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ABSTRACT

Prescription drugs are the highest single cost component for employees' benefits packages in Canada. While industry literature considers cost-containment for prescription drug costs to be a priority for insurers and employers, the implementation of cost-containment measures for private drug plans in Canada remains more of a myth than a reality. Through 18 semi-structured phone interviews conducted with experts from private sector companies, unions, insurers and plan advisors, this study explores the reasons behind this incapacity to implement cost-containment measures by examining how private sector employers negotiate drug benefit design in unionized settings. Respondents were asked questions on how employee benefits are negotiated; the relationships between the players who influence drug benefit design; the role of these players' strategies in influencing plan design; the broad system that underpins drug benefit design; and the potential for a universal pharmacare program in Canada. The study shows that there is consensus about the need to educate employees and employers, more collaboration and data-sharing between these two sets of players, and for external intervention from government to help transform established norms in terms of private drug plan design.

1. Introduction

Canada's universal healthcare system does not cover prescription drugs. Public drug coverage is mostly provided on a provincial basis to seniors and people on social assistance. Many provinces also offer public catastrophic drug coverage for the rest of the population (e.g. for patients receiving public subsidies once they contribute more than 3–4% of their annual income toward prescription drugs) [1]. Most Canadians are covered through private drug plans offered mostly by employers through supplemental health benefits: 51% of Canadian workers have supplemental medical benefits [2], and since work-related health insurance also covers dependents of employees with coverage, as many as two-thirds of Canadians are covered by health insurance plans.

Prescription drug spending in Canada's private sector has increased nearly fivefold in 20 years, from $3.6 billion in 1993 to $15.9 billion in 2013 [3]. Private drug plans in Canada are often considered wasteful because they accept

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paying for higher priced drugs that do not improve health outcomes for users and use costly sub-optimal dispensing intervals for maintenance medications. As a consequence, it is estimated that private drug plans in Canada wasted $5.1 billion in 2012, which is money spent without receiving therapeutic benefits in return [4]. This amount represented 52% of the total expenditures of $9.8 billion by private insurers on prescription drugs for that year [5].

Canadian employers have demonstrated growing concern for cost-containment in the design of their employees' drug benefits. However, the implementation of cost-containment measures for private drug plans remains more of a myth than a reality [6–10] since few plans require caps for dispensing fees, premiums from claimants, mandatory generic substitution or restrictions on more expensive but not therapeutically superior new drugs [9]. The Canadian Life and Health Insurance Association, concerned about the sustainability of private drug coverage in Canada, has asked for government help to reduce costs [11]. Growing administrative costs of private health plans continues to put additional financial pressures on the capacity to offer private health benefits [12].

A lack of published literature on how drug benefits are negotiated and implemented required us to explore the subject in interviews with employers, union representatives, insurers and consultants working for employers or unions. We focused on unionized workplaces. In 2013, approximately 13.3% of all workers in Canada were unionized private sector employees, 18% were unionized public sector employees, and the rest being non-unionized employees [13]. By focusing on drug benefits in unionized settings, we were able to benefit from the insights of union representatives who have significant expertise in supplemental health benefits. Drug benefits in unionized settings are often considered similar to those of non-unionized organizations [14].

2. Methodology

We identified key informants working within the most prominent Canadian organizations in the four organizational categories examined in this study, who provided us with leads to create a cohort of potential interview participants. After initial contact with these key informants, a non-probability sampling technique known as snowball sampling [15] was employed to reach further respondents that had key exposure to the drug benefit design process and could provide insights that could be generalized, to some extent, across their organizational categories. We extended an invitation to over 60 representatives from 14 unions, 9 private sector employers, 19 insurance companies, and 17 benefits consultancies to participate in the research project. Among those invited, 18 experts agreed to participate in the interview process, four of whom were from private firms, five from unions, five from benefits consultancies, and four represented insurance companies. We carried out one-to-one semi-structured interviews between September 2012 and January of 2013.

The study focused on large unionized workplaces that had Administrative Services Only (ASO) plans, where the employer is responsible for the costs of benefit plans and bears the risks associated with it, while insurers are just hired to manage claims. This study focused on ASO arrangements because they are the most common insurance option chosen by large private-sector firms [16]. Those organizations whose activities resided solely in the province of Québec, where the regulation of private drug plans differs [17], were excluded.

Participants were asked to participate in semi-structured phone interviews lasting 20–30 min. With a specific emphasis on drug benefits, questions focused on four main themes: how employee benefits are negotiated; the relationships between the players who influence drug benefit design; the role of these players' strategies in influencing plan design; and the broad system that underpins drug benefit design. With respect to this last theme, the respondents were asked to describe the inequities inherent in the system and their recommendations for reform, including their opinion about a national public drug plan in Canada. One insurer was unable to respond to questions pertaining to the last theme because the time allotted in this respondent's schedule prevented the interview from reaching these questions.

The research design was reviewed and approved by the Carleton University Research Ethics Board. Since the nature of the topic discussed was sensitive for some of the organizations involved, the agreed protocol guaranteed all participants anonymity by not disclosing the names of the participants and their affiliated institutions. Any details which would enable readers to identify the participants or the organizations were deliberately excluded from this paper.

We carried out a standard thematic analysis by transcribing and analyzing the contents of the audio files. Based on the results of the interviews, we developed a narrative encompassing four new themes which differ from the initial themes under which the questions were organized. The contents were then ascribed initial codes and organized into themes and sub-themes based on the transcriptions' contents. The authors relied on their judgment to identify themes from the interview data, as no quantitative standard measuring the prevalence of subject content can adequately capture the depth of such qualitative data [18]. Thus, our strategy to analyze these data involved coding the data into a conceptual framework from which the research results are drawn [19].

3. Research findings

The following four sections describe the core findings through four themes: objectives; tactics and strategies; barriers to change; and recommendations for reform.

3.1. Objectives vis-à-vis drug benefit design

Drug benefit design decisions are arrived at through professional networks of employers, unions, insurers, and benefits consultants. The interviews showed that these sets of players have different interpretations of what is at stake in drug benefit outcomes, their intentions in influencing these outcomes, as well as their perceptions of the other's intentions. Table 1 categorizes these player's intentions in

Table 1
Monetary and non-monetary objectives identified by participants.

Objectives	Employers	Unions	Insurers	Consultants
Monetary	- Cost-savings.	- Generous benefits.	- Contracts.	- Employers purchasing services.
Non-monetary	- Consistency of benefit provision with other players in the market. - Talent attraction and retention. - Control.	- Membership approval. - Demonstrating gains and thereby their utility to employees.	- A more direct relationship with their clients (cutting out the consultants).	- Maintain their usefulness.

accordance with their stated monetary and non-monetary objectives.

Both employers and other actors in this study cited cost-savings as being important. Typically, the employers indicated that monetary items in collective bargaining are discussed on a cost-neutral basis; meaning that an increase in a benefit line item must be offset by cost-savings elsewhere. Thus, changes in benefits are discussed in the context of introducing changes to compensation, as any cost increase or saving in one area affects the entire basket of goods offered to employees in their compensation packages.

Respondents from all categories indicated that consistency of benefits with other market players is of significance to employers. Three employers explicitly expressed a desire to offer benefit packages that are at least on par with their competitors. Firms constantly realign their benefit packages to meet the industry standard since employee benefits are used as a tool for the attraction and retention of talent. One employer described this need in the following words: "*The whole package of both mandated and discretionary benefits have to be within a range that allows us to compete in the marketplace. So if, for example, we were to look at our benefit costs and find out that no one in the market place provided prescription drug coverage, we would have to assess that and try to make changes in the collective agreements so as to either eliminate that or modify the benefit to make it more cost effective*."

Respondents from all categories mentioned that, in contrast to employers, the over-riding objective of unions is to maximize their benefits with minimal co-payments for their employees. In the words of one respondent on the union side, "*we as a union want as much as possible. We try to keep whatever we have or improve upon it."* This point was made by a union member who claimed that "*the union side is far more democratic and more intense because you have to deal with the membership, as well as just the leadership*." As unions function according to democratic models, their leadership is highly responsive to (and influenced by) attitudes of members relating to benefits and collective agreements. This governance model presents some difficulties for achieving optimal plan designs because even well-informed union leaders who want to implement cost-containment measures may be hamstrung by the demands of their members. Thus, effective plan design changes need significant employee engagement so that the members will ultimately buy-in to the proposed changes.

On the other hand, consultancies and insurers indicated that they are primarily interested in keeping their businesses afloat and contracting out their services though they have different motivations. The consultancies mostly want to preserve their relationships with plan sponsors, while the insurers want to play a more consultative role with their clients, and reduce the influence of benefits consultancies.

3.2. Tactics and strategies

The respondents varied in their interpretations of the use of strategies in the negotiating process. All of the actors reported using some sort of strategy to achieve objectives; however, the use of strategies and tactics by employers and unions was most prevalent.

The employers indicated that their over-riding strategy is to maintain cost-neutrality in providing drug benefits – in the context of overall compensation – to employees: any increases in the costs of a particular benefits area must be off-set by cost-savings elsewhere. Controlling knowledge was also frequently reported by the union-side respondents (and by one consultant that services employers) as a strategy to achieve greater control over negotiations and plan design by firms. According to one union representative, "*the employer always has the advantage in this stuff because they have all of the information with respect to the reports and the costs from the insurer or the advisor*" and in one circumstance the union "*almost had to threaten them* (the employer) *with legal action in order to get some basic information out of them around costing*." Thus, employers are perceived by unions as employing this tactic to prevent union negotiators from challenging their positions and proposals. Under this scenario, unions cannot optimally contribute constructive analyses and proposals since they do not have sufficient access to data. This practice was identified as being particularly problematic, for it prevents unions and employees from being sufficiently educated to contribute to plan design discussions in a meaningful manner.

One employer argued that even when information is shared, there is a lack of trust which prevents the two parties from moving forward in terms of plan design. While this employer argued that they frequently consult unions on specific plan changes and "*feel that they* (the union) *would benefit by having better support around these issues*," they also admitted to not sharing information or consulting the union when it is not required under the collective agreement. The employer "*had no obligation to ask for the consent of the union and the company*" for specific plan design changes and were "*able to make changes*" without any sort of dialog. This caused a breakdown of trust between the two parties and hindered their capacity to educate the union on plan changes, since the union is only consulted after the fact.

In the views of one employer, an important strategy used by unions negotiating with numerous employers within a sector has been to play employers against one another. Therefore, when one employer accedes to demands, its competitor feels pressured to make similar concessions to ensure that it retains a talented and motivated workforce. One employer indicated that this strategy can put less financially viable firms at risk, since wealthier companies may willingly make concessions that their competitors cannot afford.

However, another employer indicated that companies may collaborate when their employees are represented by the same union and cooperation is in their shared interest. Coordination among multiple employers can lead to the adoption of consistent proposals between firms. If achieved, this harmonization makes it challenging for unions to play employers against each other and it can help employers to negotiate declines in benefits at an industry level for specific occupation groups. This type of coordination eases firm specific fears over losing talent to competitors.

Insurers play a smaller role in the negotiating process. One strategy mentioned by all insurers was adding value to services. Or as one insurer puts it, "*we really don't have a strategy, aside from providing value and getting clients to see that value*." One example was introducing cutting-edge information technology to streamline claims adjudication. One insurer highlighted the transition from paper to electronic claims submissions processes to cut costs and reduce the burden of submitting physical claims as an example of value-added services to differentiate themselves from their competitors. Most of the respondents indicated that insurance companies are not particularly concerned with strategies and benefit outcomes, focusing instead on the administration of claims and execution of plan designs demanded by their clients (i.e. employers). This was evident by the fact that most respondents who spoke on this question (including the insurers themselves) indicated that insurance companies are indifferent as to whether cost-containment measures are included in benefit plans. Thus, insurers were reported as having no incentives for reducing the costs of plans.

On the other hand, employers use strategies in their dealings with insurers. With assistance from their benefits consultants, employers have the option of going to market, and look for competing insurers who might offer lower administrative costs, or otherwise pressure their current carrier to lower their price. Plan advisors have experience in dealing with multiple insurers simultaneously. Many employers see value in plan advisors. With a deeper knowledge of claims management and a range of methods to cut costs, plan advisors can help pool employers together, provide expert advice on costing, assist employers in going to market, and carry out expert negotiations on behalf of clients.

3.3. Barriers to change

Some clear barriers to change were identified. A majority of respondents indicated that poor information-sharing was a barrier to achieving cost-effective plan outcomes. One benefits consultant indicated that this is symptomatic of the "*old model*" where communication over benefit design is limited to a few key players. Typically, limited communication between unions and employers' plan advisors and insurers results in a loss for unions. Some workers' bargaining units might have access to internal expertise from their union; but this is more of an exception.

According to one consultant, "*no one knows the cost of drug benefit plans*." This respondent was arguing that few involved in benefit design, either in private firms, unions, or insurers, are sufficiently competent to undertake proper analyses of claims data so they do not really know how proposed plan changes could affect them. This lack of expertise has ramifications for the education of stakeholders on the outcomes of benefit design.

We also found that a lack of trust was perceived as a factor inhibiting progress in benefit design, the breakdown of which is blamed on historical precedents between unions and their employers.

A lack of employee engagement by the private sector was also considered to be a problem. Respondents from all sides frequently indicated that employees often wanted more comprehensive benefits, despite the fact that they achieve smaller pay raises if they are paying for inefficient benefits packages, rather than using more efficient drug benefit design to redistribute the savings to wages or other benefits. Employees may become resistant and distrustful when changes are introduced without sufficiently informing them on how those benefits will affect them and their families.

The democratic structure of union governance was identified as a barrier to change by respondents on the union and consultancy sides. Without information-sharing and employee engagement, especially education of employees on aspects of their benefits, union leaders cannot adopt a progressive approach to drug benefits negotiations. One insurer referred to a conversation he had with a union leader on the benefits of introducing cost-containment measures into plan design. In this purported conversation, the union leader expressed that his support for an initiative is meaningless unless the union's membership has an appetite for a more cost effective plan design. Furthermore, some union, employer, and consultant respondents claimed that when the union lacks expertise or capacity, they are working blindfolded, without the knowledge and expertise needed to negotiate better benefit packages.

Various union respondents also recognized that many Canadian unions have this capacity for generating knowledge and expertise through the use of in-house compensation specialists and/or union oriented consultants. For example, one of the interviewed unions has a research team that would "*parachute in*" to assist the local for part of the negotiating process and "*in a couple of sets of negotiations, the research department will be in there from start to finish*." Having the needed knowledge and expertise when and where you need them can translate into innovative plan designs, so long as the insights generated from this are effectively passed on to union locals at the bargaining table. One union representative said that lack of trust and

information asymmetries are less of an issue when the union is the plan sponsor.

How the insurance industry is organized and operates was also reported as being detrimental to benefit design outcomes. Some interviewees said that the biggest problem is that insurers do not have an incentive to introduce cost-effectiveness clauses in plan design. For instance, one benefits consultant stated that most companies "*in Canada will buy whatever formulary their insurance company offers*" and that "*well over 90% of group insurance plans in Canada consist of every single drug available for sale with a notice of compliance issued from Health Canada*."

While there are instances in which these companies consult their clients on plan options, most of the insurers saw themselves as reactive (and receptive) to client demands, rather than as the initiator in introducing cost-effective changes to plan design. Private-for-profit insurers were described as administrators of plan design who differ in some respects from their not-for-profit counterparts. As one of the insurer puts it, a not-for-profit insurer "*will always look to reduce costs*" and "*additional claims*" for their groups, while "*a for-profit insurer may want the additional claims because they get paid per claim*".

However, when speaking of for-profit insurers, participants from all groups argued that insurers have no financial incentives to cut costs for employers, as indicated by one employer saying: "*from my experience on the committees, I don't get the impression that the insurers are there to save costs for the employers. I haven't seen it. It's always been the other direction*." This claim was also corroborated by a benefits consultant, who argued that "*there has been a fair bit of inertia, you know, amongst the providers out there in actually doing something too radical, too leading edge*" because "*there's no direct financial incentive for insurance companies or pharmacy benefit managers to actually help employers save money*". Expanding on this, another consultant argued that an insurer's commission structure, which is based on volumes of claims expressed in a dollar value, may in fact discourage insurance companies from proposing plan designs that reduce the volumes of claims, as doing so would adversely affect company profits. Furthermore, another benefits consultant indicated that insurers are experts who calculate risk and thereby have no aptitude for the creation of formularies. According to this respondent, the impact is that insurance companies excel at managing risk, yet fare poorly in designing cost-effective plans that rely on the design and implementation of formularies.

3.4. Recommendations for reform

Greater openness and trust, in terms of information-sharing was suggested by an overwhelming majority of respondents from each category. Similarly, one insurer expressed immense support for having an "*intelligent conversation*" with all the relevant insurers, companies and unions at the national level on the potential for more sustainable plan outcomes. This comment was made with regard to a lack of information-sharing, as well as an overall lack of education in terms of the relevant players' understanding of drug benefit design. Each of the insurers that provided recommendations for reform (3 out of 4) envisioned a form of stakeholder engagement in which the government would play a role. In the words of one insurer, "*when I say stakeholders, we need federal and provincial governments there. We need doctors there. We need hospitals there. Pharmacists there. We need the drug companies there. The employers, the unions, and the insurance industry*." Next, this insurer argued that "*all of those parties need to come together cooperatively, put their self-interest aside, put their egos aside, and figure out a way to most effectively manage the exploding cost of benefits, whether they are publicly funded benefits or privately funded benefits*." This assertion was corroborated by one consultant and one union representative. However, one employer argued that there have been precedents where the government has regulated pharmaceuticals, with specific mention of generics, without adequately consulting industry. Furthermore, another employer recommended that unions and management acknowledge the merits of mutual gains and bargain for fostering greater cooperation and information-sharing between management and labor. Mutual gains bargaining presumes that positive-sum scenarios are plausible, and can be achieved through principled negotiations that separate the negotiators from the problem and focus on providing gains to both sides vested in the negotiation's outcome [20].

There was also significant support for providing universal catastrophic drug coverage, universal drug coverage for seniors, or universal drug coverage for all Canadians. An interesting finding from the interview data was that respondents from all interviewed groups declared being in favor of introducing some sort of arrangement for a national drug plan. Some favored having a universal pharmacare program which would apply to all drugs, while others favored programs tailored for catastrophic drug coverage. Two of the insurers that responded to this question explicitly favored some form of universal catastrophic drug coverage while the other favored universal pharmacare.

The benefits of such universal pharmacare, argued one insurer, is that it provides "*the employers with some breathing room*"; makes drug coverage and usage more transparent, which would result in better education on which drugs are being consumed and how; and provides opportunities for integrating public and private systems to facilitate the efficient delivery of drugs to Canadians. Each of the union representatives and one employer interviewed for this study expressed their support for universal pharmacare. Three out of five consultants argued in favor of a national pharmacare plan while the other two favored some other form of national risk pooling or formulary management to address costs.

While a majority of interviewees favored some form of universal coverage, a few respondents from the insurer and employer sides expressed concerns that universal pharmacare is not feasible. These respondents indicated that exorbitant costs would be associated with this sort of program, and that these costs would exceed the projections of its proponents. Furthermore, one consultant and one insurer suggested that a national formulary be introduced as a baseline for benefits providers across the country. Rather than open formularies, which are the most common tool used to manage private drug benefits in Canada, the suggested formulary would vet drugs according to

measures of effectiveness, safety and cost-effectiveness. One benefits consultant suggested that some sort of national pooling and/or purchasing arrangement be introduced to control drug costs for employees. Interestingly, national pooling of high drug costs (individual claims over $25,000) has been implemented among 23 insurance companies since January 1, 2013. Such pooling, however, covers fully insured plans only, and exclude ASO plans, the typical plan structure for larger enterprises analyzed in this paper [21].

Finally, employers were most concerned with the government's role in distributing the costs associated with drug coverage among public and private players in the system. In fact, each employer expressed concern over this. Three of the four employers expressed concern over the government's role as a plan sponsor and how governments shift costs to the private sector. As described by one employer, "*the government is a very big consumer of drugs*" and if the drug companies "*start losing money on the government side, they pass it on to private insurance*". Thus, government regulations that help employers contain costs are desired.

4. Discussion

Our analysis identified key issues at stake when it comes to creating and negotiating private drug coverage. The community of experts who participated in this project appeared to have a common understanding of what constitutes the salient issues facing the drug benefits in the Canadian system. The five following points were most striking in our analysis.

4.1. The necessity of information-sharing

This study's major finding is that a lack of information and poor education about drug benefit plan design lead to poorer outcomes. A lack of cooperation between unions and employers has resulted in the creation of silos which constrain the lines of communication and the cooperative use of expertise and information-sharing to improving plan outcomes for employees.

4.2. Democratic governance of unions requires engagement of informed employees

A common theme is that a fundamental lack of employee engagement has made it difficult for firms and unions to achieve the employee buy-in needed to move toward more rational, cost-effective drug benefit plans. Employees tend to treasure their benefit packages – even when it is against their own best interest – and will call on their unions to resist changes that diminish coverage. This occurs even when practical plan changes which might restrict access to higher cost drugs that are no better than lower cost alternatives are introduced. The idea that drug plans should pay for all drugs on the market (and drugs prescribed by doctors) is very strong. Such an expensive mindset poses a disservice to employees who are often forced to endure cuts to other benefits, wages, and even jobs. These are the consequences of having pay-for-anything drug benefits.

Our findings lead us to believe that Canada's private sector unions have not done enough to engage their members. Rather than creating campaigns to educate employees about progressive changes in their benefits, union leaders, by their need to appease those who elect them to leadership positions, continue to placate their members' desire for generous benefits by resisting change. For the most part, the union representatives interviewed for this study were highly aware of the problems facing plan design and supportive of introducing changes. However, an analysis of the aggregate responses suggests that this awareness by experts in prominent Canadian unions still needs to be transformed into a proactive education campaign on drug benefits in order to attain cost-efficient outcomes.

4.3. The need for incentives for insurance companies to reduce costs

Canada's insurance companies, particularly private insurers, were not seen as particularly proactive in terms of introducing plan changes. While some of the respondents indicated that some insurers were starting to take on a role in educating plan sponsors about different benefit designs, insurers were largely perceived as being demand-driven. That is, their role has been restricted to administering benefit plans with a focus on reducing administrative costs and introducing innovative technology for claims management. Some insurance companies might try to implement efficient cost-containment measures [22], but for the most part are not financially incented to work in that direction. As shown above, for-profit insurers actually face the opposite incentives, driving up the costs of claims is conducive to greater profits for this critical player in benefit design. The major point here is that there could be a role for policymakers to create a more rational incentive structure that motivates insurers to contain costs for drug coverage, for example through the principles of managed competition [23].

4.4. The need for government intervention

It appears that the problems facing benefit provision in Canada will not resolve themselves without some sort of government intervention. All players appeared to be aware of major problems and constraints facing private benefits in Canada. The momentum is not there yet, in contrast to the United States, where focusing on cost-effective formulary management is an essential part of private insurers' offerings. To resolve this situation, all have suggested some form of government intervention, either through a national formulary, a risk-pooling scheme, an arrangement designed to provide some sort of universal pharmacare to Canadians, or even a broad discussion amongst all the players with a vested interest in plan outcomes. None of the respondents indicated that the government ought to play no role in the future of benefit design. This suggests that there is a strong need for standardization or regulation which would be tolerated by those with a vested interest in plan outcomes,

but welcomed as beneficial by practitioners in the field, so long as they play a role in the formulation of government policy.

4.5. Disseminating the shared understanding of problems and solutions relating to drug benefit design

Interestingly, there appears to be considerable consensus on the nature of the problem and potential solutions. None of the participants in this study disputed the fact that most private sector firms in Canada are not managing formularies based on cost-effectiveness so the plans in place provide little emphasis on value-for-money. In line with this finding, none of the respondents disputed that employees are ultimately the loser when firms pay for over-generous drug benefit designs that eat up funds that could be shifted to other forms of compensation (i.e. wages and other benefits). Their common viewpoint was that the main players involved in crafting drug benefit plans for the majority of Canada's private sector employees are very aware of the barriers to achieving superior plan outcomes, but they feel that overall context in which these benefits are designed is wrought with constraints that leave them feeling powerless to instill progressive change. The problems are widely recognized, but this consensus among players must be recognized by policymakers in order to arrive at a political solution, without which the core problems facing these organizations are not likely to disappear in the short-term.

4.6. Limitations

This exploratory study has its limitations. First, in order to encourage participation in this study, the research design provided the interviewees with full control over what feedback they could provide, and ensured that they were aware that doing so is voluntary. This constrained our ability to probe the participants for answers on the most controversial aspects of the study, such as those pertaining to the use of strategies in the negotiating process. Furthermore, the fact that many aspects of this topic are controversial or deal in proprietary business information limits the participants' ability to disclose sensitive information that could have been quite informative for this study. Participants may have shifted the interview discussions toward the more superficial elements to prevent themselves from disclosing industry secrets pertaining to collective bargaining and plan design. In fact, some consultants refused to participate in this study because they did not want to disclose their firm's strategies.

In addition, this qualitative study is subject to selection bias, a common problem in qualitative research, where we are reflecting only the points of view of a select group of interviewees, thus limiting the generalizability to the wider population [24]. Thus, the claims made in this paper, such as that concerning actors' consensus on the issue of cost-containment, might be of limited generalizability in how they reflect the views of all insurers, unions, employers, and consultancies, even if cross-referenced responses remained consistent among the actors interviewed. Finally, the guarantee of the research participants' anonymity prevents us from exploring what types of union structures, relationships with management, and delivery options (e.g. through unions vs. management or profit vs. non-profit insurance providers) facilitate the adoption of more cost-effective plan options. Having greater freedom to explore the influence of these variables on plan design outcomes would provide for a richer analysis on the topic.

5. Conclusion

This paper explored how private sector negotiations between unions, employers, consultants and insurance companies fail to achieve drug plan designs that are both sustainable and cost-effective, and explores potential solutions to the problem. Since pharmaceuticals are the highest single cost component of private health benefits, there is an urgent need to implement measures for managing the costs of drug plans without degrading health outcomes. Our study shows that there is consensus about the need to educate employees and employers, more collaboration and data-sharing between these two sets of players, and for external intervention from government to help transform established norms in terms of private drug plan design.

Up to now, in spite of repeated concerns, employers and insurers have demonstrated little effort to implement cost-containment measures in private drug plans. This is in stark contrast to aggressively managed public plans which limit formularies in order to contain costs and ensure coverage to those drug products deemed effective, safe and cost-effective [11,25]. Therefore, it behooves private plans to emulate public approaches and strategies.

Currently, private drug plans for union members shield employees from many additional costs, but also shield them from making rational choices on drug coverage which are based on considerations of effectiveness, safety and value for money. This study has pointed out where those gaps are, especially in knowledge, capacity and data, and it is now incumbent upon unions, employers, insurers, and consultants to be proactive in organizing drug benefits in a sustainable way.

Conflict of interests

Sean O'Brady has no conflict of interest to declare. Marc-Andre Gagnon has received research funding by the Canadian Federation of Nurses' Unions for a different research project related to drug coverage in Canada. Alan Cassels is co-director of DECA (Drug Evaluation Consulting and Analysis). The authors would like to acknowledge the financial contribution of the Canadian Health Coalition in order to pay for the transcription of interviews.

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