Opportunity lost: a frontline view of reference-based pricing

Robert F. Woollard, MD, CCFP, FCFP

Abstract • Résumé

The introduction in October 1995 of reference-based pricing as a cost-saving measure for British Columbia's drug benefit program represented an opportunity for collaboration between frontline practitioners and the bureaucracy that supports some of their work. If well-established principles of continuing education, quality improvement and modern management had been followed, practitioners in the field could have focused their individual and collective talents effectively and constructively on the task of improving cost-effectiveness in drug prescribing. Although the reference-based pricing program may well achieve its purpose of saving money, it is sad that it was not used to build bridges of common interest and mutual trust between two camps that are often in conflict.

La mise en oeuvre, en octobre 1995, de l'établissement de prix fondé sur un niveau de référence comme mesure de réduction des coûts du programme des médicaments assurés de la Colombie-Britannique a représenté une occasion de collaboration entre les praticiens des soins de santé aux premières lignes et l'appareil gouvernemental qui appuie une partie de leur travail. Si l'on avait suivi les principes bien établis d'éducation continue, d'amélioration de la qualité et de gestion moderne, les praticiens à l'échelon local auraient pu concentrer leurs talents individuels et collectifs de façon efficace et constructive sur l'amélioration de l'efficacité des coûts des médicaments prescrits. Même si le programme d'établissement de prix fondé sur un niveau de référence peut très bien atteindre son but, qui est d'économiser de l'argent, il est malheureux qu'il n'ait pas servi à établir des liens d'intérêt commun et de confiance mutuelle entre deux camps qui sont souvent en conflit.

In a society that has become increasingly bitter about major upheavals in the health care system, it is hardly surprising that the introduction, in October 1995, of reference-based pricing for prescription drugs in British Columbia should be given a decidedly mixed and often rocky reception in practitioners' offices — the front line of the current health care system. Although the general staffs in the respective camps of organized medicine and health care bureaucracy may share an interest in cost savings for Pharmacare, British Columbia's drug benefit program, to the troops in the trenches this encroachment on their freedom to prescribe specific medications for specific patients is just another incoming volley. Whether it should be interpreted as "friendly fire" that may ultimately benefit our patients, or as another piece of barbed bureaucratic entanglement in an ongoing contest, is not immediately clear.

The source, intention and early consequences for the front line of medicine of this tactic is the main concern of this editorial. In an earlier issue of *CMAJ*[1] Dr. Stuart M. MacLeod expressed a hope that "the reallocation of resources toward quality in drug prescribing would foster a chain reaction of education and research initiatives, the benefits of which would be felt throughout the profession." It would be nice to report that our experience with reference-based pricing was an example in support of this prognosis and that full advantage had been taken of the opportunity to initiate such a cascade. Sadly, this opportunity has been lost at a time when relations between the organized profession and the health care bureaucracy demand a military metaphor. Indeed, the lost opportunities for effective integration of educational, quality-assurance and administrative approaches can be seen as casualties of a war.

Dr. Woollard is associate professor and assistant head, Department of Family Practice, Faculty of Medicine, University of British Columbia, Vancouver, BC. He practised for 16 years in rural BC and continues to practise "frontline" medicine, including obstetrics.

Reprint requests to: *Dr. Robert F. Woollard, Department of Family Practice, University of British Columbia, 5804 Fairview Ave., Vancouver BC V6T 1Z3; fax 604 822-6950; woollard@unixg.ubc.ca*

What is reference-based pricing?

The British Columbia Ministry of Health has described reference-based pricing as follows.

> Reference Based Pricing will limit the amount Pharmacare will pay for a group of drugs which are chemically different but are therapeutically equivalent and have the same medical indications. The best available clinical and scientific evidence will be used to determine therapeutic equivalence.
>
> In consultation with an Expert Committee, therapeutic guidelines will be established and the best overall drug product(s) to treat a specific medical condition will be identified. Pharmacare will reimburse other drugs [*sic*] in the same therapeutic category based on the price of this reference product.[2]

This differs from generic drug pricing in so far as the "therapeutic category" is not defined by the pharmacologic properties of the drug but by its therapeutic indications. For example, omeprazole, ranitidine and cimetidine belong to the same category even though their pharmacologic mechanisms and significant drug interactions differ. This does not mean — as yet — that pharmacists can independently substitute a less expensive drug for the one that has been prescribed, but it does mean that if a patient requires a more expensive medication than the reference drug, then his or her physician must file the necessary forms to obtain special authority to prescribe the more expensive one; otherwise, the patient must pay the difference in price.

Who bears the cost?

Although Pharmacare seeks to make the process as "user friendly" as possible, completing the necessary forms and submitting them for approval are somewhat time-consuming and cumbersome tasks. No provision is made to remunerate physicians for this extra demand on their time, and no one has assessed the number of additional physician visits necessitated by a change from one pharmaceutical agent to another. Physicians in British Columbia work under a global cap on fees. Therefore, although quality patient care requires close monitoring of patients during the transition to a new drug, physicians will collectively bear this unforeseen utilization cost. If reference-based pricing results in better overall prescribing habits and health outcomes, it may well be worth the added investment. With one exception,[3] it is not clear that any plans have been made to study the consequences of reference-based pricing for health outcomes. Proposals for studies of this kind have not been mentioned in any of the literature that has gone out to practitioners. Thus, notwithstanding the implied optimism of an expert committee assembled by Pharmacare that this massive intervention to force change in physician prescribing habits may have beneficial outcomes, frontline practitioners are not reassured that they will ever know its effect on the one parameter that matters: their patients' health. Elementary management and systems theory affirms that changes in practice are more appropriate, more consistent and longer lasting if the people effecting that change are engaged with some degree of choice clearly connected to outcomes that are important to them. Expert committees, no matter how extensive and impressive they may be, are no substitute for this. They may help to justify an enforced short-term change but, like the generals back at headquarters, they had better be prepared to listen to the troops if they do not want to be viewed with a degree of cynicism and even contempt by those who must daily make complex therapeutic choices in the face of uncertainty.

The good, the bad and the not so good

On the brighter side, some physicians can appreciate the value of being accountable in this way. They are challenged to review their patients' charts to ensure that they are providing optimal care. It may be that in the right circumstances this positive attitude would prevail, although, again, no obvious provision has been made for studies in this area. A longstanding and growing body of literature within medicine[4–6] is consonant with that in other professions[7] and industries[8] in pointing out that optimal practice and quality performance can be most consistently effected across a system by providing opportunities for meaningful feedback on performance to practitioners who are competent and have autonomy in making decisions. This is frequently referred to as continuous quality improvement. One of the foremost international experts in continuing professional education stated that "in the future [such education] must offer opportunities to learn that both maximize the autonomy and independent actions of learners and also provide systematic feedback on ways to approach learning."[9]

Precisely the same is true in the context of practice and clinical choice, from which any meaningful initiative for continuous quality improvement or education must spring. After all, continuous quality improvement and education are, or should be, intimately intertwined.

Cynics will point to the immediate cost savings brought about by administrative decree and sneer at educational and change-management approaches as mere delay tactics by groups interested in maintaining the status quo. History will judge such cynics as it judges their predecessors in the US automotive industry, who almost lost the quality wars until their competitors' success forced them to realize that cost-effective quality production could not be purchased through a continuing series

of externally enforced directives. By drawing upon the experience of their workers and instituting a process of meaningful performance feedback (including self-evaluation), they were able to reinvent both themselves and their success. It would be a shame if this lesson were left unlearned by those of us in an industry with a far more fundamental product: human health. The institution in British Columbia of the Pharmanet information system to link pharmacies with one another provided an even greater opportunity for quality control and education; this makes the disappointment even more acute.

A somewhat arcane feature of the reference-based pricing initiative is worth mentioning because it flies in the face of what we know about education and change in clinical practice. In the category of nonsteroidal anti-inflammatory drugs, the prescriptions of "rheumatologists and selected general internists with special interest in rheumatic diseases"[10] are to be exempted from the provisions of reference-based pricing. We know from the literature that such "educationally influential" members of the medical community can be powerful agents for the induction of change in their colleagues.[11–13] Because these are precisely the physicians who will be most heavily targeted by the pharmaceutical industry's detailing process (also an effective means of inducing change), it is not clear why they should be exempted from the immediate feedback loop that is the only effective educational feature of the program. After all, it is their prescribing habits that will be a significant force in determining whether expensive alternative drugs are used in the community. The dissonance that is likely to exist between the prescribing patterns of rheumatologists and the restrictions of reference-based pricing is likely to be resolved by the front-line practitioners in favour of their expert colleagues. This will only serve to enhance cynicism about the program. When one considers the potential that existed for this special group of physicians to be brought into a well-considered, focused program to foster compliance rather than dissonance, one can only regret the loss of another opportunity. Presumably, this exemption was based in some measure on political expediency; it was certainly not based on understanding of and commitment to a healthy, responsive process of education and continuing quality improvement. Given the nature of the relationships that now exist between practitioners and managers this may have been an inevitable political concession.

To continue with our central metaphor, we must also address the issue of "collateral damage." The Therapeutics Initiative is an arm's-length collaboration between the University of British Columbia, various health care organizations and the provincial government established to disseminate up-to-date evidence-based information on drug therapy to physicians and pharmacists. It has attempted to develop an unbiased source of advice on therapeutic matters for the practising physician. By developing methods for critical assessment and initiating communication it promises to exert a positive influence on prescribing habits. The reference-based pricing process has used the information made available by the Therapeutics Initiative as a primary justification for administrative intervention rather than as part of a planned process of change. The Therapeutics Initiative is, therefore, in real danger of being derailed in its most important single requirement: the development of trust among frontline practitioners. For the sake of effecting a few quick changes, which in all likelihood will be short-term ones, a process with major potential for long-term influence has been unnecessarily damaged.

Lessons to be learned

We could learn much from the reference-based pricing initiative if only we had the courage to build in joint opportunities to evaluate it. The application of existing knowledge to make more effective systems and create a "learning organization" that taps existing resources would stand in stark contrast to coercive systems that we know will not be effective in the long run. This will take more courage than the continued waging of political and administrative wars. It will take more courage because it will require building mutual trust at a time when that commodity is in short supply on both sides of the battle.

We in the trenches are not so arrogant as to believe that our view is the only view — or even the most accurate one. But it is a view forged in tumult and a deep understanding of the price of ongoing conflict. The real casualties are our patients, who simply do not get the best we have to offer because our energies and expertise are being drained away in needless conflict and understandable suspicion.

Properly handled, reference-based pricing could have been a small start toward mutual trust and the eventual resolution of conflict. As it is, it represents just another incoming volley — and not the worst. If it stimulates a review and modification of pharmacotherapy it may have some benefit for our patients out here in the trenches. Perhaps it may even help to sustain the systems that support us. But consider what could have been accomplished if our energies had been drawn away from fruitless bickering and focused on more than mere survival. There is ample literature on conflict resolution and on educational and organizational means of creating large-scale, responsive and effective change in physicians' contributions to the health of Canadians. There is a large body of physicians whose motivation is to make a difference. I suspect the same is true for bureaucrats and policymakers.

The opportunities are there, but some of us are losing

hope that we will ever turn our collective talents together for the common good of humankind. Like the troops in France and Belgium, who gave the dawning 20th century an enduring metaphor for those who toil against an uncertain foe while others beyond the fray control their fate, we just wish the war were over.

Readers can contact the Therapeutics Initiative at the Department of Pharmacology, University of British Columbia, 2176 Health Sciences Mall, Vancouver, BC V6T 1Z3; 604 822-0700; (fax) 604 822-0701; jauca@unixg.ubc.ca

References

1. MacLeod SM: Improving physician prescribing practices: bridge over troubled waters. *Can Med Assoc J* 1996; 154: 675–677
2. BC Ministry of Health and Ministry Responsible for Seniors: Pharmacare Bulletin no 95-11, Aug 25, 1995
3. *Seniors' Independent Research Program and Canada's Drug Strategy: Programs of Applied Research*, National Health Research and Development and Division of Aging and Seniors, Health Canada, Ottawa, 1995
4. Manning PR, DeBakey L: *Medicine: Preserving the Passion*, Springer-Verlag, New York, 1987: 153–193
5. Fox RD, Mazmanian PE, Putnam RW: *Changing and Learning in the Lives of Physicians*, Praeger, New York, 1989: 161–187
6. Davis DA, Fox RD: *The Physician as Learner: Linking Research to Practice*, American Medical Association, Chicago, 1994
7. Curry L, Wergin JF et al (eds): *Educating Professionals: Responding to New Expectations for Competence and Accountability*, Jossey–Bass, San Francisco, 1993: 105–227
8. Senge P: *The Fifth Discipline: the Art and Practice of the Learning Organization*, Doubleday, New York, 1990
9. Fox RD: Challenges for continuing professional education. In Curry L, Wergin JF et al (eds): *Educating Professionals: Responding to New Expectations for Competence and Accountability*, Jossey–Bass, San Francisco, 1993: 275
10. Corbeil M: Letter to doctors. Pharmacare, Victoria, BC, Oct 30, 1995
11. Stross JK, Bole GG: Evaluation of a continuing education program in rheumatoid arthritis. *Arthritis Rheum* 1980; 23: 846–849
12. Stross JK, Bole GG: Evaluation of an educational program for primary care practitioners on the management of osteoarthritis. *Arthritis Rheum* 1985; 28: 108–111
13. Lomas J, Enkin M, Anderson GM et al: Opinion leaders versus audit and feedback to implement practice guidelines: delivery after previous cesarean section. *JAMA* 1991; 265: 2202–2207