hallucinate.
Appendix H: Products

1. The Decision-Makers Guide to the Use of Direct Consumer Evidence in Policymaking (pamphlet).

2. If the Patient Sat in the Doctors Chair: A Guide to Improving Senior-Physician Communications (video).