THE INSIDE STORY®

AUGUST/SEPTEMBER 2019

Don't miss episode 19 of our podcast as we discuss better approaches to health care with Dr. Danielle Martin, family physician, author, chief medical executive at Women's College Hospital, and YouTube star.

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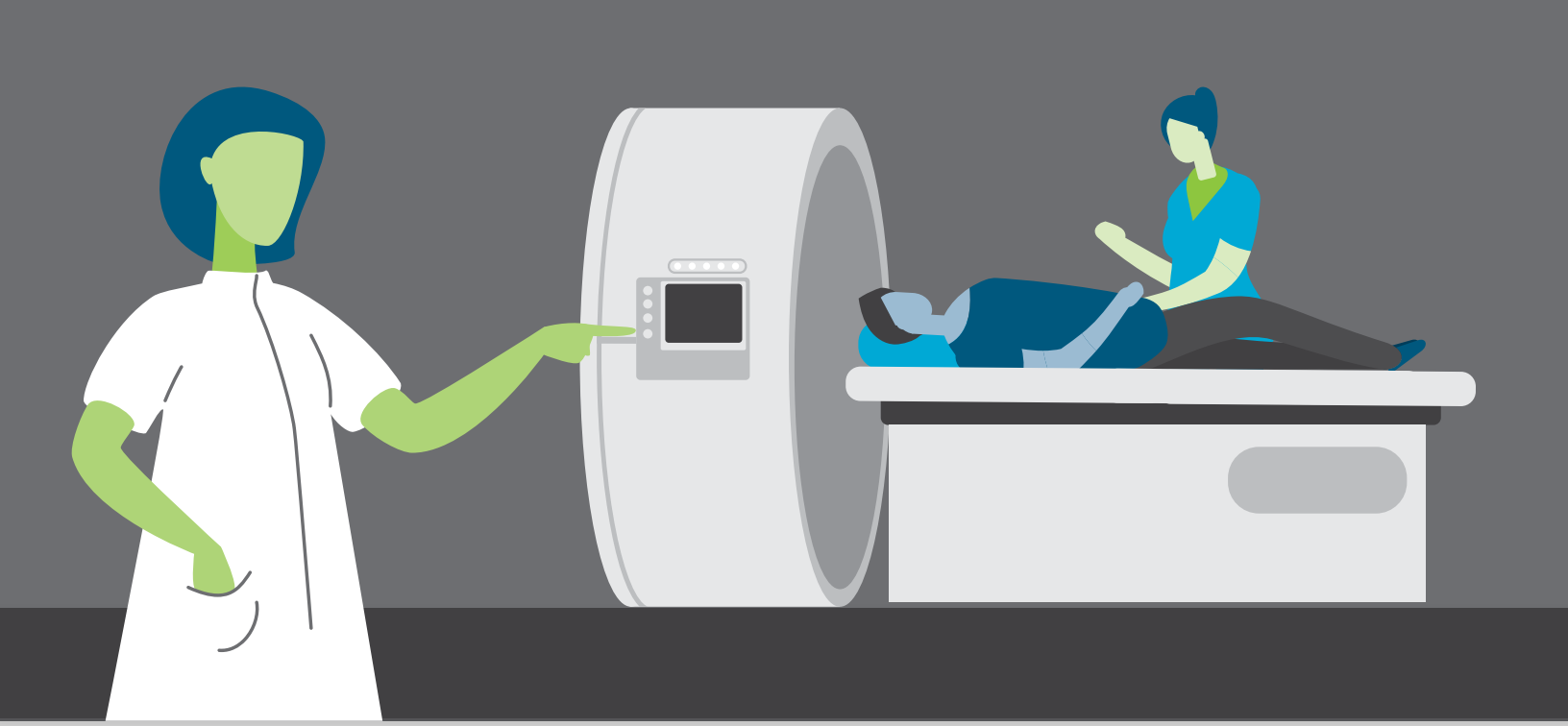
WHAT'S INSIDE



MORE HEALTH CARE DOESN'T NECESSARILY MEAN BETTER HEALTH

...But it can mean more harm

Turns out that 60 really is the new 40—and even 80 is the new 60—as people worldwide are living longer. In fact, we can expect to live more than twice as long as our ancestors.[1] So why then, if we are healthier and more active than ever, are more people becoming patients? It's because health care is no longer considered just for the sick, it has expanded into also focusing on the well.

At first blush, this may sound like a good thing; it may sound like prevention. But if your plan members are healthy—in that they don't have health problems that need solving—health services may actually create problems. Problems like overdiagnosis and in turn, overtreatment—including all the anxiety, energy, time commitment, potential costs, and even physical harm that can come along with it. The controversy surrounding the medicalization of healthy people raises awareness of the difference between what is truly prevention versus what is just early diagnosis that may—or may not—be a good thing. You'll see...

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THE STATE OF THE NATION

Dr. Danielle Martin is a Canadian doctor focused on helping improve our health care system. She emphasizes the need to reduce unnecessary tests and interventions: "Expensive technology, early diagnosis, and aggressive treatments can save lives—but only when they are properly applied. Every year, millions of Canadians are harmed by unnecessary, inappropriate, harmful and wasteful medical tests and interventions. We need to stop talking only about the benefits of health care and start talking about the harms."[2]

Similarly, a 2017 Canadian Institute of Health Information (CIHI) report conveys that Canadians have more than one million potentially unnecessary medical tests and treatments each year.[3]

*Don't miss our conversation with Dr. Martin in episode 19 of our podcast – "**And now for something completely indifferent**."*

Have we turned into a society of sick people minus the actual symptoms?

It used to be that the realm of hypochondriacs was reserved for people that catastrophized symptoms: a persistent cough is surely pneumonia, a mysterious lump must be cancer, and a bad headache likely means a brain tumour. Today, we seem to have adopted this philosophy of fear—that to keep illness and, worse case, death at bay requires vigilance. The idea that, even for healthy people, seeking health care is part of prevention. But what if it's not? What if healthy people—as in, not experiencing any symptoms—potentially risk more harm than good when they pursue health care that they don't necessarily need?

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Looking at the trend towards medicalization of healthy people—such as having voluntary screening, tests, and treatments—reveals that instead of preventing illness, this approach often leads to unnecessary diagnosis and avoidable harms. This idea that more is always better where health care is concerned and that the Hippocratic Oath (*first, do no harm*) will always prevail is questionable when we see potential harms such as an increase in:

- Anxiety and stress due to unnecessary findings or false positives, often leading to further potentially harmful interventions,
- Complications as well as side-effects—like radiation exposure that potentially increases patients' lifetime risk of cancer,
- Time and energy expended by both health care professionals and patients, and
- Health care costs—both labour and equipment costs.

Also, of course, we need not tell you that data is very important. We need solid data to be able to accurately assess not only the incidence of health issues but also to track outcomes. But early diagnosis can skew the data. For example, outcomes are typically reflected in terms of five-year survival rates from the point of diagnosis. However, early diagnosis may dramatically increase the reporting of five-year survival rates when in fact, there is no real change in long-term outcomes like death.[4] Makes you think, has our society become addicted to health care services? Are we hooked on the idea that more health care is always better than less?

Healthy people increasingly turned into patients

Of 363 studies about clinical practices published between 2001 and 2010 in *The New England Journal of Medicine*, 146 proved or strongly suggested that a current standard practice either had no benefit at all or was inferior to the practice it replaced.[5] Although response to the various studies' conclusions is diverse, it is precisely this kind of controversy that points to the importance of taking notice of the issues:

Screening – Research shows that acute lower-back pain typically goes away within about four weeks, with or without imaging, and that imaging rarely shows the cause of the pain. However, a report by CIHI, in collaboration with Choosing Wisely—a campaign focused on helping patients and health care professionals discuss unnecessary care—sheds light on unnecessary treatment. For example, 30% of Albertans with lower-back pain—who had no indication that anything more serious is lurking—had at least one unnecessary X-ray, CT scan, or MRI. This seems more like the norm than the exception as Canada's rate of imaging is above the Organization for Economic Cooperation and Development average.[6]

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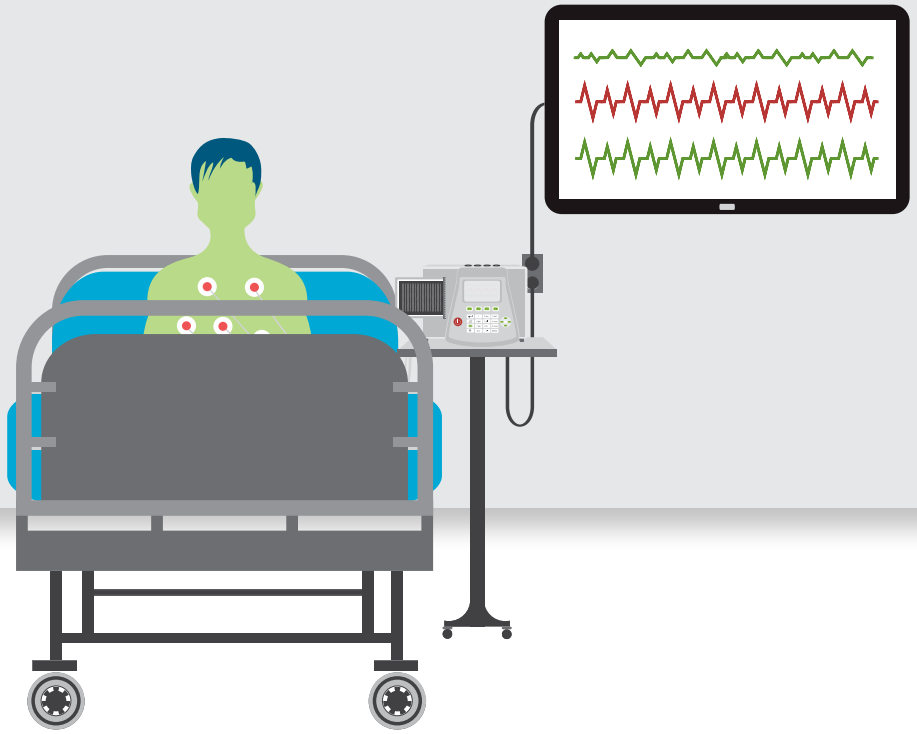

Testing – Evidence indicates that preoperative tests before low-risk surgeries can, of course, be stressful for patients and use valuable resources, when in fact, they do little to improve care. Nevertheless, in 2012-2013, 18–35% of patients who had a low-risk procedure in Ontario, Saskatchewan, or Alberta, had a preoperative test; the most common being an electrocardiogram.[7]

EVIDENCE OFTEN SHOWS THAT LESS IS ACTUALLY MORE

- **Annual physical exam:** Healthy people who have an annual physical are no less likely to be hospitalized, become disabled, miss work, or die than those who don't.[8]
- **Back pain:** 20–40% of back surgeries are not successful in relieving pain leading to a new term: "failed back surgery syndrome" or FBSS.[9]
- **Knee pain:** An MRI will reveal a knee-muscle tear in at least one-third of adults over 50, but only two-thirds will have symptoms. "Once they have the imaging, they may well end up having surgery that doesn't work for a problem they don't have."[10]

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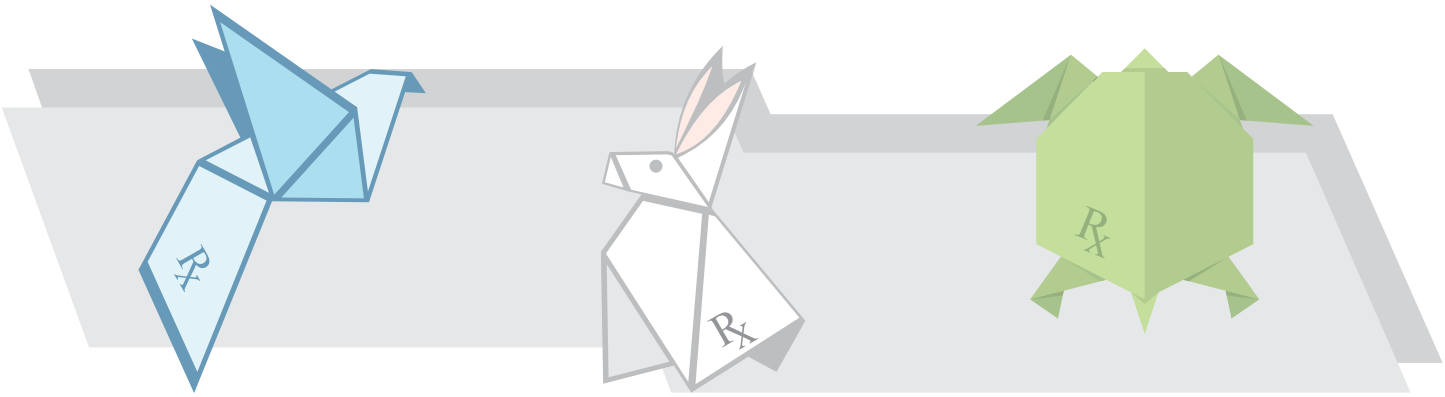
Drugs – Fortunately, certain drugs called beta-blockers are shown to decrease blood pressure, which is a risk factor for heart disease. However, a study that compares using a beta-blocker versus just a sugar pill found that, although the beta-blocker did lower blood pressure, it didn't prevent heart attacks or extend life. Similarly, another study analyzed clinical trials that included more than 24,000 patients and concluded that taking a beta-blocker did not reduce heart attacks or death compared to no treatment at all. And, the most recent review of beta-blockers in 2017 recommends that beta-blockers "are not recommended as first-line treatment for hypertension as compared to placebo due to their modest effect on stroke and no significant reduction in mortality or coronary heart disease."[11]



CANCER IS AS DIVERSE AS BIRDS, RABBITS, AND TURTLES...

As the body of research around cancer continues to reveal how diverse cancers are, questions also continue to emerge about the value of early diagnosis. An analogy for the issue is known as The Barnyard Pen of Cancers:[12]

- **Birds:** Aggressive cancers that have already spread by the time they are detectable, meaning no such thing as "early detection." They have already flown the pen.
- **Rabbits:** Slowly progressive cancers, so early detection may help—or it may not—because these cancers might not materialize. They may just continue harmlessly hopping around the pen.
- **Turtles:** Cancers where early detection isn't relevant because they aren't going anywhere—just like turtles sitting tight in the pen.

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Treatment – Increasingly controversial are treatments for cancers where people are considered low risk and for cancers that will not necessarily progress. Take prostate cancer for example, as the Canadian Cancer Society explains, "in general, most men diagnosed with prostate cancer do not die from the disease itself and will die from other causes."[13] However, estimates regarding *low-risk* prostate cancer include that approximately 1,500 Canadian men receive treatment each year; some of which is unnecessary and may lead to side-effects or other treatment-related complications that could have been avoided. And not just any side-effects, we're talking incontinence and impotence. Estimates include that reducing treatment by 15% annually—and replacing it by close monitoring—could not only avoid risks, but also save $1.7 million in treatment costs.[14]

So just why isn't healthy, healthy anymore?

There appears to be a number of drivers leading to the medicalization of healthy people, including the expanding definition of disease. To help diagnose disease, doctors look for measurable parameters and when these parameters reach certain thresholds, they indicate that a certain condition is present. Accordingly, lowering a threshold leads to identifying conditions earlier and, in theory, before any damage. Sounds good, right? Maybe. And maybe not.

For example, the 2017 recommendations from the American College of Cardiology and the American Heart Association to lower the threshold for defining hypertension have been exceedingly controversial. The American College of Physicians raised concerns that changes are "not supported by evidence and may result in low-value care" and the American Academy for Family Physicians states that the "harms of treating a patient to a lower blood pressure were not assessed."[15]

Similarly, an analysis of the threshold change estimates that it will end up identifying an additional 13.7% of all adults—that's 31 million additional Americans—as having hypertension. However, 80% of those newly diagnosed with hypertension will not decrease their risk of cardiovascular disease by lowering their blood pressure. Accordingly, the analysis concludes that the majority—about 25 million people—who are at low risk and not recommended for drug treatment should not be classified as having hypertension.[16] Critics of the lowering of the hypertension guideline describe it as replacing a fishing rod with a fishing trawler and as a result, "capturing many more innocent subjects than it should."[17]

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Of course, the threshold change in the United States has sparked debate in Canada, with a 2019 study concluding that "adoption of the ACC/AHA BP guidelines would result in a near doubling in the prevalence of hypertension in Canada. The changes would largely affect individuals who are younger and at low-to-moderate cardiovascular risk" and this "may produce a surge in hypertension cases, creating challenges in an already overburdened publicly funded health care system with limited resources, such as Canada."[18]

Speaking of health care funding, of course the mighty dollar can also influence the medicalization of healthy people. Although for healthy people who become patients, the benefits can be minimal, not so for other players in the business of health or rather, the business of sickness. For instance, there is the argument that lowering thresholds potentially bolsters physicians' practices and big pharma's sales. Speaking of big pharma and self-interest, a lot of sales can be generated by targeting healthy people who think they are sick.

In 1992, a medical journalist coined the term "disease mongering" (sometimes referred to as malady mongering), describing it as "trying to convince essentially well people that they are sick, or slightly sick people that they are very ill."[19] Since then, research continues to support that disease mongering occurs by, for example, drug companies or other medical manufacturers pushing their products by essentially inventing and/or promoting diseases. Basically, a drug company, through its marketing practices, medicalizes normal life by pathologizing everyday health issues as symptoms of an invented condition by "raising awareness" of the "problem" to both the medical community and the public. And bingo! There you have it, a call for essentially healthy people becoming patients.

Case study: Disease mongering in action

The executive director of the National Women's Health Network in the United States explains that "companies who brought the first non-hormonal drug to market about 30 years ago wanted a larger market than just the very old who were already suffering from osteoporosis."[20] So why not invent a disease? Say hello to osteopenia, a label for bone thinning that is part way between healthy bone and osteoporosis (a real disease in which fragile bones are more susceptible to fractures).

Doctors received free screening machines to help diagnose women with osteopenia, regardless of whether they were at low or high risk of developing osteoporosis. A public education campaign emphasized the importance of screening, and experts received funding to determine which level of bone loss should be considered osteoporosis. The result? For about 20 years, millions of women took a drug who didn't need it, resulting in not just cost and inconvenience—many suffered a previously rare type of femur fracture.[21]

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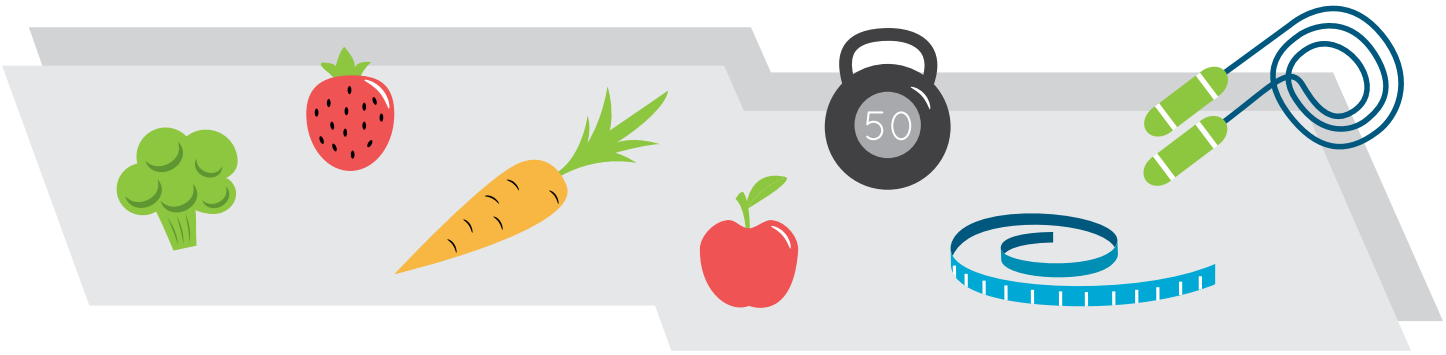
Today, this kind of disease mongering is still very much alive and well. Think gastroesophageal reflux disease or GERD. This is essentially what used to be called acid reflux or heartburn. In the old days, doctors would just tell patients to, for example, eat less, don't sleep on a full stomach, and take antacids as needed. But this disease has become a boon for pharma. If folks are now diagnosed with GERD, they can take a drug continually.



Instead of looking for sickness, promote health

Early diagnosis and prevention are two different things: prevention is to stop disease from occurring, whereas, early detection is to discover disease. But as Peter Gove, GSC's former innovation leader – health management, explains, "The thing is that no one is completely normal in every way. Instead of trying to detect typically harmless abnormalities, we need to raise our comfort level about abnormality; that it is part of the human condition—that abnormal is actually normal. So to keep plan members healthy, focus on what truly is prevention, meaning the usual suspects like diet, exercise, and smoking cessation. And then, when unhealthy, choose health care wisely weighing the pros and cons."

Speaking of making wise choices, the Choosing Wisely campaign is focused on taking action. The basis of the campaign is the recommendation that health care professionals and patients have conversations about tests and treatments as a way to make smart and effective choices. For instance, the next time your doctor suggests a test or treatment, don't just listen, talk! Ask questions like:

- Do I really need this test, treatment, or procedure?
- What are the downsides?
- Are there simpler, safer options?
- What happens if I do nothing?

Be ready to not just passively follow instructions. Instead, choose wisely.

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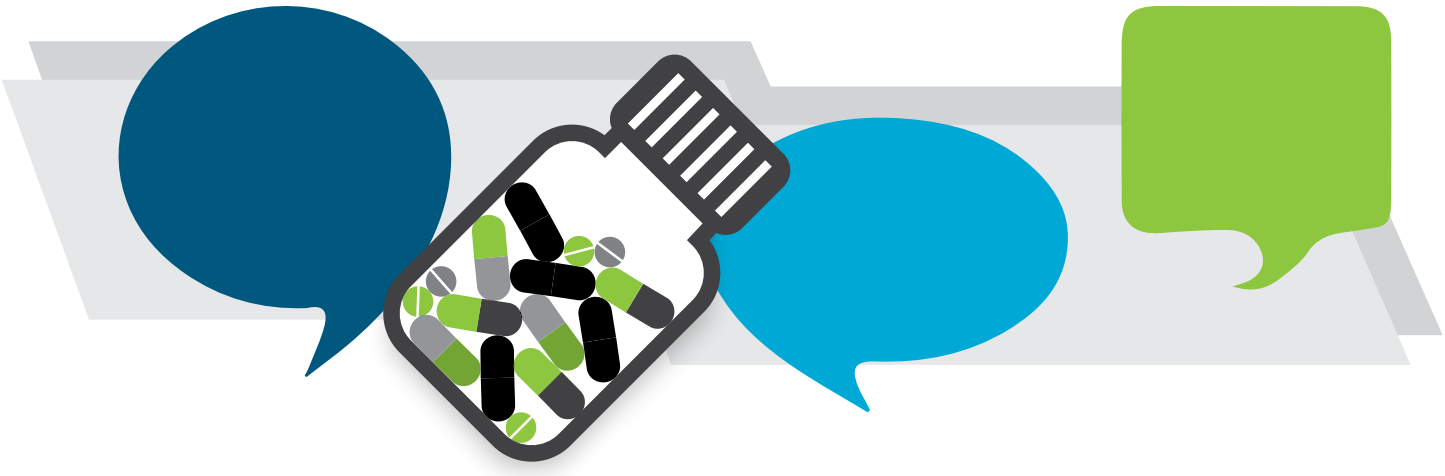

CHOOSE WISELY: SOUNDS GOOD, BUT HOW?

Choosing Wisely Canada has developed over 300 recommendations across over 50 clinical specialities since its launch in April 2014. These recommendations identify tests and treatments that, although commonly used, are not supported by evidence. In fact, these tests and treatments could put patients in harm's way. The campaign also takes the recommendations a step further by partnering with health systems and patient organizations to help put these recommendations into practice.

Choosing Wisely Canada is organized by a small team from the Canadian Medical Association, University of Toronto, and St. Michael's Hospital (Toronto). Modeled after the Choosing Wisely campaign in the United States that started in 2012, now over 20 countries are choosing wisely including Australia, Brazil, Israel, Italy, Japan, New Zealand, Wales, and the United Kingdom.

Tailored to each international environment, the heart of each region's campaign is the same: to encourage conversations between doctors and patients to determine appropriate treatment together. It does this by partnering with professional associations representing different clinical specialties to develop recommendations of "things clinicians and patients should question."

For instance, Canadian recommendations range from working with the Canadian Headache Society to develop "Four things physicians and patients should question" to collaboration with the College of Family Physicians of Canada to develop "Thirteen things physicians and patients should question." Make sure you choose wisely by checking out the recommendations by speciality here: ***choosingwiselycanada.org/recommendations/.***

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WHAT'S UP...

Drug pricing in the news

Canada announces changes to lower patented drug prices

The government of Canada has announced amendments to Canada's *Patented Medicine Regulations* aimed at lowering the cost of patented drug prices and laying the foundation for national pharmacare. These regulations direct how the Patented Medicine Prices Review Board (PMPRB) determines whether or not the prices of patented drugs are excessive; that is, new, brand-name (not generic) prescription drugs entering the market. These amendments are the most significant reforms to the regulations since their introduction in 1987. Savings are estimated at about $13 billion over the next decade. The amendments reflect a consultation process that began in May 2017 and include:

- Revising the list of comparator countries the PMPRB uses to compares its prices internationally. Going forward this will provide more useful information because Canadian prices will be judged against countries that are similar to Canada in terms of population, economy, and approach to health care.

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- Providing the PMPRB with the market price of patented drugs (manufacturers' list price plus rebates) rather than just the list price. When setting price ceilings, this will help the PMPRB more accurately assess whether or not prices are reasonable.

- Allowing the PMPRB to consider whether or not the price of a drug reflects the value it has for patients.

What does this mean for your plan? Given that currently Canada pays the highest patented drug prices in the world, behind only the United States and Switzerland, these amendments should help decrease overall drug costs. In addition, going forward, we should be able to get a more accurate perspective on Canada's drug pricing due to the new list of comparator countries, which should more effectively compare "apples to apples." The updated list removes the United States and Switzerland while adding Japan, Spain, Norway, Australia, Belgium, and the Netherlands. Remaining on the list are France, Germany, Italy, Sweden, and the United Kingdom.

To review the amendments, visit ***gazette.gc.ca/rp-pr/p2/2019/2019-08-21/html/sor-dors298-eng.html***.

Collaboration leading to more affordable generic drugs

Since 2007, to help public and private drug plans make pricing, purchasing, and reimbursement decisions, the PMPRB has been monitoring trends in Canada's generic drug market via the report called *Generics360*. The most recent edition reviews the decade-long impact of generic pricing policies in Canada. Findings include that:

- Price-setting policies facilitated by the pan-Canadian Pharmaceutical Alliance (pCPA) has made a significant impact on lowering generic drug prices in Canada.

- The most recent agreement between the pCPA and the Canadian Generic Pharmaceutical Alliance (which represents generic prescription drug manufacturers) has brought Canadian prices closely in line with international prices.

- Due to significant price reductions, although Canadians are using generic drugs more than ever, total spending on generic drugs in 2018 is the same as in 2010.

- From 2007 to 2018, prices for some of the most commonly used generic drugs decreased by 80% and certain oral generic drug prices decreased by almost 60%.

What does this mean for your plan? Lower prices can only mean good news for your plan and your plan members.

For more information, visit ***http://pmprb-cepmb.gc.ca/news.asp?a=view&id=214***.

Message of health care survey: evolve with the times

Buck's *2019 Canadian Healthcare Trend Survey* not only looked at cost trends but also at other trends that are important to consider in plan design. For example, cost trends include:

- *Prescription drug costs:* Represent the majority of private payor health spend and have the greatest impact on employer benefits cost trends. Claim costs are expected to rise 3-5% and could be as high as 11% with projected market inflation.
- *Hospital costs*: In 2019, hospital inflation increased to 10.03% from 2.60% in 2018 but showed a decreasing trend from 2015 to 2018. However, it represents a relatively small portion of private payor health spend.
- *Dental utilization:* Increased slightly over the past two years to 5.86% in 2019.

Other trends to consider include:

- *Medical advances*: For example, on one hand, diagnostic technology may lead to early detection that lowers plan costs in the long run, but on the other hand, testing costs may add to plan costs.
- *Demographics:* For example, younger employees' needs may differ from what could be considered traditional health care.
- *Regulatory oversight:* For example, the cancellation of OHIP+ may increase plan costs, however, a national pharmacare plan potentially would shift costs away from employer plans.

To download the report, visit ***https://content.buck.com/hubfs/buck_pub_krc_nhct2019_report_CA%20(1).pdf?utm_campaign=US%20%7C%20Q32019%20%7C%20Healthcare%20Trends%20Survey%20Report&utm_source=Media%20Outreach***.

Out and about… events not to miss

2019 Halifax Benefits Summit

September 24, 2019, Westin Nova Scotian, Halifax

www.benefitscanada.com/conferences/halifax-benefits-summit

Ned Pojskic, GSC's leader, pharmacy and health provider relations, will be speaking about value-based pharmacy.

CPBI Ontario, London Chapter Breakfast Seminar

October 1, 2019, Lamplighter Inn & Convention Center, London

www.cpbi-icra.ca/Events/Details/Ontario/2019/10-01-London-Chapter-breakfast-seminar

Peter Gove, GSC's former innovation leader—health management, will be presenting on cognitive behavioural therapy and digital therapy products that are emerging in the marketplace. And Ned Pojskic, GSC's leader, pharmacy and health provider relations, will be discussing biosimilars and transition programs.

Cannabis at Work – One Year Later

October 15, 2019, The Globe and Mail Centre, Toronto

www.conferenceboard.ca/web/cannabis/index.html?AspxAutoDetectCookieSupport=1

Ned Pojskic, GSC's leader, pharmacy and health provider relations, will be a member of a panel discussing medical cannabis in a safety-sensitive industry.

August/September haiku

Tests drugs and more tests
We medicalize a lot
Of our normal lives

Fitbit Winner

Congratulations to **T. LIU**, of **NEPEAN, ON**, the winner of our monthly draw for a Fitbit. Through this contest, one name will be drawn each month from plan members who have registered for Plan Member Online Services for that month.

Windsor	1.800.265.5615	**Vancouver**	1.800.665.1494
London	1.800.265.4429	**Montréal**	1.855.789.9214
Toronto	1.800.268.6613	**Atlantic**	1.844.666.0667
Calgary	1.888.962.8533	**Contact Centre**	1.888.711.1119

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