

SOLUTIONS in drug plan management

**A workshop forum
for invited guests**

Thursday, April 4
Stop 33, Sutton Place Hotel, Toronto
8:00 a.m.-1:45 p.m.

Summary of the discussions

- ▶ The big picture: breaking down silos page 2
- ▶ Case studies: successful drug plan management page 4
- ▶ Compliance: the forgotten solution page 8
- ▶ The physician's role page 10
- ▶ Lifestyle drugs: do they fit in? page 12

A joint project by:

Pharmacy Post

Pharmacy
PRACTICE

BENEFITS
CANADA

Sponsored by:



Life is our life's work

**SHOPPERS
DRUG MART.
PHARMAPRIX**



Green Shield
CANADA

Busting silos in benefit plans

By Kathryn Dorrell

“Silo management” has clearly emerged as one of the biggest problems today in the delivery of health benefits. Finance departments don’t communicate with human resources departments; drugs are delisted without considering long-term absenteeism costs; decisions are made to satisfy quarterly forecasts rather than long-term objectives. The challenge is huge, without easy solutions, yet participants in this ‘big picture’ workshop at the Solutions in Drug Plan Management event nonetheless set out to define a process for change.

Communication is lacking among key parties both within and outside of an organization. As a result, employers do not have a clear understanding of how drug expenses (which have outpaced inflation and most company’s profits) affect other areas such as absenteeism, disability and overall productivity.

“There is far too much focus on cost without looking beyond the short-term decisions,” said Jim Bates, director of sales and marketing at Green Shield Canada.

Stating a philosophy

Escalating drug prices mean sponsors can no longer simply provide benefits without considering what type of investment they want to make in the organization, noted Marc Hurwitz, director of marketing, Canadian group benefits, for Manulife Financial in Waterloo, Ontario. He added that employers should ensure their plan is aligned with the goals of the organization.

Fred Holmes, national practice leader, group health and welfare with Buck Consultants in Toronto, concurred. “Are plans [simply] benefits or are they an investment in healthy employees? If [we determine] they are [an investment] we have to change the mindset around them.”

Once an organization builds a benefits plan that supports the company’s philosophy it needs to break down the communication barriers between benefits professionals and the finance department. When the two parties work in isolation, benefits managers are not able to make a solid business case for their drug coverage.

Communication between sponsors and plan members must also improve. Employees need to be aware of the value of their plan and what it covers.

Outside of the organization, silo management has a significant impact on the ability of healthcare professionals to deliver services. Both physicians and pharmacists frequently struggle to treat employees with a bare minimum of information about the plan, said Martin Chung, manager of patient access, Pfizer Canada. “The pharmacist is the key liaison person of your plan [with your plan members]. The [irony] is that [he or she] probably does not know much about it.”

Another example of silo management is on the provider front. Consultants, sponsors and insurers all have different information about the plan, its usage, employee needs and the organization’s health, and there is little communication among these parties to exchange data and identify trends. New privacy legislation is only making matters worse, said Holmes.

New connections

Jeanette Wang, vice-president of pharmacy services with Drug Trading, based in Markham, Ontario, called for less reactive decisions on the part of insurers and employers and encouraged these parties to involve healthcare providers in the design of benefits plan.

Bates added that sponsors need to “find a way to get employees more involved with the management of their own health care.”

Along this vein, John Elliott, manager of external affairs with Aventis in Laval, Quebec, pointed to research that shows employees who are most satisfied with their plan feel that their employer cares about their health. “Communicating your philosophy and the intent of your plan is better than squeezing out inefficiencies,” he said.

“We talk to [our employees] about owning the plan. It creates a better sense of accountability,” agreed Jane Bawtenheimer, manager, total rewards and benefits for Sears Canada in Toronto.

Imma Monardo, manager of pensions and benefits with Federal Express in Mississauga, Ontario, added that it is best to use real-life examples to explain the cost pressures that employers face. When Fedex employees recently inquired about increased coverage, Monardo talked to them about how many more packages they would have to deliver to pay for it.

An integrated approach to benefits and health management must stress prevention, said Laura Mensch, assistant vice-president of group products and services, Liberty Health in Toronto. “We are an aging society and need to focus on disease states to prevent them from having a greater impact [on the organization].”

Hurwitz of Manulife added that “when employers see that [investments] in health become a competitive advantage, they will start building a comprehensive business case for benefits.”

When it comes to communicating with the finance department, Holmes of Buck Consultants emphasized that employers may need to change their vocabulary and speak in terms such as prescriptions per person against a national norm.

“We do a lot of that, properly framing issues. [Talking in terms of] demographics. ‘The average age is 46, predominantly female,’ etc., [and this is what health expenses we can expect],” said Bawtenheimer.

Lastly, technology can be the industry’s best friend if systems are integrated so that all parties are ‘talking’ to one

another and sharing information on the plan’s structure and aggregate usage. “It would be ideal to have electronic kiosks in pharmacies where plan members can [use] their electronic drug card, [input] their query and it will be answered,” envisioned Chung of Pfizer.

Kathryn Dorrell is the managing editor of Benefits Canada.

Action steps:

- Reexamine and reinstate the intent or philosophy of the plan. Only then can plan sponsors make meaningful changes and communicate them to other stakeholders.
- Communicate to and educate plan members. Employees need to know the value of their plans.
- Benefits managers should develop stronger ties with the finance department, making a strong business case for the plan.
- Open dialogues need to be established with outside stakeholders such as physicians and pharmacists.
- Measure outcomes such as absenteeism, productivity and disability rates to understand how they affect drug costs. Enlist the aid of pharmaceutical manufacturers, who have information on what drugs can do in terms of health and cost benefits.
- Exchange information. While privacy legislation remains a barrier, aggregate data can be shared and better analyzed to determine a plan’s cost drivers.

Participants:

Kevin Press, editor, *Benefits Canada* (moderator)

Jane Bawtenheimer, manager, total rewards and benefits, Sears Canada

Imma Monardo, manager of pensions and benefits, Federal Express

Steve Dyce, manager, benefits, pensions and information, University of Toronto

Glenn Fabello, consultant, Business & Executive Planning Group

Fred Holmes, national practice leader, group health and welfare, Buck Consultants

Marc Hurwitz, director of marketing, Canadian group benefits, Manulife Financial

Laura Mensch, assistant vice-president of group products and services, Liberty Health

Jim Bates, director of sales and marketing, Green Shield Canada

Jeff May, director, government and regulatory affairs, Shoppers Drug Mart

Jeannette Wang, vice-president pharmacy services, Drug Trading

John Elliott, manager of external affairs, Aventis

Martin Chung, manager of patient access, Pfizer Canada

Table 2

Managing drug plans better

By Christina Arandjelovic

Case studies of real drug plans took centre stage at two of the tables at the Solutions in Drug Plan Management workshop forum. At the table moderated by Sandi Hutty, a Toronto-based consultant-pharmacist, an unidentified company's drug claims for 600 employees almost doubled over a three-year period, from \$160,857 to \$300,525.

Closer examination revealed that claims for AIDS and AIDS-related drugs accounted for much of the increase. As well, a significant portion of claims for medications to treat rheumatoid arthritis and high cholesterol were for a relatively young age group—which could spell trouble for this company down the road.

“If they're having these types of health problems now, imagine the costs they'll incur in the future,” said Hutty. “[Plan sponsors] need to start taking a closer look at their costs and figure out where their problems lie. If they don't know what's going on within their plan, they'll lose total control.”

Coverage that makes sense

Plan sponsors also need to review their formularies. “Take a good look at what you're covering and make sure it's not redundant,” said Hutty. “For example, vaccines are covered by Public Health, so why would you bother covering them too? In Ontario, cancer drugs are covered by Cancer Care Ontario, so there's no need to cover those either.”

Drugs should be delisted if they've been proven to be ineffective in their indications, continued Hutty, citing the U.S. Food & Drug Administration's 'DESI' (Drug Efficacy Study Implementation, www.fda.gov) list as a resource.

The table's participants agreed that drug plans can be better managed, resulting in savings. But proper communication and education are key, for all stakeholders.

“The challenging thing is getting everyone to collaborate. We have to involve all parties,” said Keith Fairbairn, national manager of corporate and government affairs at Pharmacia.

Everyone at the table

“We all need to understand each other's stake in the plan before we can move forward,” stressed Wayne Marigold, director, provider and professional relations at ESI Canada/CAPSS. “Everyone, from the physicians to the insurers to the adjudicators, needs to have a say.”

Start with plan sponsors, said Jayne Bonnett, senior consultant at Watson Wyatt. “Employers don't necessarily see the relationship between compliance—which will essentially cost more to the drug plan—and their bottom line. We have to remember that the people we deal with are in the business of making money and we need to recognize their financial issues. At the same time, it would be nice if we could get them to start seeing further down the road instead of the next quarter.”

Actual plan members must play a bigger part. Communicating with them and making them more accountable should be a priority.

“We really need to strengthen the concept of compliance, especially in patients with chronic diseases,” said Steven Smith, director of government and regulatory affairs at Shoppers Drug Mart. “We already know that 50% to 60% of people are off of their drug before the first year of use.... It would be ideal if there was a way to motivate employees to be compliant through their drug plan.”

Bonnett suggested doing just that. “Why not make the members accountable for part of their health plan? This would get them thinking about how much their employer is spending on the plan.

“Get them on your side by letting them know this is their money and they're basically in charge of it. If the employees are in a union, for instance, let them know increasing plan costs could prevent them from getting a raise further down the road.”

Accountability works

David Johnson, director of membership at the Canadian Council of Christian Charities in Elmira, Ontario, has witnessed first-hand the benefits of increased employee accountability. “We see a dramatic difference between our 80% plan members and our 100% plan members,” he said. “Even though they’re only responsible for paying 20%, they still get a sense of what the medication would cost them if the plan was not in place.”

The Insurance Trustees for Simcoe County School Board, Ontario, recently tried something new to bring down costs. “We identified the various long-term maintenance drugs our members were using and decided to up them from 90-day supplies to 200-day supplies,” said Bruce Stevens, the board’s chairperson. “Our members seem to appreciate this and we’ve had no problem getting buy-in from them.”

Isabel Leong, manager of individual and association benefits at Green Shield, noted that physicians and pharmacists should not be left out of the discussion.

“Often, these people are the last ones we approach, but really, they should be the first,” agreed John Newton, president of Dorbar Insurance in Toronto. Particularly in smaller cities and communities, “much can be said for getting all

of the doctors together in one room and addressing the issues or concerns about the plan.”

“Communication between all the players needs to be constant,” stressed Hutty. “Not just when things are going poorly, but when things are going well, too.”

Christina Arandjelovic is the staff writer for Pharmacy Post.

Action steps:

- Analyze your drug plans to pinpoint problem areas and redundant coverage.
- Educate employees on the costs of their drug plan.
- Make employees accountable through cost-sharing and promoting compliance.
- Involve pharmacists and physicians to get buy-in and to benefit from their expertise.
- Bridge the communication gaps—between plan sponsors, unions, benefits consultants, adjudicators, insurers, pharmacy benefit managers, pharmacists and physicians.

Participants:

Sandi Hutty, consultant-pharmacist (moderator)

David Johnson, director of membership, Canadian Council of Christian Charities

Bruce Stevens, chairperson, Insurance Trustees for Simcoe County School Board

Jayne Bonnett, senior consultant, Watson Wyatt

John Newton, president, Dorbar Insurance

Wayne Marigold, director, provider and professional relations at ESI Canada/CAPSS

Isabel Leong, manager, marketing and individual products, Green Shield Canada

Steven Smith, director, pharmacy marketing and business development, Shoppers Drug Mart

Keith Fairbairn, national manager, corporate and government affairs, Pharmacia

Table 3

Do you know your drug plan?

By Vicki Wood

At the second case study table, moderator Christine Stewart, a pharmacist, walked participants through the most common drivers of growing drug plan costs. They include:

- the rising cost of the average prescription, largely due to the launch of new drugs;
- more prescriptions for new, more expensive therapies, where older, less-expensive medications exist;
- more people with chronic conditions (e.g., arthritis, hypertension, diabetes).
- the growing use of drugs for the central nervous system (e.g., antidepressants).
- the growing use of some prescription drugs (i.e., nasal anti-inflammatories, prescription antifungals) when there are over-the-counter medications that may do the job (but aren't covered).

These cost-drivers have become all too familiar to the participants at the table. “We’ve been saying for 20 years, watch the drug plan, it’s going to go up,” said pharmacist Ken Burns, owner of Errington Guardian Pharmacy in Chelmsford, Ontario. “This didn’t just suddenly happen, it’s been happening slowly over 20 years.”

“This snuck up on our senior people,” agreed Paul McLenachan, manager of pension and benefits at Dofasco, Hamilton. “We’re still talking about it. So far, we’ve done the education, which is new for us. The next step is either take-aways, or make some bad decisions health-wise—which we are capable of—or doing something in a partnership for better health and more efficient use of dollars. When I say partnership we’re talking pharmacists and other providers of medical services.”

Beyond cost-cutting

While the analysis of spending data helps set budgets and flag the so-called ‘Cadillac’ drugs (when less-expensive, equally effective drugs are available), everyone agreed that it’s not enough. Are the right people getting the right drug for their condition? Are they taking the medications properly? Are the medications helping people stay at work? Are

there other treatment options (e.g., one-on-one counselling, physiotherapy) that would do the job as well as prescription drugs?

There are no easy answers. For one thing, confidentiality ties the hands of plan sponsors and insurers. “You can’t simply tell everyone, ‘We’ve got someone with AIDS, or MS or erectile dysfunction,’ and discuss what to do about it,” said Burns.

Hence the importance of communicating better with local physicians and pharmacists, who safeguard confidentiality while addressing such issues as appropriate prescribing and compliance.

Labour relations also loom large. McLenachan and Celine Chiovitti, manager of benefits and employee services for City of Toronto, have to work with “legacy” plans that cover everyone (employees, dependents, retirees and their dependents) for everything. They need to be weary of making changes that would be considered “take-aways” by beneficiaries.

Better education

Better communication with unions and employees has to be the first step, said Penny Zanussi, senior consultant at Cowan Wright Beauchamp, Kitchener, Ontario. “Otherwise, they don’t know how much this benefit costs. They don’t know their employer is spending \$5,000 a year for just their health/dental plan. We’re trying to change the sentiment from entitlement to education.”

Cost sharing goes hand-in-hand with education to increase members’ accountability. “Cost sharing increases awareness, helps members take ownership of the plan,” said Michael Prousalidis, clinical services associate at Claimsecure, Toronto. “When employees take the benefit for granted, they see any change as an intrusion. When employees know exactly what their plan covers, it empowers them to use their benefits more wisely.”

Pay-direct cards have made accountability more of a challenge, noted Chiovitti. “With pay-direct, employees don’t see

the costs. It's only when something's not paid that they call the office and start demanding, 'Why wasn't this covered?' ”

Leap of faith

Disease management and preventive care are the biggest frontiers. “We get into these discussions all the time,” said Aubrey Browne, national vice-president of pharmacy services for Shoppers Drug Mart. “We tell an employer, ‘You have a maintenance program for your equipment, your trucks. How about a really good wellness program for your employees, to maintain their good health?’ They say, ‘We can't do that, it costs too much.’”

“As employers we intuitively buy into that [wellness] link,” said McLenachan, “but we still can't tell that story [because of confidentiality] and ... the business case has not yet been strongly made.”

“The problem is, we don't have the data on the days spent at work thanks to migraine medication, to show that productivity was helped by spending on medication,” said Browne. “Same with Crohn's disease, diabetes management, depression ...”

“We do have lots of data, there have been many, many pilots,” said Bessie Wang, vice-president at BCE Emergis eHealth Solutions Group. “We just haven't promoted this fact well to employers.”

Ruth Mallon, vice-president of pharmacy services for the Ontario Pharmacists' Association, cited a 1997 pilot project involving pharmacists and the former municipality of Metro Toronto. “We did get measureable results. For example, we found patients who were on long-term GI [gastrointestinal]

meds who had never been treated for *h.pylori* eradication. The company invested in those patients and afterward, we measured them as drug-free.”

“There's a point at which employers have to take that leap of faith,” said Burns.

Vicki Wood is the managing editor of Pharmacy Post.

Action steps:

- Implement cost-sharing that doesn't penalize the sick.
- Allow pharmacists and physicians to adjust days' supply, or dispense trial prescriptions, according to the individual patient.
- Create protocols that encourage appropriate prescribing and communicate these to area physicians. “Our data shows that first-line drugs are the most commonly prescribed, simply because doctors don't know how much they cost,” said Zanussi. Added Proussalidis: “One of our employers is thinking of a giving employees a physician card they can keep in their wallet to show their doctor which drugs their plan covers.”
- Delist drugs that deliver negligible value (e.g., certain combination products).
- Encourage employees to stick with one pharmacist.
- Invest in wellness. Start with small steps (e.g., antibiotic awareness, migraine counselling, *h.pylori* eradication) that are proven to work.
- Look to area pharmacists and physicians as allies. Communicate your objectives and listen to their suggestions.

Participants:

Christine Stewart, consultant-pharmacist (moderator)

Paul McLenachan, manager, pension and benefits, Dofasco Inc.

Celine Chiovitti, manager, benefits and employee services, City of Toronto

Barb Martinez, senior consultant, health strategies practice, Aon Consulting

Penny Zanussi, senior consultant, Cowan Wright Beauchamp

Michael Proussalidis, clinical services associate, Claimsecure

John Reid, president, Reid & Associates

Bessie Wang, vice-president, BCE Emergis eHealth Solutions Group

Ruth Mallon, vice-president pharmacy services, Ontario Pharmacists' Association

Ken Burns, pharmacist, Errington Guardian Pharmacy

Aubrey Browne, national vice-president, pharmacy services, Shoppers Drug Mart

Table 4

Compliance: the forgotten solution

By Karen Welds

Should plan sponsors be making sure their employees are taking their drugs properly? How would they do it? Why aren't they doing it?

These were some of the questions debated at the workshop on compliance, moderated by Karen Welds, editor of *Pharmacy Post*. The first challenge, they all agreed, is getting employers to realize the costs of noncompliance.

"Compliance isn't well understood. The average drug supply of a medication has a compliance rate of 30% to 40%," said Don Renaud, a consultant-pharmacist with Solutions in Health in Windsor, Ontario. "[Plan sponsors] are paying for these drugs and if they're not being taken properly, all this investment goes down the drain."

"The problem is getting the attention of the employer," said Tim Taylor, product manager at Manulife Financial, Kitchener, Ontario.

Claire Parkinson, project manager, health care charter, at Inco in Sudbury, Ontario, agreed that compliance is not on the radar screen for most plan sponsors. "We look at the numbers and if you can't tie compliance to the numbers we're not going to do anything," she said.

Money well spent?

What complicates matters is the fact that the numbers on drug plan costs may actually go up as a result of improved compliance, because people are more likely to get prescriptions refilled. The lack of immediate, direct dollar savings makes the promotion of compliance a tough sell.

"There's a disconnect," said Don Bisch, editor of *Canadian Healthcare Manager*. "Employers don't see the benefits [of promoting compliance]."

"We're looking at it the wrong way," said Kevin West, president of Rx Canada in Toronto. "We're still taking the silo approach. Yes, you may spend more on drug plans with improvements in compliance, but you save elsewhere."

While this may ring true, tracking improvements in areas such as absenteeism and productivity isn't likely to happen any time soon. "We're downsizing so much that you'll have

to show me the real benefit of getting that [absenteeism] data, because we'd have to outsource that function," said Parkinson.

Still, she contends that if plan sponsors saw compelling proof of wasted dollars in these days of spiralling costs, they would take notice.

"The data [on wastage] is there so it's a matter of bringing the team together," said Taylor. "As insurers we can provide clients with an illustration of where costs are going," and others, such as benefits consultants, adjudicators, pharmacists and manufacturers, can pinpoint noncompliance hot spots.

"We do pharmacoeconomic analyses all the time for governments; manufacturers can make these available to benefits consultants, plan sponsors, etc.," said Dave Malian, director of pharmacy and trade relations for Pfizer.

The employer's role

Now that plan sponsors are convinced of the need to reduce wastage, what next? "What motivates an employer like Inco to teach compliance?" asked Mark Quinn, principal at Buffett Taylor & Associates in Whitby, Ontario.

"We're not in the business of educating patients. That's the pharmacist's job," stressed Parkinson.

While the pharmacists at the table agreed, they countered that routine counselling can only go so far, particularly for drugs most at risk for noncompliance, such as antihypertensives, cholesterol-lowering agents and antidepressants (drugs that, incidentally, belong to the largest therapeutic classes covered by private drug plans). More pharmacists are offering services such as at-home medicine cabinet clean-ups and one-hour asthma consultations, said Jane Farnham, a pharmacist-consultant. "We're taking service offerings to a whole new level but it can't be compensated by a \$10 dispensing fee."

That's a whole new challenge. "There's no trust there," said Jane Petruniak, senior consultant at Watson Wyatt. "[Employers] are thinking you're only doing this to make

money as a pharmacist.”

While compensation is a matter for pharmacy organizations to tackle, everyone at the table agreed that compliance education does not just begin and end at a dispensary counter. Employers can and should play a bigger role.

Taking responsibility

Malian offered the analogy of workplace injuries. “If something is slippery and you fall, there’s a pressure to fix it, or everyone’s going to fall,” he said.

“If it’s our property that’s one thing—you put salt on the runway,” responded Parkinson. “But property is not medically based. It’s not our responsibility to do disease management.”

“It’s the responsibility of whoever is paying for it,” countered Malian. “Plan sponsors want to have drug costs controlled so they need to take a leadership role.”

“Employer buy-in is huge to promote [compliance] internally,” said Renaud. “Union buy-in for this is huge as well.”

“The employer can be the conduit,” said Richard Jones, director of strategic customer development at Pharmacia. “You need to motivate employees and offer multiple venues and agents [for education].”

“When you’re targeting employees you have to be education specific—broad-based education is not as effective,” added Taylor. “You have to know what conditions to target.”

“We have the data,” said Sal Cimino, pharmacy benefit consultant at Green Shield Canada. “We could facilitate targeted mailings. It’s up to the employer to allow us to target employee groups.”

West cited RxCanada’s program, where patients who fill certain targeted prescriptions (determined by participating manufacturers) consent to receive a series of mailed pieces that focus on compliance and disease management. West reported that 85% of patients agree to participate, and preliminary results show an improvement in refill rates.

Employers can go even further, continued West, by requiring employees to undertake some form of compliance education—from something as simple as educational mailings to something as in-depth as one-on-one counselling—to ensure continued coverage for certain drugs.

The ultimate goal, of course, is to get employees themselves

Action steps:

- Analyse existing data to determine drugs and conditions most susceptible to low compliance rates.
- Use the expertise of insurers, adjudicators, benefits consultants, manufacturers and pharmacists.
- Facilitate learning opportunities such as on-site lunch and learn sessions, targeted mailings and community programs (e.g., disease state programs at local pharmacies).

to take more personal responsibility. The “psychology of noncompliance” is driven by such factors as denial, self-‘diagnosis’ (where patients decide to stop therapy because they’re ‘feeling better’) and plain forgetfulness, said Renaud. While employers can’t be expected to ‘cure’ noncompliance, any efforts to raise or facilitate education are bound to make a difference.

Karen Welds is the editor of Pharmacy Post. With notes from Rosalind Stefanac, managing editor of Pharmacy Practice.

Participants:

Karen Welds, editor, *Pharmacy Post* (moderator)

Claire Parkinson, project manager, health charter, Inco Ltd.

Jane Petruniak, senior consultant, Watson Wyatt

Mark Quinn, principal, Buffett Taylor & Associates

Tim Taylor, product manager, Manulife Financial

Sal Cimino, pharmacy benefit consultant, Green Shield Canada

Kevin West, president and CEO, Rx Canada

Don Bisch, editor, *Canadian Healthcare Manager*

Don Renaud, pharmacist, Solutions in Health

Jane Farnham, consultant-pharmacist

Dave Malian, director of pharmacy and trade relations, Pfizer

Richard Jones, director of strategic customer development, Pharmacia

Table 5

Putting physicians on the map

By Celia Milne

Physicians have been described as the ‘missing link’ in successful drug plan management. They usually have little or no awareness of the cost of drugs, yet the impact of their prescribing decisions can be significant.

“Awareness is pretty low,” admitted Dr. Jeff Main, a family physician at Grandview Medical Centre in Cambridge, Ontario. “We have other priorities, such as how the drug works, drug interactions, side effects, knowing the dosing. We are very poor at estimating drug cost.”

More importantly, most physicians do not want to learn or become involved in the complexities of drug plan management, said Dr. Main. They almost always ask about a patient’s coverage, but beyond that, they do not micro-manage. “We ask the questions: ‘Do you have allergies? Do you have a drug plan? Great!’”

Physicians make decisions using clinical guidelines, which usually have nothing to do with cost or coverage. “In fact, there is often a contradiction between what clinical guidelines say and what that patient can actually get [based on their drug plan],” said Dr. Main.

Building awareness

Doctors don’t have enough tools to help them use alternatives to expensive drug therapy, said Dr. Mike Evans, family physician and assistant professor at the department of family and community medicine, University Health Network, University of Toronto. Unlike clinical guidelines, these tools need to take into account the day-to-day time pressures that doctors face.

Mental health conditions, for example, would benefit from such tool kits. “For depression or anxiety the literature basically comes out equivalent for drug therapy and talk therapy,” said Dr. Evans. “Talk therapy probably lasts a little longer; drug therapy probably acts a little quicker. But what is the busy family doctor who’s overwhelmed going to do? Five minutes for drug therapy or hours doing talk therapy? That patient will get a year of Paxil.”

Somebody needs to make it easier for doctors to look for

alternatives, continued Dr. Evans. “I’d love to have some benefits company sponsor a six-session cognitive behavioral therapy course. Why isn’t someone offering that?”

Janet Cooper, senior director of professional affairs at the Canadian Pharmacists Association, spoke for all when she observed that real progress won’t happen until the delivery of primary health care is reformed. “Fee for service promotes poor care because doctors see so many patients in one day.”

“That’s right,” agreed Dr. Main.

“I diagnose, I prescribe, you comply. That doesn’t work with chronic disease and lifestyle,” added Dr. Evans. “We have to change the paradigm.”

Healthcare reform

The ‘new paradigm’ is essentially a team approach to health care, said Mary Catherine Lindberg, a consultant and former assistant deputy minister of the Ontario Ministry of Health and Long-Term Care. She cited the SMART study, conducted by researchers at McMaster University and St. Joseph’s Hospital in Hamilton and partly funded by the Ontario Ministry of Health and Long Term Care. It linked specially trained pharmacists and family physicians to optimize the drug therapy of older people and cut down on inappropriate utilization of drugs. “Patients trust their doctors. We have to bring them in on the side of education, to bring down medicalization.”

Meanwhile, pharmacists are picking up the slack. Not only are they chasing claims (including paperwork for special authorizations) on behalf of patients, they’re also filling in the gaps in education. Andrea Puskas, a pharmacist at Beveridge & Brown Clinic and Pharmacy in Cambridge, is certified to teach asthma and diabetes care. When a patient comes to her with a new prescription for a puffer, for example, she helps them learn how to use an aerochamber, as well as how to avoid triggers and modify their lifestyle.

If more pharmacists could be trained, and compensated, for this kind of patient education, “the need for prescrip-

tions will greatly decline,” said Puskas. Unfortunately, she added, “the only funding is through pharmaceutical companies.”

A big part of the funding problem lies in the fact that pharmacists’ services are not recognized as non-taxable under Canada’s Income Tax Act.

Communication barriers

Doctors are often unaware of pharmacists’ value-added offerings. “We’ve got pharmacists providing great education services, but not all physicians realize that’s happening or are willing to refer to a pharmacist,” said Deb Saltmarche, director of pharmacy at the Canadian Association of Chain Drug Stores. These silos stand in the way of real progress.

Meanwhile, employers also feel left out in the cold. They pick up the tab for prescriptions, but have little say in whether those prescriptions are appropriate. “They pay but they don’t know what’s being prescribed,” said MacKay. Privacy guidelines often prevent the identification of drugs or even classes of drugs. “If there are not 30 scripts per therapeutic class, then the information cannot be released,” he said. This makes it difficult to do lifestyle education.

Employers would very much like to be in better communication with doctors, who are in effect the gatekeepers of how all that money gets spent, said David West, a consultant with Mercer Human Resources Consulting in Toronto. “[Employers would] like it but they are not good at it. It’s a difficult subject to broach. So they just pay.”

Last but not least, people at the table voiced their con-

cerns over direct-to-consumer-advertising of drugs. Patients get the idea that a certain drug is a panacea, said Dr. Evans. “It drives the system away from lifestyle changes.” He also questioned the need for “a whole bunch of new drugs that are a tiny little bit better for a small subpopulation, [that are] well marketed and that cost five times as much,” said Dr. Evans.

Action steps:

- The Canadian Medical Association, the Canadian Pharmacists Association and the Canadian Association of Chain Drug Stores need to establish joint efforts in such areas as primary healthcare reform, national standards for special authorizations and changes to the Income Tax Act (to include pharmacists as recognized healthcare providers).
- Organize local-area drug plan workshops involving all stakeholders, including physicians and pharmacists.
- Focus on collaborative drug therapy management between physicians and pharmacists.
- Educate patients and physicians on alternatives to prescription drugs.
- Encourage pharmaceutical manufacturers to balance advertising efforts with education on lifestyle modification and prevention.
- Consider technology solutions that include information on cost and coverage.

Participants:

Chris Bonnett, president, H3 Consulting (moderator)

Dr. Mike Evans, department of family and community medicine, University Health Network, University of Toronto

Dr. Jeff Main, family physician, Grandview Medical Centre

Andrea Puskas, pharmacist, Beveridge & Brown Clinic and Pharmacy

Deb Saltmarche, director of pharmacy, Canadian Association of Chain Drug Stores

David West, consultant, Mercer Human Resources Consulting

Noel MacKay, senior benefits consultant, Williamson Group

Mary Catherine Lindberg, consultant, former assistant deputy minister, Ontario Ministry of Health and Long-Term Care

Janet Cooper, senior director, professional affairs, Canadian Pharmacists Association

Table 6

Lifestyle drugs: do they fit in?

By Natale Ghent

Participants in the workshop on lifestyle drugs grappled with questions familiar to every plan sponsor: what are lifestyle drugs and who should carry the burden of their cost? Two other issues also came to the forefront: employee education and accountability.

Merle Chittick, benefits administrator at Kinark Children and Family Services in Toronto, represented plan sponsors at the table. A growing concern for her is employees' sense of entitlement, which became very clear when her organization implemented co-pays and deductibles. "We have approximately 800 employees and they're getting hostile since we've started sharing costs."

The 'hostility' appears to be growing on both sides. "We had a debate with a client because a claim was made for \$30,000 and it was for fertility drugs," said Dianne Russet, group sales manager, southwestern Ontario, Green Shield Canada. "The employer said, 'Not only did I pay \$30,000, I had to pay for maternity leave too, so I want fertility drugs off my plan.'"

When it comes to cost-saving measures, it appears intuitive that lifestyle drugs are usually the first to go. But what can be defined as a lifestyle drug? Unfortunately, no two parties can agree on what a lifestyle, quality of life or life-choice drug is.

No definition

"There is no good definition of these drugs," stressed Margaret Ingram, assistant vice-president, provider services and formulary management at BCE Emergis eHealth Solutions Group. "Even when it gets down to methadone programs. [Insurers] hold up their hands and say, 'We're not paying for this. It's a lifestyle situation.'"

Often, lifestyle drugs are considered medically unnecessary, noted Tom Smiley, a pharmacist-consultant with Pharmavision Health Consulting in Brantford, Ontario. But should these drugs be considered less important than other drugs, given the issue of employee morale and productivity? Who gets to decide?

"A lot of decisions are made upfront at the individual

insurance office. Each insurer can have a different interpretation of the term 'medically necessary,'" said Mike McMurray, product manager group marketing at Maritime Life in Halifax.

"It gets really complicated," added Rose Fishman, principal at Phase4Health in Toronto, citing instances where a drug can be covered for one indication or use, but not another. "And what about travel vaccines? What if you need to travel for work?"

"Extensive discussions need to take place between plan sponsors and insurers when they agree to do business, so the insurer understands the plan sponsor's intentions, and the plan sponsor understands the claims management practices of the insurer," stressed McMurray.

Evidence, please

While most formularies used to cover drugs that legally required a prescription, the tide changed when Viagra, for erectile dysfunction, hit the market. With so many new lifestyle drugs coming on the market (such as memory enhancers, anti-shyness medications, etc.) how can decisions be made?

Smiley suggested the development of mechanisms that will allow evidence-based decisions using solid proof such as cost effectiveness, employee productivity and morale. Demographics can also be better used to determine what should and shouldn't be covered.

"If your employees are all over 50, then birth control probably shouldn't be covered. We need to look at what the literature says about certain medications, their use on average, etc., so you can get a fairly good idea of where you're at," said Smiley.

Another problem is less tangible: many plan sponsors don't have a defined philosophy for drug benefits. Do we cover medically necessary drugs only, or do we cover drugs for conditions such as obesity and smoking based on the belief that it will probably reduce spending on related medical treatments (e.g., for hypertension, high cholesterol) down the road?

Who's responsible?

Poor communication makes the situation even stickier, said Dave Haber, president of Heath Lambert Benefits Consulting in Vancouver. "Whatever solutions an employer comes up with, they have to be sufficiently simple. They have to be communicated in a manner that actually works."

"Much of the problem stems from the fact that people don't understand what their drug plans are about," agreed Ingram. "They don't know how much it costs their employer. Better education of employees is needed, then you can start doing more sophisticated things with health spending accounts."

Employee literature should use humorous illustrations and other reader-friendly devices to make employers' messages accessible and transparent, suggested Ingram. And don't forget to clearly spell out what *isn't* covered, added Russet.

But do employees really care, particularly in these days of a highly transient workforce? Everyone agreed that the lack of employee accountability has become a huge problem.

"It really comes down to who's responsible," said Haber. "Is it the employee who's responsible for these drugs?"

Haber's firm recently launched a pilot project in which the plan covers 100% of everything in the B.C. Pharmacare formulary, while employees are responsible for 50% of the cost of all other drugs. The object is to look at drug use behaviours in employees who bear some financial responsibility for their medications. Preliminary findings should be available in the summer months.

Employees can also be more responsible about taking their lifestyle drugs properly. Several people at the table cited 'bundle plans,' where lifestyle drugs are covered but beneficiaries must participate in a counselling or educational program. Monitoring the success of employees in such programs is

paramount to determine value, added Fishman.

But tracking compliance may not be so easy, cautioned McMurray, as the cost of monitoring patients may exceed the cost of doling out drugs.

Compliance monitoring doesn't need to be complicated or require huge investments. For instance, "we need to run more trial prescriptions and track outcomes. Pharmacists could be an important part of this. There should be some risk sharing between all parties," said Fishman.

Physicians also need to be part of the process. The increasing incidence of direct-to-consumer advertising is bringing more people to doctors' doors, asking for prescriptions they may not need, and lifestyle drugs are advertised more than others.

"It's a problem," stressed McMurray. "Advertising and drug reps push certain popular and high-profit drugs when there are drugs just as efficient already on the market."

Natale Ghent is a writer for Pharmacy Post.

Action steps:

- Plan sponsors need to determine their plan's philosophy.
- Plan sponsors and insurers need to define 'medically necessary.'
- All stakeholders, including pharmacists as the drug therapy experts, need to develop mechanisms with which to make evidence-based decisions.
- Communicate coverage of lifestyle drugs using simple language.
- Increase employee accountability: e.g., capped coverage based on the number of times a certain treatment is attempted, tiered co-pays, bundle plans that require counselling/education.

Participants:

Ruth Hanley, editor, *Pharmacy Practice* (moderator)

Merle Chittick, benefits administrator, Kinark Children & Family Services

David Haber, president, Heath Lambert Benefits Consulting

Mike McMurray, product manager group marketing, Maritime Life

Diane Russett, group sales manager, southwestern Ontario, Green Shield Canada

Margaret Ingram, assistant vice-president provider services and formulary management, BCE Emergis eHealth Solutions Group

Rose Fishman, principal, Phase4Health

Tom Smiley, pharmacist, Pharmavision Health Consulting