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L'Agence des médicaments du Canada

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Drugs Health Technologies Health Systems

Expert Committee Deliberation at Canada's Drug Agency

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Purpose of This Document

This document is provided for informational purposes to describe the health technology assessment (HTA) process and how deliberations are conducted at Canada's Drug Agency (CDA-AMC). It does not supersede any official CDA-AMC procedures or policies.

Introduction to Deliberation in HTA

What Is HTA?

HTA is "a multidisciplinary process that uses explicit methods to determine the value of a health technology at different points in its life cycle. The purpose is to inform decision-making in order to promote an equitable, efficient, and high-quality health system."[1]

Health technologies include drugs, medical devices, diagnostic tests, clinical interventions, and complex health system interventions, such as models and programs of care.

Overall value may vary depending on the perspective taken, the participants involved, and the decision context.

What Is Deliberation in HTA?

Deliberation is the informed and critical examination of an issue. It involves the careful consideration of arguments and evidence to guide a subsequent decision.

Deliberation can create opportunities to reveal possibly conflicting values and perspectives, which can be useful to those ultimately making health policy decisions.[2]

Overview of the Process

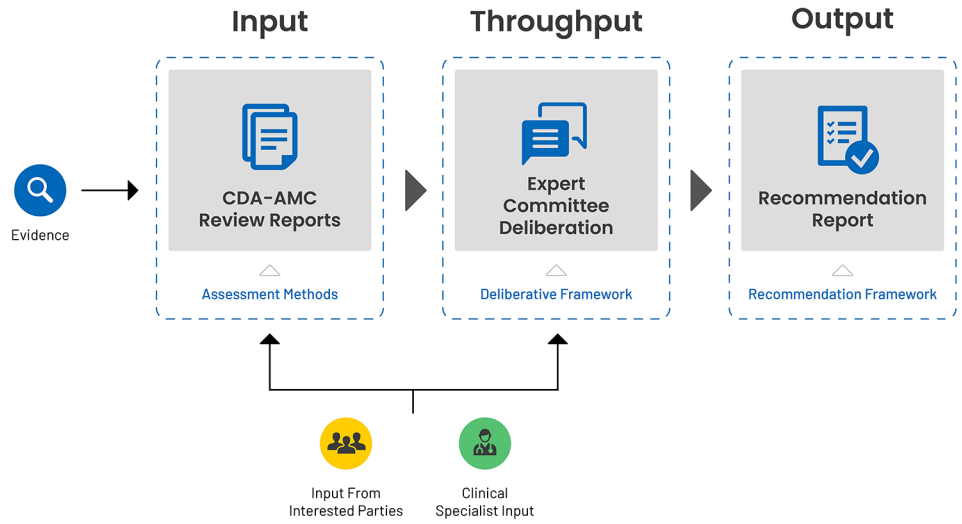
Figure 1 displays the input-throughput-output model of deliberation. During the deliberation, committee members review CDA-AMC evidence reports and supporting materials from interested parties (products of the input phase) that assess the evidence, information, and perspectives relevant to the health technology under review. Following deliberation (throughput phase), the committees issue recommendations or guidance to senior health system decision-makers (output phase).

Expert Committees at CDA-AMC

CDA-AMC has 4 expert committees that deliberate and provide guidance or recommendations on health technologies.

Members of these committees represent a range of expertise, including patient members; ethicists; health care practitioners; and specialists in health economics, pharmacy, epidemiology, or evidence-based medicine. In addition to the core members, expert members may be invited to participate in the deliberation based on their expertise with respect to the condition or technology under review. Table 1 presents the scope of each expert committee at CDA-AMC.

Figure 1: Input-Throughput-Output Model of Deliberation



CDA-AMC = Canada's Drug Agency.

Adapted from Bond K et al.[3]

Table 1: Scope of Expert Committees

Expert committee	Scope
CDEC	Recommendations about the reimbursement and optimal use of non-oncology drugs to publicly funded drug programs in the federal, provincial, and territorial ministries of health in Canada that participate in Reimbursement Reviews
pERC	Recommendations about the reimbursement and optimal use of oncology drugs to publicly funded drug programs and cancer agencies in the federal, provincial, and territorial ministries of health in Canada that participate in Reimbursement Reviews
FMEC	Recommendations that will help public payers to maximize the value of drugs across their lifespan; currently, the second objective is to test innovative approaches to reviews, methods, deliberative processes, inputs, and the communication of outputs
HTERP	Guidance or recommendations on the appropriate use of medical devices, diagnostic tests, and clinical interventions inclusive of models of care, programs of care, and health systems

CDEC = Canadian Drug Expert Committee; FMEC = Formulary Management Expert Committee; HTERP = Health Technology Expert Review Panel; pERC = pan-Canadian Oncology Drug Review Expert Review Committee.

Input: Synthesizing the Evidence and Information

CDA-AMC produces evidence reports that evaluate the available clinical evidence and economic evidence, as well as patients', caregivers', and providers' experiences; impacts on health systems; and broader social and ethical considerations.

In addition to this evidence, the deliberation is informed by direct input from interested parties (as relevant), including federal, provincial, and territorial governments and decision-makers; industry and manufacturers of

drugs and health technologies; clinicians and other health care professionals; and patients. Many different perspectives and values are considered to contextualize the evidence that we assess.

Refer to Table 2 for an overview of the sources of evidence and information.

For information about our assessment methods, refer to the Methods Guide for Health Technology Assessment and the Guidelines for the Economic Evaluation of Health Technologies: Canada.

Table 2: Summary of Sources of Evidence and Information

Source	Committees	Description of evidence and information during input phase
Patient groups and clinician groups	CDEC pERC FMEC	• When assessing the available evidence, CDA-AMC considers input from patient and clinician groups, focusing on unmet needs, known advantages and disadvantages of currently available treatments, and expectations for new therapies. • Patient group and clinician group input submissions are posted on the website and included in committee briefing materials.
Engagement with interested parties	HTERP	• CDA-AMC staff may convene broader engagement sessions with groups and individuals involved in any aspects of health care and health system delivery in Canada to better understand relevant context. • Outputs of the sessions may inform the conduct of the review or be included as inputs to the deliberation.
Clinical specialists	All	• All review teams include at least 1 clinical expert with expertise in the diagnosis and management of the condition for which the technology is indicated. • Clinical experts are involved in all phases of the review process (e.g., assist in the critical appraisal of clinical evidence, interpret the clinical relevance of the results, and provide guidance on the potential place in therapy). • Complex drug Reimbursement Reviews may involve greater consultation with clinical experts; for example, a panel of clinical experts from across Canada may be convened.
Drug programs	CDEC pERC FMEC	• Participating drug programs provide input on each drug being reviewed through the drug Reimbursement Review process by identifying issues that may impact their ability to implement a recommendation.
Industry	FMEC HTERP	• For nonsponsored reviews (i.e., those that are not submitted by the sponsor), industry may provide input on the technology under review. • CDA-AMC solicits input (e.g., on a list of included studies or about costs) and feedback from manufacturers of health technologies under review.
CDA-AMC evidence reports	All	• CDEC and pERC: ◦ CDA-AMC assesses the available clinical evidence that informs the efficacy or effectiveness and harms of the drug relative to relevant comparators in clinical practice in Canada, including pivotal trials and RCTs identified by the sponsor using a systematic review, long-term extension studies, indirect evidence, or studies that address gaps in the systematic review evidence. ◦ CDA-AMC reviews the sponsor's pharmacoeconomic report, economic model, and budget impact analysis, and critically appraises the sponsor's methods, inputs, and assumptions. ◦ For complex drug Reimbursement Reviews, CDA-AMC may also conduct an ethics review exploring relevant ethical considerations. • FMEC: ◦ CDA-AMC conducts 1 or more independent systematic literature searches or evidence--

Source	Committees	Description of evidence and information during input phase
		based analyses of relevant information, in accordance with a protocol or project plan, and summarizes and assesses relevant studies. ◦ CDA-AMC includes a cost-comparison table of the treatments indicated and/or used in clinical practice in Canada. • HTERP: ◦ CDA-AMC prepares evidence reports using the available evidence and inputs, which may consist of 1, or a combination, of the following: an Environmental Scan of current practices, a rapid or systematic review of clinical effects, an economic review, and a review of patients' perspectives. It may also include an analysis of the ethical, social, implementation, environmental, or policy implications of the health technology.

CDA-AMC = Canada's Drug Agency; CDEC = Canadian Drug Expert Committee; FMEC = Formulary Management Expert Committee; HTERP = Health Technology Expert Review Panel; pERC = pan-Canadian Oncology Drug Review Expert Review Committee; RCT = randomized controlled trial.

Throughput: Conducting the Deliberation

Roles and Responsibilities

Refer to Table 3 for an overview of the participants in a CDA-AMC expert committee meeting.

Table 3: Summary of Roles and Responsibilities

Participants	Committees	Roles and responsibilities during throughput phase
Chair	All	• Meet with the CDA-AMC team to prepare for the expert committee meeting and to discuss any potential issues. • Keep the meeting on time and provide guidance on the meeting agendas. • Open the meeting, review the agenda, and provide necessary explanations. Remind the committee of its role and meeting objectives. • Ensure, with support from CDA-AMC staff, that conflicts of interest are disclosed and managed in accordance with CDA-AMC policies. • Guide the decision-making process, ensuring productive, meaningful, and respectful discussion and dialogue.
Core committee members	All	• Actively participate in the deliberation as well as discussions leading up to and following the meeting. • Develop guidance and recommendations on the optimal use of health technologies based on multidisciplinary, evidence-informed analyses led or supported by CDA-AMC, alongside any other relevant inputs. • Follow a deliberative process that is transparent, inclusive, and impartial.[3] • Adhere to the Code of Conduct. Lead discussants (CDEC, pERC, FMEC): • Provide input on the scope of the review and offer their own assessment of the review results. • Complete a presenter report before deliberation that describes their assessment of the evidence according to the domains of value in the deliberative framework.

Participants	Committees	Roles and responsibilities during throughput phase
CDA-AMC staff	All	• Summarize the evidence in the review report and the CDA-AMC critical appraisal of the evidence and answer questions from expert committee members.
External experts (guest specialists)	CDEC pERC FMEC	• Provide input regarding the health technology under review, address questions from core committee members, and may assist in establishing and refining reimbursement conditions. In some cases, this may be the clinical expert consulted during the input phase. They do not vote on the recommendation.
Specialist members	HTERP	• Provide input regarding the health technology or condition under review and address questions from core committee members. They vote as full committee members.
Drug programs	CDEC pERC FMEC	• The lead jurisdiction (or designate) attends the meeting to address questions from core committee members regarding any potential implementation issues associated with the recommendation.
Persons with lived experience	FMEC pERC CDEC	• Make a brief presentation and respond to questions from the core committee members. The person with lived experience only attends the portion of the meeting allotted for the presentation and questions.

CDEC = Canadian Drug Expert Committee; FMEC = Formulary Management Expert Committee; HTERP = Health Technology Expert Review Panel; pERC = pan-Canadian Oncology Drug Review Expert Review Committee.

Appraising the Evidence

Guiding Principles

The guiding principles for deliberative processes reflect the overarching goals of the health systems that our recommendations are intended to support, as follows:

- need: allocating health care resources according to the severity and urgency of health conditions, capacity to benefit, and the acceptability, availability, and effectiveness of alternative health technologies
- patient benefit: prioritizing health technologies that deliver net positive outcomes and improvements for individual or population health
- health system sustainability: meeting the health and health care needs of the population in a way that leads to optimal health in the present without compromising availability of resources to current and future generations
- health equity: distributing health care resources and arranging health care practices and systems to minimize unfair or avoidable disparities in health outcomes and experiences of care across the population.

These guiding principles are operationalized in the deliberation using a deliberative framework.

Using Deliberative Frameworks

The deliberative framework ensures consistent, transparent reasoning, and supports legitimate, impartial, and inclusive deliberations.[2]

The deliberative framework also aligns deliberations with decision-makers' needs and strengthens public confidence in the legitimacy of the deliberation and the subsequent recommendations or guidance.

In evaluating health technologies, the committees are asked to consider 5 domains of value (refer to Table 4):

- clinical value
- unmet clinical need
- distinct social and ethical considerations
- economic considerations
- impacts on health systems.

Table 4: Summary of Deliberative Framework Domains and Considerations

Domain	Description	Considerations
Clinical value	This domain addresses the value that patients derive from a health technology in terms of its effect on their health and health-related quality of life. The determination of the clinical value of a health technology requires the measurement of its clinical benefits and harms and an assessment of the impact of these effects on patients. Clinical benefits and harms are assessed against relevant comparators.	• Whether the technology under review demonstrates at least comparable clinical value (if expected to be substitutive treatment) or added clinical value (if expected to be additive treatment) • Whether the technology under review demonstrates acceptable clinical value for the full patient population under review or for a subpopulation • Magnitude of differences in clinical effectiveness and harms between the health technology under review and relevant comparators • Alignment of comparators with clinical practice in Canada • Importance of outcomes to patients • Certainty of the clinical evidence • Assessment of unmet clinical need and whether there should be greater allowance for uncertainty in the clinical evidence
Unmet clinical need	This domain addresses the morbidity and/or mortality arising from a condition or symptom that is not addressed effectively by available treatments.	• Availability (i.e., public funding status), effectiveness, and harms of alternative treatments • Severity of the condition • Challenges with evidence generation due to rarity of the condition or ethical issues (e.g., the patient population includes a vulnerable population, such as pediatric patients or individuals with mental illness) • In addition, the committee is asked to consider the following equity consideration: Does the technology under review have the potential to address inequities in access to alternative treatments across different patient populations or jurisdictions?
Distinct social and ethical considerations	This domain addresses the social and ethical implications of health technologies not already assessed in the other domains, and how they affect patients, caregivers, populations, and the organization of health systems. It includes nonclinical needs, which are the social, psychological, and logistical factors that influence the appropriateness, accessibility, and acceptability of a health	• Patient, caregiver, and provider perspectives and experiences of the condition, as well as expectations of the technology under review, including: ◦ accessibility and acceptability of the health technology and relevant comparators ◦ care setting (e.g., tertiary, inpatient, ambulatory, community, home care) ◦ geographic distribution of health services ◦ treatment burden on patients (e.g., psychological, financial, physical, relational) ◦ treatment burden on family and caregivers

Domain	Description	Considerations
	technology beyond its direct clinical outcomes. It also examines the broader social and ethical considerations related to the design, evaluation, and implementation of health technologies.	◦ mode of administration ◦ referral and/or prescriber requirements • Implications for relevant ethical principles (e.g., respect for persons and communities, autonomy and dignity, confidentiality and patient privacy) • Environmental impacts of the production, use, or disposal of the health technology • In addition, the committee is asked to consider the following equity considerations: Does the condition that the technology under review aims to address disproportionately impact systematically marginalized or equity-deserving groups? Are there equity considerations for subpopulations who may not be eligible for treatment with the technology under review?
Economic considerations	This domain addresses economic evidence to inform the financial, human, or other resource implications associated with the technology under review, and whether it is worthwhile to allocate resources to the technology under review given its expected clinical benefits. Considerations may include the potential resource or cost impacts of the technology under review vs. relevant comparator(s).	• The magnitude of difference in clinical effectiveness and harms between the health technology under consideration and relevant comparators • The magnitude of difference in total costs associated with the health technology under consideration and relevant comparators • Resource or cost considerations that fall outside the health care system • Certainty of the clinical and economic evidence
Impacts on health systems	This domain comprises 2 distinct but interrelated components: *organizational feasibility of adoption* is the ease with which the health technology can be implemented in the health system while realizing its clinical value, and *economic feasibility of adoption* examines how the adoption of a health technology will economically impact the payer or budget holder.	• Expected utilization of the health technology under consideration • Implications of implementing the health technology for the health system relating to: ◦ infrastructure requirements (e.g., treatment with the technology under review requires that all patients access another technology or infrastructure that may not be in place) ◦ expected impacts on the use of other technologies or resources (including health human resources) ◦ training and competency requirements • Expected budget impact of implementing the health technology • In addition, the committee is asked to consider the following equity consideration: Are there any factors that need to be addressed to support the equitable implementation of the technology under review?

vs. = versus.

Recommendation-Making Process

Deliberating

The Chair invites the lead discussant to provide their assessment of the health technology according to the domains of the deliberative framework, and their underlying reasoning (Canadian Drug Expert Committee [CDEC], pan-Canadian Oncology Drug Review Expert Review Committee [pERC], Formulary Management Expert Committee [FMEC]).

The Chair facilitates a discussion among all committee members of their assessment of the health technology according to the domains in the deliberative framework, reframes and prompts for clarification when needed, and highlights points of convergence and divergence.

Reaching Consensus

Health Technology Expert Review Panel (HTERP) recommendations and guidance are based on consensus.

- If the Chair determines, after a reasonable effort to achieve consensus, that consensus will not be reached, the matter is decided by a majority vote of the members in attendance.
- In the event of a tie, the Chair may exercise a vote.

CDEC, pERC, and FMEC recommendations are made by a majority vote of the members once a potential consensus is identified and the reasons for the recommendation are drafted.

- If consensus cannot be reached, a straw poll may be used to gauge the direction of the recommendation.
- In the event of a tie, the Chair may exercise a vote.

Drafting of the Recommendation or Guidance

The basis for the recommendation needs to be clearly communicated to interested parties.[4]

CDEC, pERC, and FMEC use a single recommendation framework with 3 categories (i.e., reimburse, reimburse with conditions, do not reimburse).

- To support the committees in translating their assessment of the domains of value in the deliberative framework to a recommendation category and transparently communicating the rationale for recommendation, the committees will endeavour to follow a standardized flow chart (i.e., recommendation pathway) for Reimbursement Reviews (Figure 2).
- The flow chart has a series of 3 questions to guide the committee on whether to recommend a drug for reimbursement. The first question asks whether the drug demonstrates acceptable clinical value versus appropriate comparators. If the clinical value is uncertain, the committee considers whether the drug addresses a significant unmet clinical need with an acceptable level of certainty in the clinical value. If the committee determines that the unmet clinical need is uncertain or not addressed by the drug, the committee will consider whether there are significant unmet nonclinical needs or health inequities that overcome the uncertainty in the clinical value and potential risks. If the committee recommends reimbursement based on these 3 questions, the committee moves through subsequent questions to determine whether reimbursement conditions need to be applied.
- If applicable, the committee members draft the reimbursement conditions.
- The committee may also identify implementation guidance to support the optimal use of the technology.

HTERP considers the audience for the recommendation, the type of guidance or recommendation required, and any ways of implementing the technology that would optimize its value.

- Recommendations can include selection of the appropriate population for use of the technology; the optimal use of the technology; or recommendations to fund, provide, or discontinue use of a technology.
- Evidence gaps may also be identified in the recommendation report to suggest conduct of primary research.

Finalizing Draft Recommendations

The CDA-AMC team refines the draft recommendation report based on comments during the deliberation, and expert committee members review and comment.

The CDA-AMC team and the Chair finalize the draft recommendation reports for dissemination.

Output: Communicating Recommendations and Guidance

Posting Recommendations or Guidance for Feedback

Draft recommendation or guidance reports are posted on the CDA-AMC website for 10 business days for feedback from interested parties.

Finalizing Recommendations or Guidance

Final recommendation or guidance reports are posted on the CDA-AMC website.

Recommendation reports are distributed to relevant partner organizations.

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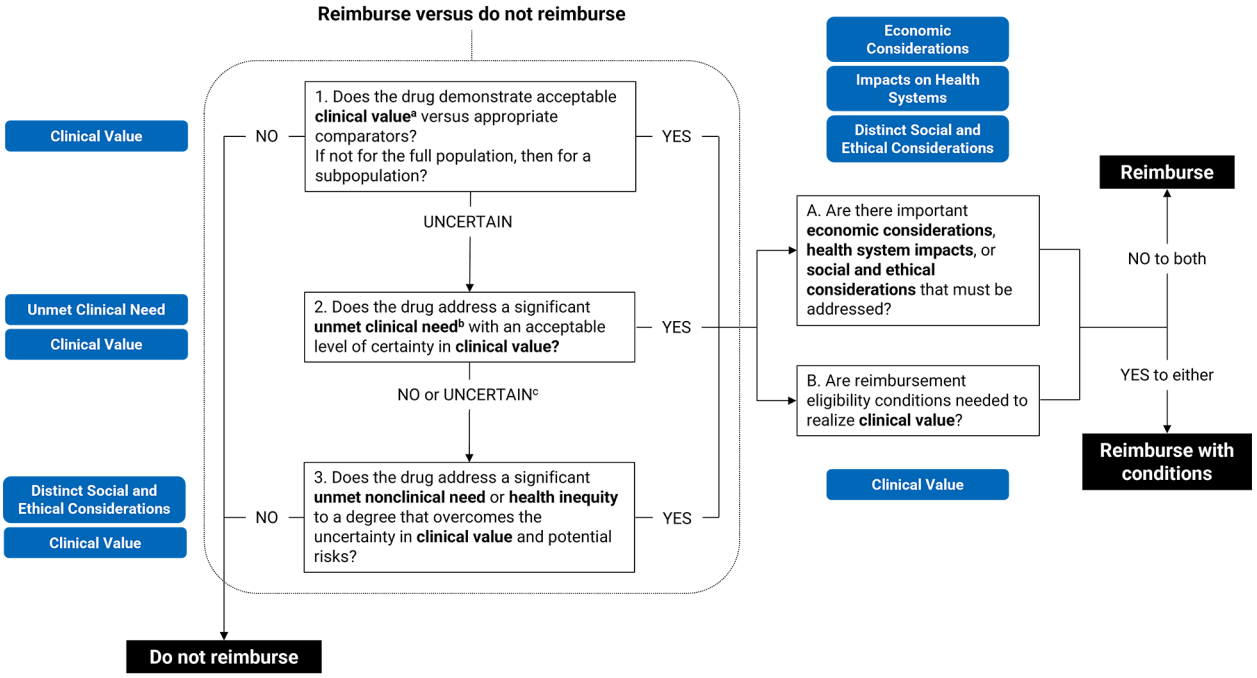
Appendix 1: Flow Chart

Figure 2: Recommendation Pathway for Reimbursement Review Recommendations



[a] Acceptable clinical value refers to at least comparable clinical value (if the drug is expected to be substitutive treatment) or added clinical value (if the drug is expected to be additive treatment) versus appropriate comparators.

[b] Significant unmet clinical need depends on the following: severity of the condition, availability of effective treatments, and challenges in evidence generation due to rarity of the condition or ethical issues.

[c] If the drug is eligible for consideration for a time-limited recommendation, are the evidence generation plans expected to address the gaps in the evidence? If the answer is yes, the time-limited reimbursement recommendation category applies.

Appendix 2: Glossary

Table 5: Glossary

Term	Description
Acceptability	The extent to which people delivering or receiving a health technology consider it to be appropriate, based on anticipated or experienced cognitive and emotional responses to the technology.[5]
Accessibility	The degree to which a patient or group is able to obtain care or services, taking into account the health system's financial and organizational constraints.[6]
Adverse event	Any noxious, pathological, or unintended change in a physical or metabolic function, revealed by signs or symptoms or a change in the results of laboratory tests, in any phase of a clinical study, whether or not the change is considered treatment related. It may involve the exacerbation of a pre-existing condition, intercurrent diseases, an accident, a drug interaction, or a significant worsening of the disease.[6]
Autonomy	The principle of the right of self-determination (i.e., patients' right to make their own decisions regarding health care).[6]
Availability of alternative treatments	Public reimbursement status of the relevant comparators.
Benefits	The positive outcomes or advantages that a health technology provides to patients, health systems, or society.
Budget impact	The financial impact of the introduction of a technology or service on the capital and operating budgets of a public payer.[6]
Care setting	The environment or location where health services are provided (e.g., primary care, secondary care, tertiary care, home care, community care).
Caregiver	A person (often a family member or friend), paid or unpaid, who regularly provides a person who has a disease or disability with any form of care.[6]
Confidentiality	An ethical requirement and rule based on privacy that implies an obligation for health professionals to keep to themselves what they have learned, seen, and heard in the practising of their profession.[6]
Cost-effectiveness analysis	A type of economic evaluation that compares the change in cost associated with different treatment options to the change in health outcomes, which can be measured in a variety of ways (e.g., life years gained, events avoided).
Cost comparison	Comparing the costs of 2 or more interventions or programs.
Data ownership	The rights and responsibilities related to the control and use of health data.
Economic evaluation	The comparative analysis of the costs and consequences of 2 or more possible options.[6]
Effectiveness	The effect of a technology seen under routine conditions (in contrast to efficacy).
Efficacy	The effect of a technology seen under ideal conditions, such as a clinical trial (in contrast to effectiveness).
Environmental impacts	How health technologies affect the environment. This includes the carbon footprint, resource consumption, waste generation, and potential pollution associated with the production, use, and disposal of health technologies.[7]
Equity-deserving group	A group of people who, because of systemic discrimination, face barriers that prevent them from having the same access to the resources and opportunities that are available to other members of society, and that are necessary for them to attain just outcomes.[8] In Canada, these groups include, but are not limited to, 4 designated groups (women, racialized groups, Indigenous Peoples, and people with disabilities), as well as people in the 2SLGTBQ+ community or people with diverse gender identities and sexual orientations.[9]

Term	Description
Evidentiary uncertainty	A lack of confidence in the conclusions of an HTA or evidence-based analysis owing to limitations in the available evidence.[6]
Harms	The potential negative effects or risks associated with a health technology.
Health-related quality of life	The measures of the impact of an intervention on patients' health status, extending beyond the traditional measures of mortality and morbidity to include dimensions such as physiology, function, social life, cognition, emotions, sleep and rest, energy and vitality, health perception, and general life satisfaction.[6]
Health technology under review	The drug, medical device, or clinical intervention (e.g., surgical procedure or diagnostic test) under review by CDA-AMC.
Informed consent	The legal and ethical obligation not to perform any significant medical procedure until a competent patient has been informed of the nature and risks of the procedure and the alternatives to it, as well as of the prognosis if the procedure is not done.[6]
Infrastructure requirements	The necessary physical, technical, and organizational resources needed to effectively implement and support a health technology.
Interested parties	Groups and individuals involved in all aspects of health care and health system delivery in Canada. This includes federal, provincial, and territorial governments and decision-makers; industry and manufacturers of drugs and health technologies; clinicians and other health care professionals; and patients.
Mode of administration	The method by which a health care intervention, such as a drug or treatment, is delivered to the patient. This can include various routes, such as oral, IV, subcutaneous, or inhalation, among others.
Morbidity	The incidence or prevalence of a disease or medical condition within a population. It encompasses the effects of the disease on patients' quality of life, including symptoms, complications, and overall health status.
Mortality	The rate of death within a population. It measures the number of deaths attributed to a specific disease or condition over a certain period.
Nonclinical Needs	The social, psychological, and logistical factors that influence the appropriateness, accessibility, and acceptability of a health technology beyond its direct clinical outcomes. This includes the perspectives and experiences of patients, caregivers, and providers regarding the condition and the expected outcomes of the treatment, as well as considerations of the care setting; geographic factors (e.g., distribution of services and travel requirements); treatment burden on patients, family, and caregivers; mode of administration; and referral or prescriber requirements.
Rare disease	There is no common internationally or nationally accepted definition of a rare disease. In Canada, the Canadian Organization for Rare Disorders defines a rare disease as one that affects fewer than 1 in 2,000 people, which is also the figure the European Union uses.[10]
Referral requirements	The criteria and processes that determine when and how patients are referred to specific health services or specialists for a particular treatment or technology.
Relevant comparators	Treatments or forms of care currently used for the indication or condition under review in clinical practice in Canada. In CDA-AMC projects, relevant comparators may be identified through published literature, consultation with interested parties, and/or consultation with clinical specialists. In drug Reimbursement Reviews, there is a focus on treatments currently reimbursed by at least 1 CDA-AMC–participating public drug program for the indication under review, reimbursed treatments that are currently used off-label in practice in Canada, and treatments that have previously received a recommendation in favour of reimbursement for the indication under review.
Severity	The extent and seriousness of morbidity and/or mortality associated with a health condition or disease. It encompasses how significantly the condition impacts a person's quality of life, daily functioning, and overall health status.
Side effect	Any unintended effect of an intervention.

Term	Description
Stigma	Negative attitudes, beliefs, or behaviours about or toward a group of people because of their situation in life. It includes discrimination, prejudice, judgment, and stereotypes.[11] This can lead to discrimination and social exclusion, and undermines access to necessary health services.[12]
Systemically marginalized groups	Populations who experience health inequities due to entrenched social, economic, political, or institutional systems that produce or perpetuate unfair treatment and oppression. These groups experience ongoing barriers and unfair disparities in health outcomes. Examples include low-income populations, rural communities, people with disabilities, and persons who are underhoused or incarcerated, among others.
Training and competency requirements	The necessary education, skills, and qualifications that health professionals must possess to effectively use and evaluate a particular health technology.
Treatment burden	The impact of a health technology on daily life and overall well-being. This includes the psychological, financial, physical, and relational demands placed on patients, family, and caregivers.

CDA-AMC = Canada's Drug Agency; HTA = health technology assessment.

Canada's Drug Agency
L'Agence des médicaments du Canada
Drugs. Health Technologies and Systems. Médicaments, technologies de la santé et systèmes.

Canada's Drug Agency (CDA-AMC) is a pan-Canadian health organization. Created and funded by Canada's federal, provincial, and territorial governments, we're responsible for driving better coordination, alignment, and public value within Canada's drug and health technology landscape. We provide Canada's health system leaders with independent evidence and advice so they can make informed drug, health technology, and health system decisions, and we collaborate with national and international partners to enhance our collective impact.

Questions or requests for information about this report can be directed to Requests@CDA-AMC.ca.