Commentary

Health Care Organization Perspective

William Goldman, M.D.

United Behavioral Health provides various types of counseling, disability support, substance abuse treatment, psychiatric treatment, and other services to about 22 million people employed by our clients. I represent the private, for-profit sector. Profit is the elephant in the living room when people discuss issues such as cost escalation and cost control. However, despite the pharmaceutical industry's goal of making a profit, in the end their relentless pursuit of new therapeutic agents results in an overall social good. The question is how to pay for these agents.

For the last several years, I have been involved in clinical services research. Evidence[1,2] shows that an attempt to restrict clinical pharmacotherapies is irrational from a total health care cost-effectiveness point of view. Pharmaceutical benefit managers tried and failed to demonstrate a reduction in overall health costs by using restricted formularies and prior authorization procedures. This generated antagonism from patients as well as physicians, and increased administrative time and related costs. Despite prior authorization requirements for nonformulary medications, virtually all requests were approved at the end of the day, so practice was basically unaffected. However, data have not permitted a careful examination of whether these policies led to increases in other health costs either, such as hospitalization.

However, there may be an important function for prescription oversight and review if it is focused on quality, not just on cost containment. This oversight should be on influencing clinician-prescribing patterns toward increased concordance with evidence-based guidelines in pursuit of best practice. In mental health, most psychotropic agents are prescribed by nonspecialists rather than by psychiatrists. The people who are being treated for mental disorders by their primary care physicians are frequently misdiagnosed and are often undertreated or inappropriately treated. A new wave of research projects to try to rectify this situation is underway.

Formularies are one of the latest fashionable tools of cost containment. I suggest that the use of formularies is beginning to enter its endstage. The use of formularies is now the rule, not the exception. Almost all companies have moved to a multitiered formulary, and they are more inclusive—not exclusive. The managed care world has devised various tools to try to contain costs by squeezing one portion of the health care industry to transfer wealth to another portion until there is a push for it to be transferred in another direction. Now, with the increased privatization in the hospital industry, we are seeing the focus on pharmacy shifting to hospitals as cost drivers. This is as it should be because hospitals represent a far bigger percentage of the spent medical dollar. I suggest, therefore, that 3-ptier formularies are essentially going to go the way of preauthorization because there are other ways to make more money. For example, hospital chains and conglomerates, with a pressing need for cost containment, will serve this function. Free access to and quality control of pharmacotherapeutics may increasingly be acknowledged as part of the solution of containing escalating hospital costs.

Issues remain, however, regarding the current use of formularies. Over time, prescription drug copayments for a 30-day supply may increase from, for example, $5.00 to $10.00 for generic, from $15.00 to $30.00 for brand name, and from $25.00 to $45.00 for a brand name that is not on the preferred drug list. I believe this type of cost containment—the formulary mechanism—raises an ethical issue. It has the potential, by shifting costs to the patient, of inhibiting medical regimen adherence. When those patients at the lower end of the economic scale see an escalation in their copayments, it is inevitable that fewer poor people will adhere to their medical regimen than middle class and upper-middle class people. This, in an (I hope) unintended way, contributes to the inequality of medical care in our country.

The reescalation of medical premiums, combined with the economic slump, is giving a rebirth to this cost-shifting dynamic but in a new form. I predict that, in the

From the Behavioral Health Sciences Department, United Behavioral Health, San Francisco, Calif.

This commentary was presented at the symposium "The Case for Physician Choice: Implications for Restricted Formularies," which was held November 4–5, 2002, in Washington, D.C., and supported by an unrestricted educational grant from Eli Lilly and Company.

Corresponding author and reprints: William Goldman, M.D., 13 Channing Way, Sausalito, CA 94965 (e-mail: whgoldman@yahoo.com).

next few years, formularies will drop off the radar, partly because there is a slowdown in the new drug pipeline. The huge rush, for instance, that came in the 1980s and 1990s with many big expensive drugs has become relatively quiet now. Also, a number of expensive drugs are going off patent and will be generic, which contributes to a flattening of the curve in the escalation of the annual percentage increase of drug costs. Instead, hospitals, technology, and the aging population will continue to be the dominant factors driving medical cost escalation.

REFERENCES

1. Goldman W, Sturm R, McCulloch J. New research alliances in the era of managed care. J Ment Health Policy Econ 1999;2:107–110
2. Goldman W, McCulloch J, Cuffel B, et al. More evidence for the insurability of managed behavioral health care. Health Aff 1999;18:172–181