



Managing the Unmanageable - The drug cost crisis A conversation with Helene Lipton PhD

Those who travelled to outer Parnell for our April seminar were treated to a scintillating conversation with our guest speaker Helene Lipton. Helene is Professor of Health Policy and Pharmacy at the Department of Clinical Pharmacy & Institute for Health Policy Studies, Schools of Pharmacy & Medicine, University of California at San Francisco. Her long-standing research and teaching interest is in developing and evaluating innovations designed to improve the quality and economy of health care services, with a particular focus on physicians' prescribing decisions for vulnerable patient populations.

After only a few days in New Zealand she had absorbed a mountain of information on our health care delivery systems. Her understanding of New Zealand conditions allowed her to frame her presentation in a New Zealand context and ensured a lively debate with those present.

Helene's presentation was based on her study into physician drug holding - USA style. *

What are the take home messages from her study on the drug cost crisis? It is driven by both an increased use and increased cost of drugs. By tracking the same basket of drugs, cost increases can be readily measured. In the U.S. between 1990 and 2000 there was a 300% increase in the total expenditure on prescription drugs. The greatest rate of increase of any component in the health care sector. Why are costs increasing so quickly and so substantially? Conventional wisdom suggests drivers such as the greying of the population with more Americans living longer and using drugs to manage chronic illness. "The elderly have enormous clout in our country", said Helene. "They vote in very large numbers and if you lived in America during the past two elections you would believe that the most pressing concern in the country was prescription drug charges. Some 30% of our elderly have no drug (insurance) and we have busloads of people going up to Canada to get their same drugs for a cheaper price."

More Americans are using drugs and using more than in the past; drugs are increasingly replacing more invasive procedures to treat conditions and coupled with increased availability is the ease of drug use compared to non-drug therapies. The medicalisation of drugs to treat conditions such as shyness and hair loss creates another driver.

There are other important but less studied drivers. More and more of the American population are being insured for drugs and therefore the patient and physician are insulated from the cost. Co sharing of costs is minimal but the introduction of part user charges always creates a trade off. At what point does the charge cause the patient to not use the drug at all.

* Managing the Unmanageable: the Nature and Impact of Drug Risk in Physician Groups
Helene Levens Lipton, PhD; Jonathan D. Agnew, PhD; Marilyn R. Stebbins, PharmD;
R. Adams Dudley, MD, MBA

(Continued on page 2)

Inside this Issue

Managing the Unmanageable - The drug cost crisis A conversation with Helene Lipton	1
The Next Generation US Health Plan: Not If, But When and How	5
Committee Profile	7
Upcoming events	7



Helene Lipton

(Continued from page 1)

There is a risk that a patient will not be able to distinguish between medically necessary and discretionary drugs and the cost consequences of this for the healthcare system can be significant.

Many insurance companies will only offer generic drugs but they are often not the drugs that the elderly require.

Those who study the industry do not see a lot of “break through drugs” in the pipeline right now so what that means is a lot more aggressive marketing by the drug companies, promotional activities targeted towards physicians and direct to consumer advertising. Promotion to physicians, which in 2001 cost \$13.5 billion in the US, and promotion to patients really drives up the cost of pharmaceuticals.

Promotion to physicians includes “consulting” honoraria, CME support, unrestricted grants and drug samples. Helene knows of one physician who was paid to allow a pharmaceutical sales representative into examining rooms to meet with patients and recommend treatment. Another was given a free computer with a sole proviso that he log into the drug company site twice a month for a promotion by a medical detailer. Legislative change is stifled. The 15 biggest donors to legislators, both State and Federal, in any given year are drug companies.

New Zealand and the US are the only two countries in the world that allow direct to consumer advertising. In some other countries pharmaceutical companies get around the law by advertising that does not directly name a specific drug. The advertisements are disease specific and suggest that if you have a certain condition you should contact your doctor (who will prescribe their drug). In 2000, 25 of the most heavily advertised brand-name drugs accounted for nearly 50% of U.S. drug spending. So advertising is obviously working, if it wasn't working they wouldn't be doing it.

New Zealand and the US are the only two countries in the world that allow direct to consumer advertising.

Recently the Wellington School of Medicine, supported by the other Medical Schools produced a paper calling for the ban of DTC advertising. That paper has been backed by the College of GPs.

Some argue that the advertising is educational. If that were so, advertising would be spread evenly or perhaps even predominately to those TV channels catering to lower socio economic (In California - Latino) populations. A recent survey found that of 1000 ads placed on TV in California over a six month period only 3 were aired on a Latino station.

In the early 1990s as a response to soaring drug costs, physician groups began to assume risk for drug costs as a strategy to control costs. The evidence supporting the strategy showed that changes in payment methods for physician & hospital services can have significant effects on health services use and costs.

There are three definitions of Drug-Risk Sharing

Full risk: group realizes all savings or absorbs all losses if drug spending varies from amount budgeted by an HMO.

Partial risk: groups may share savings with HMO (upside risk), share in losses (downside risk), or both

No risk: HMO absorbs all losses and profits.

Helene's team conducted a study with the goals of: examining the nature and range of drug-risk arrangements between physician groups and HMOs; and analysing the relationship between drug-risk level and drug-use management innovations and drug PMPM at the physician group level. They studied these phenomena among multiple organizations across four U.S. markets.

The study was conducted across 20 physician groups with a range of 55 to 1200 physicians per group and a mean of 737. There were 12 major contractual HMO partners in the study.

They found incentives targeting the use of generics and an expanded role for health professionals. Such as, practice groups hired pharmacists; prescribing guidelines and restrictions; prescription monitoring and modification mechanisms were set up.

The most effective innovations were academic detailing; educational outreach program in which pharmacists provide one-to-one consultations to physicians; profiling physicians by comparing physicians' prescribing patterns on cost, service use, and/or quality and setting up pharmacy and therapeutic committees. Physicians set up their own preferred drug lists where similar a drug of equal efficacy and less expense is interchanged for a non-preferred drug. In the USA there is not one preferred drug list and a physician group may be dealing with 8 or 10 Insurance Companies each with a different drug list.

(Continued on page 3)

(Continued from page 2)

The study found that there was no relationship between the number of innovations adopted and the drug-risk level in a physician group. So why did the drug risk experiment fail? There were both internal and external factors. The physician groups viewed the contracts as unfair. There was information asymmetry with no information on drug use, drug prices and rebate calculations and no control over formulary. They felt they had accountability without control.

Exogenous factors included direct to consumer advertising and the level of market competition. Sometimes there were adversarial relationships between physician groups so insurers were able to drive their costs down by negotiating drug risk contracts more advantageous to them. That is something New Zealand might face in the future with the advent of PHOs, which might start a new type of competition.

What is being seen now is the HMOs taking back drug risk, but rather than going back to full payment they are increasing co-payments with incentives to reduce utilization through payments based on quality of care. There is commonly a three-tier model, if you use a generic drug you pay nothing, if you use the preferred drug you pay a little more and if you demand the state of the art drug you pay a lot.

The policy issue is, is this a good thing? The answer is not necessarily so because the patient might go without an important drug because the co-price is too prohibitive for them. It would be good to turn the clock back just a little because ultimately the physicians are the drivers. They are the ones who put pen to paper and write the prescription. So how can we write in some accountability but deal with all the exogenous factors?

The study team thought it would be possible to get together a group of physicians who were pretty typical of physicians in practice and working together they could come up with a few drugs that could be approved to treat specific conditions, in that way they would have their own preferred drug list. When those drugs were prescribed for those conditions there would be no cost implications (risk) for the physician. If a physician were using a drug that was not approved, or not used for an approved purpose the risk would be adjusted accordingly. That way the physicians could be made accountable.

They found that fund holders who were doing very well and saving on pharmaceutical costs were being "rewarded" by having the cap lowered by the insurers. So their other recommendation to control exogenous factors was that drug costs should be taken to a national average and if people came in under they got some reward and if they came in over they paid some sort of penalty. That way, they believed physicians would have some sort of economic accountability to help control drug costs.

The other study the team are doing at the moment is looking at controlling the cost of self-administered injectable (SAI) drugs. These growing class of drugs, and there are many in the pipeline right now, are used for treating many conditions. Cost of individual course of treatment is high (Multiple sclerosis SAls =US\$ 800-1500/month; Enbrel (migraines) = US\$ 1300/month). Expenditures for biotechnology products, like SAls, are expected to grow faster than oral prescription drugs. For example, revenues for Lovenox increased 38% from 1999-2001, compared to "only" 16.8% for oral drugs over the same period

Prescriptions for an injectable medication are written by a provider, filled by a pharmacy, and administered at home by the patient or caregiver. Who is financially responsible? HMOs? Physician groups? Patients? What are the existing SAI financial risk arrangements? What kinds of strategies have medical groups adopted to manage this risk?

They found that the level of SAI risk in a physician group was linked to the number of management strategies adopted. Higher-risk groups adopted more strategies than lower-risk groups. However, 40 percent of groups surveyed did not adopt any strategies because they felt SAls were not important enough to warrant attention. The study team felt that those without strategies had their heads in the sand. Right now the burden is on patients and Physicians who can't negotiate for better arrangements (too small vis a vis HMOs, Pharma); and lack adequate expertise, infrastructure, and resources.

How can SAI risk work? Their conclusion is summarised by the acronym REAP. **Risk:** adequate risk for physicians to respond; **Environment:** conducive to controlling costs; **Ability:** groups have ability to implement strategies; **Power:** power to negotiate better contracts

(Continued on page 4)

Sometimes there were adversarial relationships between physician groupsThat is something New Zealand might face in the future with the advent of PHOs, which might start a new type of competition.

Expenditures for biotechnology products, like SAls, are expected to grow faster than oral prescription drugs. For example, revenues for Lovenox increased 38% from 1999-2001, compared to "only" 16.8% for oral drugs over the same period

(Continued from page 3)

Policymakers intent on maximizing the benefit of each REAP factor should consider which stakeholder is best able to do this. Perhaps this will not be through one group (e.g., physicians or patients), but a coalition of multiple groups.

There is a whole new entrant into the US health care system called Pharmacy Benefit Managers (Pharma). They negotiate drug prices and act as brokers between our health plans and pharmaceutical companies (Pharmac?). There are four major ones and they are not necessarily orientated towards having the cheapest drugs because they negotiate drug discounts with manufacturers. There is ongoing litigation between HMOs and Pharma because Pharma are pushing more expensive drugs for which they get higher rebates.

Helene said, "there are parallel lessons for New Zealand where fund holding is still an experiment. It is a different shape and there is less down side risk but some people are doing quite well. I think, on the whole, a lot of what you are doing would be wonderful for us. If we could have some form of reference drug pricing. The only State we have doing that is Oregon (but only for its Medicaid population."

"Some of our States are trying to innovate by using electronic prescribing. Our physicians are slower on the uptake than yours are. I am so impressed, you are way ahead with electronic medical records, so is Great Britain. In our country no one is stepping forward to fund this. One strong selling point to pharmacists is that the script is legible. If they had the money to invest in this (currently there profit margins are very slim), this creates a big safety issue for them. We joke that to be a successful physician in our country you have to fail penmanship in first grade. So we think more legible script would be a big help. One of the touted benefits of medical record keeping is that it allows drug interactions and checking that the right drug is prescribed, but we do not see much evidence of that working."

"We have a saying "when the pie gets smaller, table manners change". It is impossible to sustain ongoing health care cost increases of 20%. We have to find new ways to do things. We all have similar sets of problems. In my country I can say that there is a tremendous HMO backlash; enrolments are decreasing every year. Consumers want a choice and are not prepared to have the GP as the 'gatekeeper'. We are now much more patient-specialist centred. Capitation has not taken off. I do not think that there is the political will for universal health insurance."

"I once thought that the good group co-operatives like Kaiser were going to take over the world. Now, I don't know. California used to be called the leading edge, now it is called the bleeding edge."

Helene concluded, "If you ask me to predict the future I have to say it is as much a question mark to me as it is to you. In the end, the only answer seems to be some form of universal health insurance. I have read a lot about New Zealand before coming here and you have become quite a polygon nation as well so you are going to have to deal with different expectations as well. As the British say, "we will just have to muddle through and hope for the best".

"We have a saying "when the pie gets smaller, table manners change". It is impossible to sustain ongoing health care cost increases of 20%.

We have to find new ways to do things. We all have similar sets of problems.

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at nzihm@xtra.co.nz

The Next Generation US Health Plan: Not If, But When and How

Steve O'Dell and Jim Hansen from First Consulting Group support Helene's comment on the changing face of American Health Plans. Their paper, *The Next Generation Health Plan: Not If, But When and How*, is published in *Healthplan* 44(2): 54-58.

They report that the evolution of health plans continues. "We are ushering in the era of consumer-driven products that transfer more financial responsibility to consumers." Health care plans are under pressure to become increasingly consumer-centric. Consumerism in health care is not new - it began in the 1970s and has been mounting for nearly two decades.

Consumers clearly chose value, and through the '80s and '90s enrolment in HMOs increased dramatically. The consumer backlash of the later '90s was the result of employees feeling they were not being given a choice about joining an HMO, along with the perception that HMOs were overly concerned with cost.

Consumers have become increasingly more vocal about their health care. There is every reason to believe that consumers will continue to become more sophisticated and demanding about their health care coverage.

New health plan cost-transfer products are not a new trend, but rather a logical outcome of the devolution of employer-based health insurance, which also has been going on for a decade. Now, employers will take the next logical step and begin to increase their employees' financial responsibility for their coverage choices.

The move to consumer-driven health care is much broader than these new cost-transfer products. It is also being stimulated in the pharmaceutical sector through direct-to-consumer advertising and information and by the recent focus on patient safety in the provider market.

As employers focus more on ways to control cost and quality - not simply transfer the cost to employees - managed care will likely have resurgence. It will incorporate the changes that have already been made to soften care management rules and procedures and will become even kinder and gentler.

O'Dell and Hansen see the preoccupation with the new consumer health plan products as misplaced. They believe health plans need to be charting their path to become consumer-centric organizations, a fundamental and necessary shift. This will require difficult changes in strategy and operations and need to be enabled by IT infrastructure and software applications that most plans have not developed or integrated.

They nominate five components to consumer driven health care: consumer benefit choice; consumer financial responsibility; consumer provider choice; consumer self-management; and, information transparency.

Consumer benefit choice: Consumer-driven health care provides greater product and coverage choices through flexible benefit options. Health plan products will allow employers and/or employees to choose from a variety of benefits, deductibles, and co-pays. To help consumers make the right choice, online wizards will guide decision making based on health care needs and budgets and suggest the best alternative for each situation.

Consumer financial responsibility: Decisions about benefits, care, and who will deliver care will shift from employers to consumers - as will the financial responsibility for those decisions. In the belief that employees will become more responsible consumers of health care, employers will no longer shelter employees from the true costs of care.

Consumer choice of provider: Provider cost, quality, and satisfaction data will be necessary to help guide members to the right care options. Enhanced provider profiling - with details about cost and quality - will provide greater information transparency and much greater decision support for consumers.

Consumer self-management: Consumer-driven health care requires individuals to become active participants in managing their own care. As the number of people with chronic conditions grows, health plans will need to step up even more as the primary sponsors of voluntary dis-

(Continued on page 6)

Key Elements of Consumer Driven Healthcare

- Consumer Driven Healthcare involves increased consumer financial responsibility and decision making around benefits, quality, price care choices - all supported by information transparency.
- The availability of easily accessible information is at the core of consumer driven healthcare
- Consumers assume greater responsibility for choosing their health benefits and providers
- Consumers have a greater financial responsibility in both purchase and care decisions
- Consumers control care decisions and help manage their health

(Continued from page 5)

ease and health management programs.

Information transparency: Consumer-driven health care requires information transparency on a scale scarcely envisioned before. Such information will be enabled through consumers' increased comfort level with the Internet and the utility of Internet-based tools. System architecture can no longer limit health plan administrative functions and access to information by health plan members and employees.

Of these elements, the most difficult one for health plans and providers will be a new level of information transparency. While strides have been made in recent years, the industry has a way to go to fully meet consumer needs and expectations. The Internet has made clear how many consumers are interested in health care information.

A recent study by Pew Trust found that 6 million individuals go online every day for health information, with that number growing daily. In another recent study, Manhattan Research Group found consumers would rather go to the Internet than to their physicians for health care information. This is a dramatic shift and does not bode well for the patient-physician relationship. Trusted sources of accurate information on the Internet will become more and more important. Plans have an opportunity to provide the information that consumers are seeking on the Internet in a way that reinforces the patient-physician relationship.

While plans and doctors provide a good deal of administrative information to consumers, giving them online information about their care - and treatment options for their specific conditions - is not a universal practice. It will need to become a more common practice to support the next-generation health plans.

An Appropriate Sequence

O'Dell and Hansen say organisations will have difficulty prioritizing what to do when and in what order. To assist health plans, they have created a three-stage model based on the work of Michael Treacy and Fred Wiersma in their book *The Discipline of Market Leaders*.

Their model suggests that there is an appropriate sequence in the evolution to the next-generation health plan, moving from Operational Competence, to Product Innovation, and then to Customer Responsiveness. In each stage, plans will need to consider the business-process changes necessary, the human resources and other "people changes," and the IT required to support and lock in the changes.

Their model provides an approach to systematically reviewing that progress and developing a plan to address areas that may not be performing at the necessary or desired level.

In **Stage 1, Operational Competence**, health plans must understand and act on the fact that e-business, data access, and decision support are key to moving to the next stage of evolution. Innovative products and initiatives to improve relationships with stakeholders will require systems capable of dynamic and frictionless integration with consumers, providers, employers, suppliers, and outsourcing partners. Health plans will need to optimize or replace core systems to enable market minimum performance and support rapid new product deployment and customer responsiveness. Health plans will need greater investments in data warehouses and business intelligence to move to the next two stages.

In **Stage 2, Product Innovation**, health plans will invest in Web functionality that can attract stakeholders, save them money, and improve operations. Developers and organizations that recognize and support the needs of users will win, even if their IT is not as sophisticated as that of competitors. Health plans must adopt predictive modelling technology in order to identify and stratify populations - to estimate medical expenses and target members who can benefit from intervention.

In **Stage 3, Customer Responsiveness**, successful health plans will use customer relations management (CRM) to achieve an improved customer experience at a cost appropriate to customer value. Until now, most CRM initiatives were limited to business, process, and call-centre improvements. Now, information mined through new technology, coupled with an emphasis on operational competence, allows health plans to improve the customer experience by tailoring information, products, and services to the specific needs and desires of the individual members.

The emerging next-generation health plan will be customer-driven and IT enabled, characterized by information transparency and real-time responsiveness. Health plans running legacy systems built on old technology are struggling to meet these changing market needs. It's clear that a plan's core system architecture provides the foundation that will determine what will be easy, difficult, or impossible to accomplish.

Health plans running legacy systems built on old technology are struggling to meet changing market needs.



New Zealand
Institute of Health
Management
A Branch of the
Australian College of
Health Service
Executives

For all inquiries re Branch
activities or membership
contact nzihm@xtra.co.nz or
(09) 577 5477 Phone/Fax



Up coming Seminars

May 14th

@ Minter Ellison
BNZ Tower 125 Queen St
5.30m. for 6 p.m.

Emerging Legal issues relating to Health

Wendy Brandon, President-
Elect, Auckland Medico-legal
Society.

Non Members Welcome
Cost

Members \$20

Non Members \$30

Light refreshments supplied

June 23rd

@ Gillies Hospital

Why nurses should be over-represented in the higher echelons of health care management in New Zealand, Australia and the United Kingdom"

Rod Perkins

Profile

Donna Neal, who joined our Branch committee mid year to fill a vacancy, epitomises the modern Health Services manager, juggling the demands of career, family, ongoing study and service to NZIHM with aplomb.

Donna graduated from the Manukau Institute of Technology in 1984 with a Diploma in Nursing. Her first position as a staff nurse in the paediatric ward at Rotorua Hospital was the start of an ongoing career in paediatric nursing. After a short time at Rotorua Donna embarked on her "obligatory OE", which included spells at Royal Children's Hospital, Melbourne and Princess Margaret Hospital for Sick Children, Perth.

Donna returned to Princess Mary Hospital, Auckland in 1987; moved in 1990 to the Neonatal Unit & Paediatric Ward at Middlemore Hospital; then returned to Starship Children's Hospital in 1994. Her first foray into management followed as a Starship Children's Hospital Duty Manager. Her next two appointments recognised her analytical skills. First, as Starship's Casemix Co-ordinator with responsibility for implementing a clinical information system into Starship; and then as Clinical Information Manager with responsibility for generating and analysing clinical data and statistics, then producing reports on current trends and operational performance in relation to clinical issues.



After a very short break as a full time mother, Donna returned to two part time positions at St John Ambulance. In her role as Planning and Performance Analyst she developed a KPI reporting structure within St John; provided contract support; and ongoing audit of data quality used for reporting. As Research Co-ordinator she co-ordinated the Auckland site in an international double blind randomised trial of a Minimally Invasive Direct Cardiac Massage Device for Pre Hospital Cardiac Arrest. Her involvement included participation in an international assessment meeting held in Paris. Somehow she found time to fit in a third part time position as SREA Co-ordinator for the Ministry of Health and 3 Auckland DHB's in moving secondary services from Auckland Healthcare, to the hospital closest to patients domicile (where clinically appropriate).

In 2002 Donna moved back into a clinical role as Clinical Charge Nurse of a Level 2 and 3 Neonatal Unit Middlemore Hospital, then at the end of 2002 moved to her present position as Clinical Nurse Leader Special Care Baby Unit, North Shore Hospital where she is the Project Manager for the commissioning of the brand new neonatal unit. This involves the recruiting and education of nursing staff, developing clinical procedures and policies and day to day operational and financial responsibilities of the unit

Donna holds a Post Graduate Diploma of Health Service Management from Massey University; and an Advanced Diploma in Child & Family Health Nursing from the Auckland Institute of Technology

A couple were celebrating both their 50th birthdays and being married for 25 years. During the celebration a fairy appeared and said that because they had been such a loving couple all those years, she would give them one wish each.

The wife wanted to travel around the world. The fairy waved her wand and poof... She had the tickets in her hand.

Next, it was the husband's turn. He paused for a moment, and then said, "Well, I'd like to have a woman 30 years younger than me."
The fairy picked up her wand and poof... He was 80...