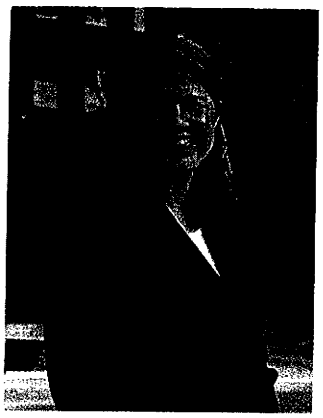
The feasibility of Falconbridge

Falconbridge's drug-plan management program is a success story. What's stopping sponsors in larger centres from following suit?

By Anna Sharratt

TALK TO LUCIO FABRIS, PRESIDENT OF MED-I-WELL SERVICES, a pharmacy and wellness consulting firm based in Sudbury, Ont., and you can't help but feel medication management is an achievable goal—anywhere.



That's because Med-I-Well has in the last two years successfully implemented drug-plan monitoring programs with two large employers—Falconbridge and Inco—which have educated members about drug compliance, saved the firms thousands and reduced reliance on costly drugs.

Falconbridge, definitely the more famous of the two cases, has been discussed at health and wellness conferences for the past two years. It is routinely held up as shining example of what can happen when companies, plan members, physicians and pharmacists work collaboratively to rein in drug costs and manage waste. The reason for the accolades is the Sudbury-based metals producer's decision in August 2002 to embark on a medication-management program with Med-I-Well, targeting the class of drugs called proton inhibitors, and later, Cox II inhibitors. These two classes were ringing up bills, due to being overprescribed and ineffectively administered.

Med-I-Well's program involved educating plan members about proper usage and cheaper alternatives to more expensive drugs and working with doctors to ensure they reduced the number of prescriptions for the two drug classes. Pharmacists were also involved, making sure patients knew how to take the drugs.

The result was impressive. Falconbridge's annual increase in drug costs dropped to 4.6% from 7% the year before—a sharp difference from the 12% to 20% most companies experience, according to Fabris. And Inco, which embarked on a similar program this past January, is also seeing results. Its usage of proton-pump inhibitors has dropped dramatically, with usage of cheaper alternatives increasing from 11% to 25%.

Success aside, the question remains: could a program like that of Falconbridge work in a larger city? And, is the marked lack of case studies in large urban centres a sign that, perhaps, population size acts as a deterrent? Falconbridge's legacy has been to ignite a debate in the benefits industry over the feasibility of larger-scale drug plan programs.

Fabris feels drug-management plans could work in major cities, within reason. "It's not so much if it's a large community. It's more: where are your employees? If they're close to where you're working, that's one thing. If they're all spread out, it's a little more difficult. [But] it can still be done."

Sal Cimino, manager, pharmacy and professional services at Green Shield in Windsor, Ont., is less optimistic. He feels smaller cities, with their limited pool of physicians and pharmacists, are ideal for such programs because of the controlled environment, one that big cities don't possess. "Something like Falconbridge, where you can actually have a physician monitor, trust me, I'd love to see that happen as a pharmacist. But it's just so difficult to do it, in say, the Metro Toronto area. Unless you target a specific disease, it's going to be very difficult. And even if you do that, you're not going to have 100% buy-in."

Where does that leave big-city sponsors? One approach is to see the benefits of a less-holistic medication-management program. Cimino suggests launching programs with a pool of physicians in the vicinity of the workplace, and talking to physicians about overprescribing costly new drugs. Or, targeting a specific disease state—such as high cholesterol—and educating plan members, doctors and pharmacists about changing medication usage. In this manner, companies can achieve cost savings—perhaps not as effectively as Falconbridge—but enough to make an impact.

Perhaps the legacy of Falconbridge should not be a debate about whether or not it can be duplicated elsewhere. Instead, it should be about what successful elements can be transplanted to companies who are forced by location to consider smaller-scale drug-plan solutions. **BC**

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