

# Retailing's critical role

in revolutionizing health care and  
revitalizing the economy:

A blueprint for improving consumer health and wellness,  
transforming the health care industry,  
and energizing the U.S. economy through retail.



Written by Dave Nazaruk  
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COMMUNICATIONS

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Author's note: this is not meant to be another essay to which sage people nod in agreement but then do nothing to remedy the underlying issues; rather, it is intended to offer practical solutions and serve as a blueprint of achievable – if admittedly difficult – measures we must undertake for the sake of every American and our nation's future.

The author gratefully acknowledges the writers and organizations whose work appears in footnoted references and/or the appendix of this document, and which underpin the thesis that retailing can play a critical role in revolutionizing our country's health care and revitalizing the economy. The citations and appendix material are included here for information purposes only and do not constitute an endorsement of the paper's thesis, or any group or organization.

## Section I:

### EXECUTIVE SUMMARY

Solving the nation's health care crisis—the unhealthy state of our citizens and our health care delivery system—is a fundamental part of healing our economy. Our country is burdened by the increasing cost of health care, as well as a lifestyle model that rewards citizens for unhealthy behaviors and does not incentivize them to take greater personal responsibility for their health and wellness. This, in turn, inhibits productivity, impedes our ability to compete and limits profitability. Because skyrocketing health care costs threaten the stability of families, businesses, and our economy, most sectors of society are prepared—and even eager—to accept wide-sweeping changes that promise to fix the currently malfunctioning system. For its part, government sees a need for considerably greater intervention and oversight and is presently driving the dialogue around proposed solutions and new paradigms of care.

Of all the hubs of health care activity in the overarching delivery system, food and drug retailers provide the greatest touch points with consumers in terms of access, frequency of interaction, and pre-existing relationships of trust and loyalty, as well as the ability to deliver powerful incentives and education to motivate desired behaviors. Yet retail is largely overlooked as an important participant in plans to re-engineer the health care system.

Ensuring that retail gains its deservedly vital role in the coming health care revolution will require an effort of solidarity by all players in the retail health care sector: independent and chain drug, supermarket and mass/club retailers, associated trade groups, supplier partners, wholesalers and buying groups. As a whole, the industry must flex its collective muscles and insist on representation in the development and implementation of a new model of consumer health management that is accessible, affordable, and engaging to consumers. If not, retailers will continue to suffer from the imposition of wasteful, poorly conceived legislation and regulations that further hinder their own growth and profitability.

## Section II:

### A HEAVY ECONOMIC BURDEN: HEALTH CARE COSTS AND THE UNHEALTHY AMERICAN LIFESTYLE

In an opinion piece in the *Wall Street Journal* (Feb. 26, 2009), Senators Max Baucus and Ted Kennedy wrote:

“For decades, obtaining affordable, high-quality health care has been a heavy weight that millions of Americans have been forced to bear on their own. Increasingly, skyrocketing health-care costs have threatened the stability of families, businesses and our economy as a whole.

Some argue that repairing the health-care system now is impossible, given the urgency and high cost of ending the financial crisis. The claim is that we can fix one problem or the other -- but not both. In truth, the two are inextricably intertwined: Solving the nation's health-care crisis is a fundamental part of healing our economy.”<sup>1</sup>

Whether or not you agree with the senators' proposed resolution for the health care crisis—in a nutshell, greater government intervention and oversight of all aspects of the delivery system—you cannot escape the sense that some radical change in the system looms on the horizon. The primacy of the issue of health care had its genesis in the 2008 campaign season but then was briefly relegated to backburner status due to the escalating urgency of the overall economic crisis. Following the inauguration and debate on the stimulus package, however, the health care issue has regained both traction and momentum as one of the remediation opportunities to regain economic footing. These reforms are underscored as necessary economic reforms: Americans spend more on healthcare than residents of any other country, yet some 46 million lack healthcare. The cost of care and insurance has been rising rapidly, with healthcare costing \$2.2 trillion in 2007, or \$7,421 per capita. <sup>2</sup>

Senators Baucus and Kennedy's call-to-arms to address the broken health care system is typical of numerous articles and opinion pieces issued immediately following the election. An article entitled “Promise & Reality” in the January 2009 issue of *Medical Marketing & Media*, for example, summed up the health care climate facing the incoming Obama administration, and continues to be echoed by many other industry observers:

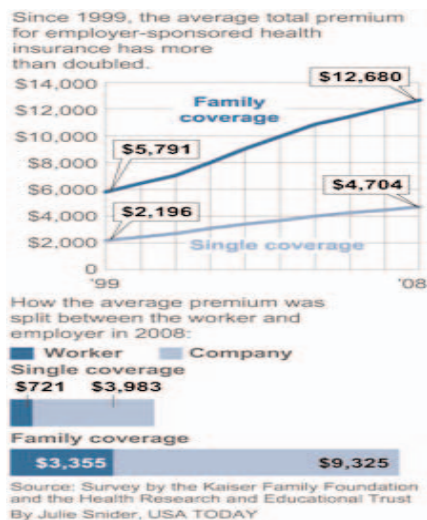
“Health care was the number-one domestic issue in the campaign prior to the economic meltdown. Given the interconnectedness of health care to the economy, many experts believe that the economy cannot be fixed without fixing health care. It is the biggest piece of the economic pie, representing one in every six dollars—17% of the gross domestic product. Indeed, President Obama has said the question isn't whether we can afford to fix health care, the question is whether we can afford not to.”<sup>3</sup>

Indeed. The currently unhealthy state of the U.S. economy is matched only by—and is a direct reflection of—the thoroughly unhealthy state both of its citizens and its health care delivery system. Our moribund manufacturing base, for example, is a microcosm of how a severely unhealthy populace—in concert with a poorly structured health system—negatively impacts commercial enterprise. Consider the following three items:

- Numbers posted by the National Center for Health Statistics, correlated with the 2006 Census (the most recent data available), show that more than 32% of American adults are overweight (73 million),

34% are obese (75 million) and 6% are extremely obese (13 million).<sup>4</sup> Being overweight or obese raises the risk of heart disease, diabetes, some cancers, arthritis and other conditions.<sup>5</sup> Put another way, 72% of the American adult population – a staggering 161 million people – is either overweight or obese, with all the attendant high cost chronic diseases that follow those largely lifestyle-induced conditions. See Appendix A for related articles and research on obesity-related health care costs.

- Absenteeism and presenteeism (people trying to work while sick) account for more than \$1 trillion in lost workforce productivity nationwide each year.<sup>6</sup>
- Rising health care costs also undermine our strength in the global marketplace. American employers pay far more for health care than their major trading partners, and manufacturers face particularly high pressure to compete internationally. U.S. manufacturers pay \$2.38 an hour for health benefits, while manufacturers among our major trading partners pay only 96 cents an hour on average, according to the New America Foundation. Health care reform is essential to spur growth and keep American businesses on a level playing field with the world.<sup>7</sup>



Simply put, of all the ills plaguing the U.S. economy, perhaps no single factor is as responsible for our current malaise as the cost burden of health care, and the attendant results of a poorly functioning health system. That burden, coupled with a model that rewards consumers for unhealthy behaviors while dis-incentivizing them to take greater personal responsibility for their health and wellness, severely impedes competition and limits profitability. Solving the consumer health crisis, then, not only will result in a healthier bottom line and more energized, productive employees but will also lift the entire U.S. economy out of its current slump and restore it to its critical leadership position of stoking global economic prosperity.

### Section III:

## RETAILERS AS VITAL CHANGE AGENTS IN HEALTH CARE

Offering varying degrees of analysis and potential solutions—relative to each member’s disparate level of passion about addressing the problem—is the Retail sector, specifically those retailers of health-related products: independent and chain drug, supermarket, and mass/club retailers and their Rx, OTC, CPG, and DME manufacturer partners. Every day, these retailers directly impact the health and wellness of the consumers they serve, not only through the enormous volume of lifestyle-enhancing and lifesaving medications they dispense, but also through the critical role they serve in meeting practically every other health-enhancing product need: from OTC remedies and nutritional supplements to a wide array of life-sustaining foods and beverages, and even fitness products and medical devices in many cases.

Add to that wealth of products the on-site clinical support provided by trained health care professionals, including pharmacists, nutritionists and dieticians, and increasingly nurse practitioners and physician assistants via the emerging retail clinic movement, and retailers can legitimately claim to be on the front lines, guiding consumers through their evolving health care needs.<sup>8</sup> Of all the hubs of health care activity in the overarching delivery system, retailers provide by far the greatest touch points with health-conscious consumers in terms of:

- Access, frequency of interaction and preexisting relationship of trust and loyalty
- A position as an embedded part of what will hereafter be referred to as “consumer workflow”
- Ability to deliver powerful incentives to motivate desired behaviors

Retailers provide the  
**greatest touch points** with  
health-conscious consumers.



Yet, while considering the high impact retailers have with consumers, retail remains largely overlooked and a seemingly unlikely sector of the health care system to revolutionize health care. A closer examination of each of the above-mentioned critical touch points, however, will hopefully move skeptics of the thesis of retail as a vital change agent to a point where they operate in concert to become that very agent for health care reform and economic stability.

## Section IV:

### THE RELATIONSHIP TOUCH POINT

Of all the “critical touch points” retailers have with consumers, their most compelling in terms of opportunity to impact the health care system and U.S. economy is their ongoing, high-frequency relationship with and accessibility to all consumers. Consumers shop food and food/drug retailers an average of 1.9 times per week,<sup>9</sup> and 92% of these consumers live within five miles of a retail pharmacy—with an average distance of 1.86 miles.<sup>10</sup> For drugstore and food/drug retailers, these touch points are further enhanced by consumers’ opinions that pharmacists are among the most ethical and honest professionals.<sup>11</sup>

Health decisions—many of them subconscious ones—are constantly being made by consumers as they plan for and then shop their favorite stores, so retailers should be doing their utmost to help these shoppers think of them in more explicit, fully conscious ways as being active, caring, trustworthy partners in their ongoing health and disease management efforts.

The number of consumers regularly seeking credible, accessible education and tools to manage their own and their family’s health is vast and represents a huge opportunity for retailers to have an ongoing dialogue and impact with these health information-seeking shoppers. Studies show that a high percentage of these “health seekers” are well-educated, affluent baby boomers, who are both:

- increasingly aware of their own mortality (and therefore looking for information-based solutions to lead longer, healthier lives), and
- caught in the “sandwich generation” conundrum (i.e. they are managing their own and their children’s health and are also assuming the role of primary caregivers for their increasingly infirm parents).

Consumers’ dual-decision making responsibilities regarding health care amplifies their need for reliable, highly relevant (to their particular situations), health information.

### Enhancing the relationship touch point with electronic engagement

In their quest for health information, more consumers (81% of all Internet users, which encompasses 61% of adults) are turning to the Internet.<sup>12</sup> Most of that health information-seeking traffic is going to dedicated eHealth sites such as WebMD, effectively disintermediating retailers from their health-conscious consumers. In one recent month, the top five online health networks attracted approximately 74 million health information-seeking consumers<sup>13</sup>.—all of them the retailers’ own shoppers—who are turning to these sites in the absence of similar health improvement resources that retailers themselves could be delivering.

Of these health information-seeking consumers, those with chronic or life-threatening conditions are more likely to engage intensely with online resources for health information – and report high decision impacts as a result of their engagement online. Research shows that 75% of e-patients with chronic conditions say their online research affected their decision about how to treat their illness, and what products to buy<sup>14</sup>.—a trend that has given rise to the proliferation of eHealth companies vying for health-seeker traffic and attendant monetization opportunities. See Appendix B., Related E-health Statistics.

Consider the example of Waterfront Media. With its recent acquisition of Revolution Health, Waterfront Media's Everyday Health network now vies with longtime leader WebMD as the largest of these sites, with almost 26 million unique visitors in the month of November 2008.<sup>15</sup> Yet Waterfront Media—a two-year old e-marketing company with no real claim to health expertise and no long-term direct relationships with consumers that the typical retailer enjoys—has through deployment of targeted health content, consumer incentives, and savvy marketing parlayed itself into one of the two dominant players in the eHealth space—siphoning off millions of dollars in advertising fees that retailers could be gaining in the process.

According to an article in the January 2009 issue of *Medical Marketing & Media*, “Waterfront Media's if-you-build-it-they-will-come approach to advertisers had paid off. ‘We're projecting huge revenue increases next year,’ says co-founder & EVP Everyday Health Mike Keriakos. Though Waterfront doesn't publicly disclose its numbers, Wolin says the company is running ‘north of \$100 million in revenue.’”<sup>16</sup>

Coupled with WebMD's reported 2008 advertising revenues of \$275 million,<sup>17</sup> just these two sites effectively divert at least \$375 million in online and email-based marketing dollars from the very health product vendors that retailers work with in more traditional advertising venues. Taken as a whole, online health product advertising is a \$1.2 billion/year—and growing—business, yet most retailers fail to see even a fraction of that spend.<sup>18</sup>

**Online health information searches are on the same level of popularity as paying bills online, reading blogs, or looking up phone numbers or addresses.**<sup>19</sup>



### **Electronic engagement and the relationship between consumers, manufacturers and retailers**

This extraordinary growth of online health product advertising is largely fueled by the eHealth sites' ability to offer manufacturers more and more precise targeting—and correspondingly higher ROI—of their ads and offers to consumers who need or already use their products, based on registration data and user preferences. They do this by offering incentives to health-seeking consumers to register—essentially filling out a brief health profile or health risk assessment—to receive e-newsletters and other eCRM vehicles addressing their specific health interests. In most cases, the incentive is nothing more than the promise of content (and in some instances, social networking tools) that are most relevant to that health seeker's personal needs.

Everyday Health is getting millions of people to do just that, by offering well-designed sites for many different health affinity groups (e.g., diabetics, dieters, fitness buffs, etc.). According to an Everyday Health co-founder,

“The heritage of our business is registration-based subscriptions, across all our sites. We get 30,000 people a day to fill in a health profile. While they're doing that, they're signing up for the Everyday Health newsletters, and that's how we get the traffic over to everydayhealth.com.”<sup>20</sup>

Incredibly, Everyday Health is driving this engagement without the benefit of any preexisting relationship with these consumers that retailers have spent decades developing or the direct monetary value that the same retailers' existing rewards programs could offer to stimulate even greater participation through incentives. Consider these statistics from a recent email from MorningNewsBeat.com:

“BrandWeek delivers a paean to the benefits of in-store marketing, noting that while 21 million people watch an average episode of “Dancing With The Stars” and 35 million people watched the most recent finale of “American Idol” – enormous numbers in a fragmenting television universe – “those audiences pale when compared to the crowds that pack the aisles of the big-box retailers. Costco, Walgreens, Safeway and Kroger boast weekly shopper counts of 20 million, 30 million, 44 million and 68 million, respectively. Passing through the revolving doors of Wal-Mart locations across America each week are 150 million people.” (AdWeek, 19 January 2009)

Now imagine the numbers of consumer registrants that retailers, en masse, could gather if they were to offer:

- The same types of content and eCRM vehicles
- The capability to connect tailored health information with what their consumers need or want (food/nutrition, medication, fitness products) to meet their health care needs
- Savings offers on those products and additional rewards points for their active participation in the program.

Further imagine how the layering on of shopping cart data would result in the ability to offer vendor partners new targeted marketing opportunities that deliver much better cost-efficiencies and quantifiable ROI than any traditional marketing program in which they're currently participating. According to the Food Marketing Institute's 2008 Food Retailing Technology Benchmark Study, retailers already capture 90% of shoppers in frequent shopper programs. Valuable data captured includes name and contact information, purchase history by product category and product name.

Not convinced shoppers aren't actively engaged in thinking about and managing their health? Consider the example of Lifeclicnic, a company that provides blood pressure kiosks in approximately 20,000 food, mass, and chain drug stores. They report over 30 million customers use those devices in retail locations every month. These are consumers that purposefully interrupt their retail visit to engage in an in-store health care encounter that provides specific, targeted information about their health status. If just 30% of that monthly traffic could be incentivized to register for a health rewards program offered by those retailers—essentially filling out a health profile similar in design to those pushed by Everyday Health or WebMD—the total aggregated registrant base would launch that particular network into the top tier eHealth sites. Put another way, if just 3% of

daily users of these monitoring devices filled out a profile, that would equal the number touted above by Everyday Health, a company that has invested significant energy and marketing money into gaining this level of consumer engagement—and which they're monetizing to the tune of well over \$100M per year.

Compared to a disconnected e-marketing company:

- Retailers already enjoy a personal, often devotedly loyal, connection with their consumers.
- Retailers are in a superior position to engage these consumers about their health care interests and needs.
- On a monthly basis, the number of consumers filling scripts—among the most health-engaged consumers—represents an enormous audience with which to have an ongoing dialogue about their health concerns, provided retailers assiduously avoid the use of protected pharmacy data in their marketing communications and follow HIPAA guidelines for all opt-in consumer health marketing programs.
- Monthly total foot traffic throughout all stores—not to mention eyeballs to FSIs, circulars, and other advertising vehicles— is significantly larger than traffic to these eHealth sites, and health-conscious shoppers represent a large percentage of consumers currently using those sites. Intelligent utilization of in-store promotion as well as traditional marketing vehicles to solicit participation in a Health Rewards program could effectively deliver millions of registered users without increasing marketing spend to acquire them.
- Through existing rewards programs and other in-store and offline incentives, retailers have the ability to convert many of these everyday shoppers into registered users of a superior online health management offering.

**US Pharmaceutical and Health Care Industry Online Advertising Spending, 2006-2011 (millions, % of total and % change vs. prior year)**

	Spending	% of total*	% change
2006	\$820.0	4.9%	31.2%
2007	\$975.0	4.5%	18.9%
2008	\$1,190.0	4.1%	22.1%
2009	\$1,530.0	4.5%	28.6%
2010	\$1,950.0	5.0%	27.5%
2011	\$2,200.0	5.0%	12.8%

*Note: includes drug manufacturers and marketers, doctors, hospitals and other entities that deliver health services, such as health maintenance organizations; \*\*% of total US online advertising spending*  
 Source: eMarketer, August 30, 2007

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www.eMarketer.com

## Section V:

### THE CONSUMER WORKFLOW TOUCH POINT

Pharmacists that are reading this article will immediately understand the concept of workflow, from a professional perspective. Recent movements to enable pharmacists to become more engaged with patients, up to and including uncovering ways such as Medication Therapy Management (MTM) to insert themselves more integrally into improved patient care (as well as the ability to find new revenue sources for providing such cognitive services) aside, the primary function of pharmacy continues to be dispensing prescriptions to patients. Products can enhance professional workflow, but ones that distract from—or worse, interfere with—that core responsibility will out of necessity be discarded; ones that can be easily incorporated (or better, absorbed) into workflow will be embraced and widely utilized.

The same goes for consumer workflow in the context of health care. Activities that can be incorporated into a consumer's workflow will be readily adopted. Those that do not easily fit into consumers' routines will not garner high engagement and use rates. That explains why many health and disease management programs—even excellently designed “free” ones offered by health plans and employers—aren't more widely accepted by the consumers they are intended to help. There are any number of factors influencing consumer adoption of such programs—including ones regarding privacy concerns on the part of employees and the wide number of points along the consumer behavior-change spectrum having to do with individual consumers' “readiness to change.” But perhaps the single biggest factor (or at least the most widely overlooked one) is the inability to integrate such programs into a large number of those consumers' “workflow.”

Simply put, today's consumers are too maxed-out time wise to adopt any additional behaviors—even health-improving, cost-containing ones—unless they can be seamlessly woven into their everyday routines/workflow.

The one health-related touch point common to a vast majority of consumers every week of the year and therefore the most ideal one to achieve this workflow integration is the shopping trip. Consumers are already in the routine of shopping to pick up their medications, food, and other health-improving products. This provides retailers with the unique opportunity to introduce and continually engage them in education, awareness, and reminders about their healthcare needs. Retailers, especially ones filling scripts for chronic diseases, have an exponentially higher level of consumer/patient engagement – in terms of frequency, loyalty, and actionable, quantifiable impact on outcomes—than any other healthcare venue, including the primary care physician. Notable chain-specific efforts to capitalize on that engagement are found across the industry, but the industry as a unified whole needs to develop comprehensive health marketing initiatives (preserving and protecting privacy rights) to more fully leverage that relationship in a strategic and cohesive way.

**The one health-related touch point** common to a vast majority of consumers every week of the year and therefore the most ideal one to achieve this workflow integration is **the shopping trip.**



## Section VI:

### THE INCENTIVES/REWARDS TOUCH POINT

Added to the workflow touch point is the almost equally underappreciated incentive/reward touch point. What reward(s), apart from better health and all the positive lifestyle enhancements that accrue from it, will motivate a large number of consumers to participate in a program designed to improve their health status? The typical health or disease management program uses a very high cost but low participant yield mechanism to acquire, and then sustain, consumer engagement: usually a cash or cash-equivalent incentive that is dangled at program inception and then often not repeated at various points throughout the program to sustain participation. This type of incentive structure—depending upon how lucrative the initial cash offer is—captures a larger portion of the targeted population at program inception (usually requiring the completion of a health risk assessment) than ever intends to actually participate in the core intervention programs, as they're usually in it only for that first payoff. Overall, such programs attract and retain only that very small percentage that is already highly motivated to improve their health status: that is, those that likely didn't need the initial offer paid to them.

In other words, employer groups and other organizations offering these one-time incentive payments potentially pay much more than is needed to recruit their at-risk populations for health and disease management intervention programs. Offering additional incentives throughout the intervention phase helps to both attract and retain additional participants, but the cost burden is more than many organizations are prepared to add to the overall program expense. In addition, though the interventions programs themselves are usually designed from a strong science of behavior change base, the one-size-fits-all incentives used to attract and retain consumers fail to take into consideration what will really motivate the largest numbers of consumers to participate. So again, the vast majority of people in need of these programs fail to utilize them.

### Enhancing incentive response by changing the incentive model through partnership

Many current incentives programs only scratch the surface, resulting in low participation levels among employees and fail to engage a large portion of those most in need of help—and further fail to sustain active participation among those who do initially respond. This failure is a given, based on the way we think about incentives as well as about the realities around employer funding limitations for such programs. But how might the picture change if we were to:

1. Enable each consumer the ability to choose his or her own rewards program—that is, effectively creating a sort of U-Promise model spanning multiple reward program-offering companies to allow consumers the option to increase their earned points in programs in which they're already enrolled. Membership in U.S. loyalty rewards programs has reached 1.8 billion, with the average U.S. household enrolled in 14.1 loyalty programs and actively participating in 6.2 of them. <sup>21</sup>
2. Remove employer funding hurdles from the equation.

We can achieve both goals by aligning the incentives of two other very powerful parties which also have a vested interest in the outcome of consumer health improvement and who are already intrinsically intertwined

in consumer workflow – retailers and manufacturers of health products (Rx, OTC, CPG, and DME). Some of the benefits for their aggressive participation in the equation include increases in:

- Store/chain and brand loyalty.
- Sales volumes of featured products.
- Ability to integrate or enhance existing rewards programs that many retailers already have in place – upwards of 352 million consumers currently enrolled in drugstore, supermarket, and mass merchant programs<sup>21</sup> – to extend to a health rewards offering, giving registered users not only additional points or discounts based on their volume of purchases, but also on their participation in a wide range of health management offerings. See Appendix C for examples of qualifying health rewards in retail-based health management programs.
- More efficient, cost-effective, scalable, targeted programs (the holy grail: connecting the right consumer with the right message at precisely the right time), could revolutionize the very practice of consumer advertising, moving it away from mass, scattershot communication (with corresponding massive “misses” in reaching your target audience) to very tightly defined, controlled, and measurable micro communications that your targets anticipate and respond to.
- Participation in their own employee health programs: retail chains and manufacturers are some of the very largest employers in the U.S., and such retail-driven health management programs could well provide substantial, quantifiable health benefit savings via wider employee utilization at a lower cost than traditional health management programs.

## Section VII:

### LEVERAGING RETAIL'S INFLUENCE

It is these three highly compelling and most overlooked factors—relationship, workflow and incentive—that retailers, more than any other segment of the healthcare delivery system, have the greatest influence over in engaging consumers to adopt healthier lifestyles. Indeed, drugstore, supermarket, and mass merchant retailers are uniquely positioned to:

- Spark a major revolution in consumer health and wellness.
- Become consumers' first choice for information, products, and services to improve their health, increasing sales of those products and services.
- Capture a large share of online advertising revenues for products currently being absconded by eHealth sites, by providing manufacturers with highly targeted shopper populations.
- Greatly enhance Rx, OTC, CPG and other health-related product sales.

#### **Models of engagement: Critical consumer health issues where retail can have enormous impact**

Consider two examples of how retailer-based health management programs could contribute significant savings to consumers and employers, increase productivity, enhance health outcomes to a wide number of participants, and help recover our faltering economy:

##### **Overweight/Obesity Issue**

Overweight and obese adults pose a grave economic threat in regard to illness, disease and lost productivity. This problem costs the nation \$61 billion annually in medical services, medications and products to treat the diseases inherent to being overweight and obese. It costs \$56 billion annually in productivity lost to illness or death. Direct contributors to the obesity problem include a sedentary lifestyle, recreational and addictive eating. See Appendix A., Costs of Obesity.

The problem of obesity is a multidimensional one, requiring an interdisciplinary approach. Consumers must take responsibility, but the outcomes can be expected to be more successful if taking responsibility for healthier choices is encouraged and rewarded. Encouragement can come from manufacturers, the government and retail.

Retailers are in a unique position to deliver nutrition/weight management programs that are both turnkey and highly personalized for their shoppers and that can track and reward participation—making them ideal new vehicles for targeted marketing opportunities for manufacturer partners. Components of a sample program could include but not be limited to the following:

- Enable consumers to set up personalized nutritional planners for themselves and family members (based on desired weight loss goals, BMI, recommended daily caloric input, etc.)
- Programmatically track and reward participation via shopping card data
- Increased rewards given for additional participation (daily food diary, fitness trackers, etc.).
- Personalized menu planners (based on goals and daily caloric recommendations), recipes and integrated shopping list functionality.
- Social networking modules to provide ongoing support and continuous utilization.

## Medication Adherence Issue

Research also shows that medication adherence—the term used broadly to signify that a patient on a prescription product for the management of a chronic condition such as diabetes, asthma, or hypertension is being both “compliant” (takes the drug as prescribed by his health care professional) and “persistent” (remains “on therapy” for the entire intended course of treatment)—is by far the most cost-effective way to produce the greatest health benefits in patients with high-cost chronic conditions. Strict adherence to a doctor-prescribed medication regimen produces the best outcomes and decreases the number of emergency room visits and other adverse and even catastrophic events (heart attacks, strokes, acute respiratory distress, etc.). Yet study after study shows that the “decay curve” for many so-called maintenance drugs—that is, the point at which patients typically “fall off” therapy (stop taking the drug or begin a pattern of very sporadic dosing)—frequently begins after the first month and quickly bottoms out by month three—producing significantly negative outcomes for everyone with a stake in that patient’s health. See Appendix E., Medication Adherence Case Study

For the patient, the cost can be as minimal as a lost day or two of work up to a catastrophic event possibly leading to disability, long-term impairment, or even death. For the provider, the result could be diminished health grade scoring and the financial impact on reimbursements. For the employer, lost productivity coupled with the looming specter of year-on-year double-digit increases in employee health benefits is crippling both financially as well as psychologically. For the drug’s manufacturer, the cost in lost sales is just as dramatic, particularly in this day of shrinking pipelines and few approved next-generation blockbusters on the horizon<sup>22</sup>. For community pharmacy, the lost dispensing fees on the number of prescriptions that figure represents is a staggering amount. (According to the Food Marketing Institute’s 2008 Food Retailing Technology Benchmarks study, the average MTM client, for example, uses 8.5 maintenance medications and spends \$4,000 annually on those medications, and non-adherence is a critical issue with this particular population.) If this revenue loss is remedied, it could lift the rapidly dwindling fortunes of retailers both small (e.g., single store independent pharmacies) and large (Rite Aid, Kroger, Target, et al). For the U.S. economy, the following statement from the 2008 Pharmacy Principles for Health Care Reform, illustrates how critical finding this adherence fix is:

“Our nation’s pharmacists play a critical role in providing affordable, accessible and quality health care. Proper use of prescription medications helps improve quality of life and health outcomes. However, the health care system incurs more than \$177 billion annually in mostly avoidable health care costs to treat adverse events from inappropriate medication use. The proper use of medication becomes even more important as treatment of chronic disease costs the health care system, \$1.3 trillion annually, or about 75 cents of every health care dollar.”<sup>23</sup>

When proper use of prescription medications does not happen, medication-related problems (MRPs) occur, and these are costly. MRPs rival the costs of cardiovascular disease and are more than the direct health care costs of diabetes and Alzheimer’s disease combined. For every dollar spent on prescription medications, we spend approximately the same amount treating MRPs associated with those medications.<sup>24</sup>

Reasons for this lack of better medication adherence range from mild to serious side effects to financial considerations (decisions especially among the elderly to forgo either food or expensive drugs) to confusing or lax prescriber instructions about the critical importance of staying on ones’ drug regimen, to lack of follow-through—by manufacturers and retailers—at the point of dispensing; in stores themselves and especially right at

the pharmacy counter. While the first factor presents a challenge not easily addressed in this article, the latter two factors are eminently fixable via pharmacist counseling at the highest touch to education, awareness and reminder programs at the most turnkey—all of which can be delivered at scale via electronic means (online, email, text, IVR) to registered users. See Appendix F, Supermarkets Help Evolve MTM.

## Funding the solution

Potential channels for funding the development and deployment of any retail industry-led consumer health management solution include:

- **Manufacturers:** new and redirected marketing spend—including monies currently going to eHealth site advertising—from supplier partners eager to reach more highly targeted consumer health-seeker populations.
- **Retailers themselves:** this component could be achieved not necessarily through new cost outlays but instead by intelligent redirection of current investment in:
  - Health benefits, specifically cost reductions resulting from employee and beneficiary utilization of the solution.
  - Marketing spend, with redeployment of a portion of traditional mass-marketing tactics to the more highly targeted vehicles that an electronic, data-driven solution provides.
- **Consumers:** the model pioneered in the 80's by Price Club – now Costco – could potentially be adapted by retailers to offer their most health conscious shoppers enhanced savings and benefits on health-related products and services in exchange for a small upfront membership fee. Consumers have widely embraced the warehouse club concept, understanding the quid pro quo of larger savings they'll achieve for their initial \$40 - \$50 annual club membership investment, and millions of them also routinely pay significant monthly or annual fees for membership in health clubs and online and offline health and weight management centers (Weight Watchers, Jenny Craig, etc.).

Could a significant percentage of health-seeking consumers be similarly motivated to pay a nominal enrollment fee (say, \$20/year) for the promise of bonus rewards points or additional savings on health-related products – or even be willing to pay more (perhaps \$5/month) for a Platinum Health Rewards offering that also delivered increased savings on prescription medications as well as advanced online personal weight and health management instruction, meal planning, trackers, and other tools similar to those provided by companies such as Weight Watchers and various eHealth sites?

Even more grandiose: could a large number of the vast uninsured population – 45 – 50 million Americans, by many accounts – purchase health insurance through a partnership between health plans and retailers? Retailers and managed care organizations have long worked together on a variety of issues of mutual concern and benefit; could they now work together on a solution to the uninsured problem, where MCOs design basic coverage plans offered at low cost to large populations that are aggregated by retailers?

- **The American Recovery and Reinvestment Act:** a portion of the stimulus package is dedicated to Health Information Technology, much of which can be standardized and widely promoted by the Retail sector.

The stimulus package recently passed by Congress commits \$20.8 billion for improved health information technology<sup>25</sup>. A well-designed retail-based consumer health initiative could be eligible for funding consideration, delivering as it can the following:

- Consumer/patient education and awareness programs: personalized for and targeted to the individual consumer and provided with the frequency and in the electronic format of the consumer's own choosing (online, e-mail, text to mobile device, voice, etc.).
- Personal Health Records: Retail is uniquely positioned to drive availability and utilization of PHRs by a wide segment of the population and to incorporate data-driven capabilities that enable, among other benefits, superior prescription drug management and weight management tools for patients and their providers.
- E-prescribing: promotion and standardization of e-prescribing capabilities will result in the vast cost efficiencies and reduced medication errors envisioned by more widespread adoption, and retail pharmacy is the commercial hub through which this initiative can be most effectively driven.
- Electronic Medical Records: Retail – through pharmacy and the growing retail clinic segment (including increasing partnerships with health systems a la the Wal-Mart model)—has the greatest throughput and commercial incentive to drive connectivity across the healthcare continuum.

Retail—or at least retail pharmacy—has already begun staking a claim for involvement in the development and potential funding of HIT components it touches upon. In a statement about the stimulus package, the Healthcare Distribution Management Association said:

“Needed and appropriate investments in prevention and wellness programs, health IT, electronic health records, e-prescribing and interoperability will improve quality of care, reduce costs, decrease or eliminate medical errors and enhance information about the use of pharmaceuticals.”<sup>26</sup>

Likewise, Principle III(A) of the Principles of Healthcare Reform issued by a pharmacy-related coalition including FMI, NACDS, NCPA, and APhA asserts that reform efforts should:

“...provide pharmacists electronic access to critical patient health care information, including diagnosis and laboratory values. This information must be provided through an interoperable electronic health record system, including electronic prescribing, that supports multi-directional communications among various health care providers and settings.”<sup>23, 26</sup>

Finally, the National Council for Prescription Drug Programs (NCPDP) stated the case for its members thus:

“Pharmacists and pharmacies will play a greater role in improving continuity of patient care and therefore medication adherence and outcomes. . . NCPDP is expanding its activities to support these goals by engaging its members and other stakeholders in removing barriers, enhancing system interoperability and developing the standards needed to support the patient-centered pharmacy care model of the 21st century.”<sup>26</sup>

Only a fraction of the full \$20.8 billion—especially when coupled with the vendor and retailer support mentioned above—would fund an industry-wide initiative, enabling retail to become the vital change agent alluded to throughout this paper.

## VIII. CALL TO ACTION

To reiterate this paper's thesis, the solution to revitalizing health care, consumer health and wellness, the economy as a whole and retailing in particular can be found in the retail sector itself. However, it will require a solid majority of the players in that sector, if not the entire sector, to come together in an unprecedentedly cohesive fashion to develop and deploy a unified vision and strategy that temporarily sets aside short-term competitive issues for the longer term collective good.

Independent and chain drug, supermarket and mass/club retailers, working in concert through the various trade associations (FMI, NACDS, NCPA, GMDC, etc.), supplier partners, wholesalers, and other buying groups—the sum of the parts of the retail industry truly being greater than the whole—would produce even faster and more stunning results, assuming competitive issues can be resolved to accomplish this greater good.

But the time to act is NOW; there may never be another such opportunity for the retail industry to affect real change, and the alternative to swift and assertive action is relegation to an even more diminished role in the new health care delivery system. The attendee list at President Obama's recently concluded Healthcare Summit illustrates the lack of prominence that the retail sector has in the current discussion about how best to reengineer health care and foreshadows the threat of being shut out of the debate permanently. Practically every conceivable health care entity was invited to participate in the Summit (See Appendix G., White House Healthcare Summit Attendee List), but not one health care retailer or wholesaler or their various trade associations was granted access. A large number of the invited players represent fairly narrow special interest groups and even the largest of those organizations cannot hold a candle to the economic clout (\$893 billion for just the 75 largest retailers) of the overall food/pharmacy industry (see Appendix H., Economic Clout of Health Care Retailers) – nor do they have anywhere near the active role, with quantifiable health outcomes, in consumers' lives that retail can boast.

In spite of the fact that retail community pharmacy is far and away the most accessible and frequented health care venue for Americans, somehow the perception of it as a critical component of the overall delivery system is well below every other part of the system in the minds of consumers, lawmakers, and even the health care industry itself. For example, consider pharmaceutical manufacturers, a group that was invited—albeit in a somewhat minor role considering their size and perceived impact on the system. Pharma manufacturers will be a big part of any retail-driven initiative, but even they currently do not have a good awareness of retail's potential leading role in the coming revolution, as evidenced by brand marketing's continued allocation of the bulk of their marketing spend aimed at physicians, with an extremely small percentage going retail's way.

**The solution** to revitalizing health care, consumer health and wellness, the economy as a whole and retailing in particular can be found in **the retail sector itself.**



The retail industry clearly recognizes its potential and economic prominence and has signaled—through its various trade associations—a strong desire to insert itself into the process, as demonstrated in the following statement from NACDS’ 2008 – 2009 Chain Pharmacy Industry Profile (see Appendix I. for additional relevant retail pharmacy statistics from this report):

“In the NACDS Principles of Healthcare Reform, the Association highlights a logical case for pharmacy’s vital role in the healthcare delivery system, and describes its view of essential components for any healthcare reform initiative. Using chronic care as an example, the white paper lays out the following case: “In addition to its dramatic human costs, chronic disease is responsible for the vast majority of healthcare spending. Pharmacist-provided care can improve outcomes for patients with chronic disease, and reduce costs. Therefore, public policy strategies should incorporate the value of pharmacy, and certainly should not jeopardize the viability or accessibility of pharmacies.

Regarding the NACDS economic analysis, the total economic impact of retail stores with pharmacies reaches well beyond their \$827 billion in annual sales. In fact, based on an analysis by NACDS, retail stores with pharmacies have a total annual economic impact of \$2.42 trillion, based on 2007 data. That is the equivalent of approximately 17% of the gross domestic product. Every one dollar spent in these stores creates a ripple effect of \$2.93 throughout other segments of the economy. That includes agriculture; manufacturing; construction; transportation and warehousing; finance and insurance; information technology; real estate; educational services; professional, scientific and technical services; and many more. However, public policy—such as pharmacy reimbursement models for government programs that reimburse pharmacies at less than their cost for some drugs—can jeopardize the ability of pharmacies to perform their vital role in healthcare delivery, as well as their ability to help drive the economy.

In promoting awareness of these and other compelling facts, NACDS looks forward to the ongoing and energizing work to foster the health of the community by advocating for pharmacies—the face of neighborhood healthcare.”

I encourage the industry to flex the economic muscles represented in the passage above to move boldly beyond ensuring that admittedly important issues such as reimbursement models get resolved to insisting that it be given its due place of prominence in driving the very development and implementation of the new model of health care delivery in this country. Failing that, the industry has the capital and people resources, supply chain infrastructure, creative and technological knowhow, and shared collaboration incentives to create—and if necessary even impose—its own solution on a nation eager for leadership on this issue. Rob Eder, editor-in-chief of Drug Store News, recently wrote about the importance of the private sector leading on health care reform. In his column on March 16, 2009, he wrote:

“As our government wrestles with the challenge of how to fix health care, lawmakers need to trust the private sector to lead us in the right direction. Because when you take a really close look at it all, you realize that so far, the private sector has led the way on much of what seems to constitute ‘health reform’ in this country.”

Not taking action will result in the missed opportunity of a lifetime, an opportunity to have a profound and lasting impact on both the physical and economic health of this nation and to ensure the spirit of innovation and free enterprise in the retail sector continues for many years to come.

### About the author:

Dave Nazaruk is Senior Vice President, Retail Business Development for StayWell Custom Communications, a division of StayWell/MediMedia USA, the world's leading provider of patient education and consumer health information.

StayWell recently launched the Retail Health Platform, which combines a fully customizable private label health portal with powerful, permission-based e-marketing capabilities that enable retailers to register and then continuously deliver personalized health content coupled with contextually relevant product ads and offers to their health information-seeking consumers in a variety of formats. For more information, contact Dave at [david.nazaruk@staywell.com](mailto:david.nazaruk@staywell.com) or 267-685-2809.

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## APPENDIX

### Appendix A. Costs of Obesity

**Example 1:** The economic impact of obesity and overweight population in terms of illness, diseases and lost productivity is significant. According to 2005 statistics, overweight and obesity costs total \$117 billion in the United States. The World Bank has estimated the cost of obesity in the U.S. at 12 % of the national health care budget, according to the Worldwatch Institute. These costs are shouldered by employers, workers and states in the form of worker absenteeism, loss of productivity, health care premiums, out-of-pocket expenses and co-payments.

- Direct cost is \$61 billion. Indirect cost is \$56 billion.
- Direct costs include the cost of physicians and other professionals, hospital and nursing home services, the cost of medications, home health care and other medical durables. Indirect costs include lost productivity that results from illness and death.
- Cancer costs related to overweight and obesity:  
**Breast cancer:** Total cost: \$2.9 billion,  
Direct cost: \$1.1 billion,  
Indirect cost: \$1.8 billion  
**Endometrial cancer:**  
Total cost: \$933 million,  
Direct cost: \$310 million,  
Indirect cost: \$623 million  
**Colon cancer:** Total cost: \$3.5 billion,  
Direct cost: \$1.3 billion,  
Indirect cost: \$2.2 billion
- Type 2 diabetes costs related to overweight and obesity: cost is \$98 billion (total).
- Osteoarthritis costs related to overweight and obesity: Total cost is \$21.2 billion. Direct cost is \$5.3 billion. Indirect cost is \$15.9.
- Hypertension (high blood pressure) costs related to overweight and obesity: Direct cost \$4.1 (17 % of the total cost of hypertension).

- Gallbladder disease costs related to overweight and obesity: Total cost: \$3.4 billion, Direct cost: \$3.2 billion, Indirect cost: \$187 million.
- Lost productivity costs related to obesity (BMI > 30) among Americans ages 17-64 is \$3.9 billion. This value considers the following annual numbers (for 1994):
- Workdays lost related to obesity: 39.3 million  
Physician office visits related to obesity: 62.7 million  
Restricted activity days related to obesity: 239.0 million  
Bed-days related to obesity: 89.5 million
- Less than one-third (31.8 %) of U.S. adults get regular leisure-time physical activity (defined as light or moderate activity five times or more per week for 30 minutes or more each time and/or vigorous activity three times or more per week for 20 minutes or more each time). About 10 % of adults do no physical activity at all in their leisure time.
- About 25 % of young people (ages 12-21 years) participate in light to moderate activity (e.g., walking, bicycling) nearly every day. About 50 % regularly engage in vigorous physical activity. Approximately 25 % report no vigorous physical activity, and 14 % report no recent vigorous or light to moderate physical activity
- Direct costs of physical inactivity are estimated at over \$24 billion

Sources include: National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), American Heart Association, U.S. Department of Health and Human Services. <<http://www.nutristrategy.com/econcost.htm>>

**Example 2:** January 2009 numbers posted by the National Center for Health Statistics, which is part of the Centers for Disease Control and Prevention, show that more than 34 % of Americans are obese, compared to 32.7 % who are overweight. It said just under 6 % are "extremely" obese. Other findings from the study include:

- More than one-third of adults, or over 72 million people, were obese in 2005-2006.

- Although the prevalence of obesity has more than doubled since 1980, the prevalence of overweight has remained stable over the same time period.
- In the 1988-1994 surveys, 33 % of Americans were overweight, 22.9 % were obese and 2.9 % were morbidly obese. The numbers have edged up steadily since.
- Being overweight or obese raises the risk of heart disease, diabetes, some cancers, arthritis and other conditions.
- In May, the CDC reported that 32 % of U.S. children fit the definition of being overweight, 16 % were obese and 11 % were extremely obese. Childhood and adult obesity has emerged as a growing problem not only in the United States but also in many countries around the world.

Source: <http://www.reuters.com/article/healthNews/idUSTRE50863H20090109>

**Example 3:** Researchers from Johns Hopkins Bloomberg School of Public Health expect that by 2030, 86% of U.S. adults will be overweight or obese, with related health care spending projected to be as much as \$956.9 billion. They concluded that without a change in people's eating habits or exercise habits, the figures will continue climbing to a public crisis. Researchers also found:

- Obesity and obesity-related conditions result in \$62.7 billion in doctors' visits and \$39.3 billion in lost workdays each year.
- In the 1990s, Americans' average weight increased by 10 lb, which meant that airlines spent \$275 million on fuel costs in one year to account for that average increase in weight.
- 1 billion additional gallons of fuel are consumed annually in the United States as a result of average passenger weight increases since 1960.
- At the level of employment, a recent study by Hertz et al showed that obesity has essentially the same effect as 20 years of aging on employees' ability to work.
- Researchers with Stanford University found

that obese people earn, on average, \$3.41 per hour less than their peers, translated into about \$7,000 in lost income a year.

- Results of another study has shown that the annual additional insurance cost for a worker who is obese can reach \$2,500.
- On a national and state level, medical expenses for overweight and obesity accounted for 9.1% of total U.S. medical expenditures in 1998 and may have reached as high as \$78.5 billion (\$92.6 billion in 2002 dollars).
- Obesity-attributable Medicare and Medicaid estimates range from \$15 million to \$1.7 billion and from \$23 million to \$3.5 billion, respectively, depending upon the state.

Source: <http://www.endocrinetoday.com/view.aspx?rid=35574>

**Example 4:** Lifetime medical costs attributable to five conditions (high blood pressure, diabetes, heart disease, stroke and high cholesterol) are \$10,000 higher for the moderately obese than for those at a healthy weight.

Source: U.S. Centers for Disease Control and Prevention. Preventing Obesity and Chronic Disease Through Good Nutrition and Physical Activity. National Center for Chronic Disease Prevention and Health Promotion, July 2003. <http://0-www.cdc.gov.mill1.sjlibrary.org/nccdp/ publications/factsheets/Prevention/pdf/obesity.pdf>.

**Example 5:** A paper written for the Analysis Group, Inc., Boston studied the short-term economic impact of body weight change among patients with type-2 diabetes. Economic benefit of weight loss was evident among type 2 diabetic patients on antidiabetic therapy, especially among obese patients.

- Weight loss significantly reduced diabetes-related costs.
- Controlling for baseline factors in the regression model, the 1-year total health care cost following 1% weight loss (or gain) was \$213 cost decrease (or increase).
- Diabetes-related cost did not appear to be associated with weight gain.

Source: [http://www.ncbi.nlm.nih.gov/pubmed/17669232?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_DiscoveryPanel.Pubmed\\_Discovery\\_RA&linkpos=3&log\\$=relatedreviews&logdbfrom=pubmed](http://www.ncbi.nlm.nih.gov/pubmed/17669232?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DiscoveryPanel.Pubmed_Discovery_RA&linkpos=3&log$=relatedreviews&logdbfrom=pubmed)

**Example 6:** A dynamic model was developed by Oster et al. (31) that projected the lifetime economic benefits of a sustained, modest weight loss (10%) considering five obesity-related diseases (hypertension, hypercholesterolemia, type 2 diabetes, coronary heart disease, and stroke). They project that a modest weight loss, if sustained, would increase life expectancy by 2 to 7 months and reduce lifetime medical-care costs of these five diseases by \$2200 to \$5300.

Source: <http://www.ajph.org/cgi/content/abstract/89/10/1536>

## Appendix B.: Related e-Health Statistics

**Example 1:** Recent research conducted by Manhattan-based Hall and Partners Healthcare found that online health consumers are hyper-engaged and leverage almost twice as many information sources to learn about disease states and prescriptions than the average consumer.

- 75% of e-health consumers share online health information with others.
- Health searchers crave information and interaction.
- Online searchers are so engaged that they look for information on more than just one condition and seek to learn about multiple conditions and symptoms.
- These consumers spend more time on search engines (68%) and health sites (51%) than with family and friends (18%) to seek information about symptoms, diagnosis and prescriptions.

Source: [us.i1.yimg.com/us.yimg.com/it/us/ayc/pdf/aa\\_insights\\_socmedphrma.pdf](http://us.i1.yimg.com/us.yimg.com/it/us/ayc/pdf/aa_insights_socmedphrma.pdf)

**Example 2:** Research shows that 80% of internet users go online for health information which translates to 8 million Americans who look online for health information on a typical day. This places health searches at about the same level of popularity on a typical day as paying bills online, reading blogs, or using the internet to look up a phone number or addresses.

Online Health Search 2006: Summary of Findings at a Glance
Eight in ten internet users go online for health information.
Eight million American adults look online for health information on a typical day.
The typical search for health information online starts at a search engine, includes multiple sites, and is undertaken on behalf of someone other than the person doing the search.
Most health seekers are pleased about what they find online, but some are frustrated or confused.
Three-quarters of health seekers do not consistently check the source and date of the health information they find online.
Successful health information searches may bolster health seekers' confidence.
Source: Fox, Susannah. <i>Online Health Search 2006</i> . Washington, DC: Pew Internet & American Life Project, October 26, 2006.

**Example 3:** Specifically related to the pharmacy market: 49% of users search for nutritional and vitamin supplements, 37% search for Rx or OTC drugs, 27% search for alternative treatments and 64% search for specific information on a disease or medical problem.

Health Topic	Internet Users Who Have Searched for Info on It (%)		
	2002	2004	2006
Specific disease or medical problem	67%	66%	64%
Certain medical treatment or procedure	47	51	51
Diet, nutrition, vitamins, or nutritional supplements	44	51	49
Exercise or fitness	39	43	44
Prescription or over-the-counter drugs	34	40	37
A particular doctor or hospital	29	26	26
Health insurance	25	31	26
Alternative treatments or medicines	23	30	27
Depression, anxiety, stress, or mental health issues	21	23	22
Environmental health hazards	17	18	22
Experimental treatments or medicines	16	23	18
Immunizations or vaccinations	13	16	16
General health information	9	9	15
Medicare or Medicaid	6	11	13
Sexual health information	10	11	11
How to quit smoking	6	7	6
Problems with drugs or alcohol	3	3	3

\*The question was not asked in the 2002 and 2004 surveys.  
Source: Pew Internet & American Life Project December 2002 Survey (n=1,221), November 2004 Survey (n=937), August 2006 Survey (n=1,396)

## Appendix C.: Examples of Qualifying Health Rewards for Retailer-Based Health Management Programs

**Example 1:** Registered users are awarded additional points (or points specific to the Health Rewards program) based on the following health-related activities:

- Purchases intelligently mapped to the user's Healthy Eating Weight Management Plan via the rewards card
- Utilization of weekly meal planner and shopping list functionality
- Click-through to retailer Web site from weekly Health Rewards e-newsletter
- Forwarding the e-newsletter to a friend
- Filling out PHR or HRA on the retailer's site
- Utilizing the auto-fill feature for user's prescriptions

- Utilization of daily food diaries and activity trackers featured on retailers Web site
- Responding to periodic surveys about their health concerns
- Taking a quiz or condition-specific health assessment or watching or listening to a recommended video or Podcast
- Signing up for health-related social networking program offered by retailer

## Appendix D.: Retailer-based Employee Wellness Programs in the News

### Article 1: Some U.S. companies reforming healthcare in-house

Tue Apr 14, 2009 11:12pm EDT

By Maggie Fox, Health and Science Editor

WASHINGTON (Reuters) - Companies impatient to rein in healthcare costs can go ahead on their own without waiting for federal legislation, Safeway Inc. president Steven Burd said on Tuesday.

He said that making employees at the third-largest North American supermarket chain accountable for their weight, smoking, cholesterol and blood pressure, has saved millions. Burd proposed the highly praised program used by his company as a model not only to other companies, but to the federal government.

"If you are part of a large organization, you really don't have to wait for government to do anything," Burd told the World Health Care Congress being held in Washington. "You can design your own healthcare reform.

"In effect your behavior is a form of currency," said Burd, who is also Safeway's chairman and chief executive officer.

Healthcare reform is a priority of both the administration of President Barack Obama and this year's Congress -- both of which say some kind of legislation must be passed this year.

Americans spend more on healthcare than resi-

dents of any other country, yet some 46 million lack health insurance. The cost of care and insurance has been rising rapidly with healthcare costing \$2.2 trillion in 2007, or \$7,421 per capita.

Healthcare accounts for more than 16 % of gross domestic product, nearly twice the average of other developed nations. This is projected to rise to 25 % of GDP in 2025.

It costs Safeway \$1 billion a year for 200,000 employees, Burd said, adding that the program had held those costs level since 2005.

Burd agrees with experts who say chronic diseases such as heart disease and cancer are responsible for most of this spending, and that behavior such as smoking, lack of exercise and poor diet are responsible for up to two-thirds of cases of cancer and heart disease.

"We took advantage of a little-known fact; that is that 70 % of healthcare costs are driven by behaviors," Burd said.

### LOWER SCORES PAY MORE

Safeway, which operates 1,775 grocery stores in the United States and Canada, has been running an experiment called Healthy Measures among 30,000 nonunion workers. Burd said 74 % of them have signed up for the plan.

Employees have to be part of the program to qualify for a discount -- those who score the lowest pay 51 % more for health insurance premiums than those who score perfectly.

To take part, employees must submit to an annual cheek swab to prove they are not smoking, have their cholesterol and blood pressure measured and be weighed yearly.

Workers who flunk a test one year but who improve over the next get a rebate of some of the added premium, Burd said.

"We didn't add anybody to our staff to do this," he said. The company already had a fitness center at its headquarters and offers discounted gym memberships and a 24-hour nurse health hotline. It also encourages employees to get their health testing done at Safeway's 1,400 pharmacies.

Steve Lampkin of retailer Wal-Mart Stores Inc said his company's voluntary program, called the Personal Sustainability Project, has inspired hundreds of thousands of employees, which it calls associates, to adopt healthier behavior.

"Nearly 20,000 associates have quit smoking," Lampkin told the meeting. "Collectively, associates have lost more than 184,000 pounds (83,000 kg)," he added.

(Editing by Eric Walsh)

## PROGRESSIVE GROCER

### Article 2: Obama Cites Safeway Among Workplace Health Innovators

May 12, 2009

Calling Safeway president and CEO Steven Burd one "of the best practitioners of prevention and wellness programs in the private sector," President Barack Obama met with top executives from the retail sector and other industries to discuss innovative ideas that are being implemented in the workplace to improve the health of workers and reduce the rising rate of health care spending.

Yesterday's meeting with officials from Pleasanton, Calif.-based Safeway -- which also included four other employers, a state health department, and a union -- followed what the White House described as a "landmark meeting" on Monday between the president and an array of leaders in the health care field -- insurance companies, hospitals, pharmaceutical companies, medical device manufacturers, and providers -- which pledged to work together to control costs in health care to the tune of \$2 trillion in savings over the next 10 years.

This week's meetings stem from the president direction to the Office of Personnel Management to work with the Office of Health Reform, the National Economic Council, the Department of Labor, and

the Office of Management and Budget to examine successful employer wellness and prevention practices that lower health care costs and improve employees' health, and to explore the possibilities of developing a plan for federal employees and their workplaces.

More generally, the discussion was designed to expand on the theme that the health care system in America needs comprehensive reform, including a much greater focus on wellness and prevention. In his closing remarks after Tuesday's meeting, the president said the sessions accomplished the goals of gathering "stories and best practices" to further spur "the health care reform discussions that take place here in Washington," and in turn implement the proven effective measures "for the country as a whole."

"You have companies like Safeway that have been able to hold their costs flat for their employees at a time when other companies are seeing double-digit inflation in their health care," President Obama said while praising the grocery chain's innovative employee health care and wellness programs.

During the session, Safeway and its chief executive, Steve Burd, were singled out for an innovative benefits program designed to reward employees' healthy behaviors and improve adherence to recommended treatments for chronic diseases. Over 74 percent of Safeway's 30,000 nonunion workers have signed up for the "Healthy Measures" program, for which participants undergo screening tests (including cholesterol, blood pressure and weight control); employees who score well pay lower health premiums. Safeway has saved millions by making employees accountable for their weight, smoking, cholesterol and blood pressure. The company also has a free fitness center at its headquarters, offers gym membership discounts and provides a 24-hour nurse health hotline. In 2006, Safeway's efforts reduced its total health care spending by 13 percent, and employees who signed up have saved more than 20 percent on their premiums.

Aside from Safeway's Burd, other workforce innova-

tors who met with the president to discuss health-and-wellness best practices included Jerry Reeves of the Hotel Employees and Restaurant Employees International Union (H.E.R.E.I.U.) Welfare Fund; Bill Weldon, chairman/CEO, Johnson & Johnson; Cecily Hall, director of U.S. benefits for Microsoft; Alvin Jackson, director, Ohio Department of Health; Murray Martin, chairman/president/CEO, Pitney Bowes; and Sally Jewell, president/CEO, Recreational Equipment, Inc (REI).

Find this article at:

[http://www.progressivegrocer.com/progressivegrocer/content\\_display/features/corporate-social-responsibility/e3if21dd856cfb9103eae0ffb2732442cf5](http://www.progressivegrocer.com/progressivegrocer/content_display/features/corporate-social-responsibility/e3if21dd856cfb9103eae0ffb2732442cf5)

## **Appendix E: Medication Adherence Case Study**

### **Adheris Study Finds Antidepressant Discontinuation Most Likely at the Start of Therapy Among Newly Treated and Previously Lapsed Patients**

BURLINGTON, Mass.--(Business Wire)-- Fri Sep 26, 2008 9:32am EDT -- Adheris, Inc., a leader in patient adherence and education programs, announced today the results of a new study that examined adherence rates among patients on SSRI/SNRI antidepressant therapy.

Study results showed that patients new to antidepressant treatment and those who had restarted therapy after a lapse of 6 or more months were twice as likely to discontinue therapy in the first 30 days of treatment versus patients previously dispensed an antidepressant.

According to lead author Mark Vanelli, MD, MHS, a practicing psychiatrist at Harvard Medical School and Chief Medical Officer at Adheris, Inc., "The practical implications of this study are that while all patients lapsed at an alarming rate over time, increased patient

follow-up and education within the first 30 days of therapy in newly treated and lapsed patients restarting therapy are critical to help improve adherence and patient outcomes."

The study also found that the greatest differences in the duration of antidepressant use were observed not among patients taking different antidepressants, but among patients taking the same antidepressant but who had different levels of prior antidepressant experience. Such data suggests that modifiable factors associated with patient knowledge, attitude, and practice--not the use of a specific medication--are the appropriate focus of efforts to improve the effectiveness of antidepressant use and treatment outcomes. For newly treated or lapsed patients, the median time to discontinuation was 67 day versus 187 days for patients who had previously been dispensed an antidepressant. Antidepressants commonly treat depressive disorders, which are the second leading cause of lost productive years of life in the world today. Antidepressant treatment for 180 days or more is typically recommended to treat depressive episodes and to prevent relapse.

The study, to be published in the September issue of *Clinical Therapeutics*, included over 211,000 patients taking SSRI/SNRI from 1,157 retail pharmacies across the country.

Patients in the study received venlafaxine XR, sertraline, paroxetine CR, fluoxetine, escitalopram, or citalopram prescriptions between October 1, 2003 and March 31, 2004. Patients were followed over a year's time. The study was funded by Adheris, Inc.

Source: <http://www.reuters.com/article/pressRelease/idUS140632+26-Sep-2008+BW20080926>

## Appendix F: Supermarkets help evolve MTM.



### Example 1: Boomers Advance MTM

Mar 30, 2009 12:00 PM,

By CHRISTINA VEIDERS

Supermarkets are on track to help an aging population manage their disease states and drug therapies as the industry awaits health care reform and the resources available to pay for services

Medication Therapy Management (MTM) — a broad range of pharmacy consultative services to maximize medication effectiveness and use — should get a boost in 2011 when the first of 80 million Baby Boomers turn age 65.

Check out these statistics submitted in a report, “Medication-Related Problems in Older Adults: A Hidden and Costly Epidemic,” by the American Society of Consultant Pharmacists, to President Obama's transition team last year:

- Medication-related problems cost over \$200 billion in direct health care costs.
- Although people over age 65 make up only about 12% of the population, they account for over 36% of all reported adverse drug reactions.
- Adverse drug reactions and noncompliance are responsible for 28% of hospitalization in the elderly and 23% of nursing home admissions.
- Researchers estimate that about 25% to 30% of all medication-related problems are preventable.

While demand for MTM will be high, rising health care costs, a pullback in government support, and barriers to implementation of MTM services could curtail MTM progress in becoming a viable component of integrated health care.

Supermarkets to date have embraced MTM to var-

ious degrees. Cathy Polley, vice president of pharmacy services, Food Marketing Institute, Arlington, Va., said that 83.6% of supermarket pharmacies offer MTM services or plan to implement such service. The vast majority (96.3%) of all supermarket pharmacies offer MTM services in at least one location and are compensated for those services.

More than half of reimbursements to supermarket pharmacists for their clinical services are paid for by pharmacy benefit managers, 24% by Medicare and 8% by patients, said Polley.

While the majority of the food chains are practicing some form of MTM, most would agree that MTM practices are still evolving.

Jim Wonderly, vice president of pharmacy for Ahold's Stop & Shop/Giant Food, Quincy, Mass., said his organizations have limited experience with MTM in a few pharmacies in Maryland. “There is still much work to be done to educate the consumer and develop an effective staffing model,” he added.

Chains such as Minneapolis-based Supervalu have long pursued developing MTM programs in partnership with others. Medication Management Systems (MMS), also based in Minneapolis, a provider of MTM software and support services, is one such partner and is running a pilot with Supervalu in 22 Minnesota stores.

Supervalu could not be reached for comment, but Tom Albers, a founder of MMS and vice president of sales and marketing, said Supervalu has about five MTM-trained pharmacists, who rotate through the stores to conduct 30-minute patient assessments. The assessments are by appointment only.

MMS advocates a full patient assessment and follow-up. Albers said that MTM delivered in intervals (very brief advisory sessions) during the course of routine dispensing has proved less effective than full patient assessments that require 30 minutes or more of counseling. Reimbursement rates for such service are also higher — \$90 as opposed to \$8 to \$10 for a several-minute consultation.

Reimbursement is critical, but having a practice a payer can understand is equally as critical. There are 25 versions of MTM. This only confuses patients and

payers,” said Albers. “This is an effort to coordinate care, and that is where health care reform and medical reform comes in as well. We cannot have health care providers performing as an island. The costs are too high.”

John Fegan, vice president, pharmacy, Winn-Dixie Stores, Jacksonville, Fla., said the 405 pharmacies in the chain are well into MTM practices. Pharmacists concentrate on patient compliance. Once the pharmacist is assured patients are properly taking medications, Winn-Dixie then focuses on the medical condition. Fegan said protocols have been written by Winn-Dixie pharmacists for diabetes, women's health and cholesterol/hypertension. Pharmacists are also looking at Coumadin therapy, using the blood-thinning drug.

Winn-Dixie also offers free quarterly health screenings in partnership with Bayer and Cholestech. This gives pharmacists an opportunity to alert patients to Winn-Dixie's MTM services.

Working in conjunction with the American Pharmacists Association, Fegan said all of Winn-Dixie's pharmacists will be trained in inoculations. “The services our pharmacists will provide are going to be as valuable or more valuable than medications dispensed.”

Winn-Dixie is part of the Outcomes Pharmaceutical Health Care network. Outcomes, based in Des Moines, Iowa, is another facilitator of MTM services, with an emphasis on integrating MTM as part of the total pharmacy practice, including dispensing.

“We allow pharmacists to bill for services that occur within the workflow of the pharmacy. Picking up the phone to call a doctor about a formulary medication is a payable service in our program and can be billed. We have tools to help the pharmacy integrate that into the regular workflow of dispensing,” explained Brand Newland, Outcomes vice president.

Just how far MTM can be developed with support from the new Obama administration is anybody's guess.

But Anne Burns, a pharmacist and vice president of professional affairs for APhA, warns that the health

care reform debate is moving very rapidly. She said legislation could be introduced by early summer. “We're calling on pharmacists to be very engaged in this debate, and for those providing MTM services to invite congressional representatives and senators during the mid-April break to visit their local pharmacies to see the work being done.”

A positive sign comes with the Centers for Medicare & Medicaid Services' 2010 draft call letter proposal for new mandatory standards for Part D MTM programs. The new standards may make it easier for patients to qualify for MTM services, and it may lower the annual drug spend from \$4,000 to \$3,000. The final standards are expected in April.

According to CMS, less than 7% of Medicare Part D beneficiaries are eligible to receive MTM services under the eligibility requirements of existing Part D MTM programs, and only a small %age of eligible beneficiaries are actually served.

Bruce Kneeland, president of Pharmacy Connections, a consulting firm in Valley Forge, Pa., said grocery stores are best positioned to deliver MTM. The food retail channel offers the added value of the whole store combining nutrition for improved and better health. “You have frequency of visit, close proximity to the patient. Most grocery store pharmacies are underperforming, so the pharmacist has the time to be involved. That platform is the basis of success,” Kneeland said.

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**Example 2:** According to a 2008 Food Marketing Institute Supermarket Pharmacy Trends study, supermarket pharmacies use MTM:

- 49% use MTM in some or all pharmacies
- 35% plan to implement MTM
- 31% have a central facility for MTM records

Source: Food Marketing Institute. Food Retailing Technology Benchmarks 2008.

**Appendix G.:**  
**White House Healthcare Summit Attendees**  
**Community Leaders and Stakeholders (in alpha-**  
**betical order by organization name)**

AARP,

Bill Novelli, President

ADAPT,

Bobby Coward

AFL-CIO,

Gerry Shea, Assistant to the President for  
Governmental Affairs

AFSCME,

Gerry McEntee, President

AFT,

Randy Weingarten, President

AIDS Action

Rebecca Haag President and CEO

Alliance for Retired Americans,

Ed Coyle, Executive Director

America's Health Insurance Plans,

Karen Ignani, President and CEO

American Cancer Society,

Daniel Smith, President

American College of Physicians,

Jeff Harris, President

American Academy of Pediatrics,

David Tayloe, President

American College of Cardiology,

W. Douglas Weaver, President

American Academy of Family Physicians,

Ted Epperly, President

American Diabetes Association,

Larry Hausner, CEO

American Heart Association,

Timothy J. Gardner, President

American Hospital Association,

Rich Umbdenstock, President

American Medical Association,

Nancy Nielsen, President

American Nurses Association,

Rebecca Patton, President

Asian and Pacific Islander Health Forum,

Dr. Ho Tran, Executive Director

Association of Asian Pacific Community Health  
Organizations,

Jeff Caballero, Executive Director

Building and Construction Trades Department,

Mark Ayers, President

Better Health Care Together,

Jody Hoffman, Executive Director

Blue Cross Blue Shield Association,

Scott Serota, CEO

Campaign for America's Future,

Roger Hickey, Founder and Co-Director

Campaign for Mental Health Reform,

William Emmett, Director

Catholic Health Association,

Sister Carol Keehan, President and CEO

CCD Health Task Force,

Peter Thomas

CED,

Charlie Kolb, CEO

Center for American Progress,

John Podesta, President and CEO

Change to Win,

Anna Burger, Chair

Children's Defense Fund,

Marian Wright Edelman, Founding President

Columbia University Mailman School of Public  
Health,

Irwin E. Redlener, M.D.

Communications Workers of America,

Larry Cohen, President

Families USA,

Ron Pollack, President

Federation of American Hospitals,

Chip Kahn, President

General Mills,

Ken Powell, President and CEO

Health Care for America Now,

Richard Kirsch, National Campaign Manager

Hispanic Medical Association,

Elena Rios, President

Human Rights Campaign,

Joe Solmonese, President

Jennings Policy Strategies Group, Inc,  
Chris Jennings, President  
League of United Latin American Citizens,  
Brent Wilkes, Executive Director  
Markle Foundation,  
Zoe Baird, President  
National Association of Counties,  
Valerie Brown, Incoming NACO Chair  
National Association of Manufacturers,  
John Engler, President and CEO  
National Association of People with AIDS,  
Frank Oldham, President and CEO  
National Association of Community Health Centers,  
Tom Van Coverden, President and CEO  
National Council of La Raza,  
Janet Murguia, President and CEO  
National Jewish Hospital,  
Dr. Michael Salem, President  
National Congress of American Indians,  
Jacqueline L. Johnson Pata, Executive Director  
National Federation of Independent Businesses,  
Dan Danner, President  
National Indian Health Board,  
Stacey Bohlen, Executive Director  
National Medical Association,  
Mohammad Akhter, Executive Director  
National Partnership for Women and Families,  
Debra Ness, President  
National Business Group on Health,  
Helen Darling, President  
National Association of Children's Hospitals,  
Larry McAndrews, President and CEO  
National Association of Public Hospitals,  
Larry Gage, President  
National Rural Health Association,  
Dennis Berens, President  
National Coalition on Health Care,  
Henry Simmons, Founder  
National Association for Home Care & Hospice,  
Val Halamandaris, President  
National Women's Law Center,  
Marcia Greenberger, President  
National Minority AIDS Council,  
Paul Kawata, President

National Gay and Lesbian Task Force,  
Rea Carey, President  
National Hispanic Health Alliance,  
Dr. Jane Delgado, President  
National Education Association,  
Dennis Van Roekel, President  
Pfizer,  
Jeffrey Kindler, CEO  
Pharmaceutical Research and Manufacturers of  
America (PhRMA),  
Billy Tauzin, President and CEO  
Physicians for a National Health Plan,  
Dr. Oliver Fein, Director  
PICO,  
Scott Hersey Reed, Executive Director  
Planned Parenthood Federation of America,  
Cecile Richards, President  
Racial and Ethnic Disparities Health Coalition,  
Fredette West, President  
Robert Wood Johnson Foundation,  
Dr. Risa Lavizzo-Mourey, President and CEO  
SEIU,  
Dennis Rivera, Chair  
SEIU,  
Andy Stern, President  
Small Business Majority,  
John Arensmeyer, Founder and CEO  
Teamsters,  
Jim Hoffa, President  
Trust for America's Health,  
Jeff Levi, Executive Director  
UAW,  
Ronald Gettelfinger, President  
UFCW,  
Joe Hansen, President  
University of Chicago Medical School,  
Eric Whitaker, Executive Vice President For  
Strategic Affiliations  
University of Miami,  
Donna Shalala, President  
USW,  
Leo Gerard, President  
US Chamber,  
Tom Donohue, President

## Appendix H: Economic Clout of Health Care Retailers

### Top 10 North American Food Retailers

[source: SN's Top 75 Retailers for 2009]

Per Supermarket News: “The 75 largest food retailers and wholesalers in the U.S. and Canada combined to produce \$893.08 billion in revenues in 2008, up 7.6% over their total in the preceding year. The sales volume includes revenues from both food and nonfood merchandise in North America for the companies' current or recently ended fiscal years. The volume increase reflects both the high levels of food inflation — estimated at about 5%-6% in for the year — combined with traffic growth at the chains on the list. The 10 largest companies on the list accounted for about 68.7% of the total volume on the list, the same proportion they comprised a year ago. Those 10 largest food retailers had combined revenues of \$613.2 billion — up 7.5%, or \$42.9 billion, over year-ago levels. They accounted for about two-thirds of the increase in volume among the entire Top 75. The top 20 companies on this year's list had revenues of \$732.9 billion, up about 7.6% over year-ago volume levels. Those 20 largest operators accounted for 82.1% of the total volume among the Top 75, almost exactly the same as a year ago.”

Source: <http://supermarketnews.com/profiles/top75/2009-top-75/index.html?imw=Y>

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#### Top Food Retailers

**Wal-Mart Stores**  
Corporate Stores: 3,395  
Sales in \$ Billions:  
258.5 est.  
[378,799.0, per Fortune]  
Number of employees:  
2,055,000

**Kroger Co.**  
Corporate Stores: 4,397  
Sales in \$ Billions:  
77.2 est.  
Number of employees:  
323,000

#### Top Pharmacies

**Walgreens**  
Corporate Stores:  
5,997  
Sales in \$Billions:  
53,800

**CVS Caremark**  
Corporate Stores:  
6,245  
Sales in \$Billions:  
76,300

#### Top Drug Wholesalers

**McKesson Corp.**  
Sales in  
\$Billions: 101,000

**Cardinal Health**  
Sales in Billions:  
91,091.4

**Costco Wholesale Corp.**  
Corporate Stores: 544  
Sales in \$ Billions: 72.5  
Number of employees:  
98,500

**Supervalu**  
Corporate Stores: 2,491  
Sales in \$ Billions:  
45.0 est.  
Number of employees:  
191,400

**Safeway**  
Corporate Stores: 1,743  
Sales in \$ Billions:  
44.8 est.  
Number of employees:  
201,000

**Loblaw Cos.**  
Corporate/Franchise  
Stores: 1,036  
Sales in \$ Billions:  
31.5 (U.S.) est.

**Publix Super Markets**  
Corporate Stores: 990  
Sales in \$ Billions:  
24.0 est.

**Ahold USA**  
Corporate Stores:  
704  
Sales in \$ Billions:  
21.8

**Delhaize America**  
Corporate Stores:  
1,581  
Sales in \$ Billions:  
19.2 est

**C&S Wholesale Grocers**  
Corporate Stores: 0  
Sales in \$ Billions:  
19.0 est

**Rite Aid**  
Corporate Stores:  
5,059  
Sales in \$Billions:  
24,300

**Leader**  
Corporate Stores:  
3,350  
Sales in \$Billions:  
13,600

**Good Neighbor  
Pharmacy**  
Corporate Stores:  
2,700  
Sales in \$Billions:  
7,700

**Kmart**  
Corporate Stores:  
3,800  
Sales in \$Billions:  
50,700

**Target**  
Corporate Stores:  
1,613  
Sales in \$Billions:  
83,400

**Longs**  
Corporate Stores:  
510  
Sales in \$Billions:  
5,260

**Health Mart**  
Corporate Stores:  
1,850  
Sales in \$Billions:  
3,100

**Medicine Shoppe**  
Corporate Stores:  
1,397  
Sales in \$Billions:  
2,500

**AmerisourceBergen Corp.**  
Sales in \$Billions:  
70,189.7

**Owens & Minor**  
Sales in \$Billions:  
6,800.5

**Henry Schein**  
Sales in \$Billions:  
6001.3

**Patterson**  
Sales in \$Billions:  
2798.4

Additional Sources: Hoovers and Fortune 500 2008 listings

## Appendix I.: Chain Pharmacy Profile Statistics

### Chain Community Pharmacy in America The Story Behind the Face of Neighborhood Healthcare

Community pharmacy is essential to the healthcare delivery system. Its convenience, pharmacist consultations, and ability to help patients take their medications as prescribed and prevent other health problems deliver remarkable value.

For most Americans, the community pharmacy is their community health resource center, offering easy, convenient access to a trusted health professional. Indeed, pharmacists are among America's most trusted professionals who, working in alliance with other healthcare providers, play a pivotal role in monitoring and maintaining patient health.

Today, two out of every three patients who visit a doctor leave with a prescription. As medical science advances and doctors rely more and more on drug therapy, outpatient prescription drug use is now at an all-time high. In 2007, more than 3.5 billion prescriptions were filled in retail pharmacies – a 52% increase since 1997.

Chain pharmacy represents the largest component of pharmacy practice, comprising more than 22,000 traditional chain drug stores and an additional almost 17,000 pharmacies within supermarkets and mass merchant stores. The chain drug industry has more than 132,000 pharmacist positions (approximately 118,000 full-time equivalents) and more than 170,000 pharmacy technician positions, and fills about 72% of prescriptions dispensed annually in the United States.

Between 2006 and 2007, retail sales in traditional drug stores rose 4.1%, with prescription sales rising 3.4%. Overall, the retail prescription market reached nearly \$260 billion in 2007, and chain pharmacies accounted for more than 61% of retail prescription dollars (\$159 billion).

This thriving business has also secured pharmacies' place as valuable economic and business resources in their communities. In 2007, community pharmacies and their associated retail stores employed more than 2.6 million people and generated sales of more than \$820 billion.

The chain community pharmacy industry is growing in other ways as well. The pharmacist's role has grown and evolved over the years to become more inclusive of patients' healthcare needs as a whole. Patients can now look to their pharmacy as a total healthcare provider, and today's pharmacists play an important role in improving patient outcomes.

Pharmacists help patients with healthcare advice and guidance on their general prescription or over-the-counter medication information. Pharmacists are often on the front lines to guide patients through

their evolving healthcare needs. Much of a pharmacist's time is spent interacting with patients, identifying possible drug interactions, and advising how to best use an over-the-counter medication.<sup>9</sup>

In the age of convenience – with 24-hour and drive-through pharmacies – pharmacists understand the need for fast and effective prescription and healthcare information. Pharmacists seek money-saving alternatives for their patients such as offering generic substitutions or informing patients about various prescription drug coverage plans that are available.

Today's pharmacies offer a variety of healthcare screenings and programs for a wide range of ailments and illnesses so that patients may maintain a healthy lifestyle. Pharmacies are creating, or partnering with, centers or clinics where patients can obtain information on asthma and diabetes as well as take screening tests for blood pressure, cholesterol, and osteoporosis, or receive flu shots. Often the centers or clinics are staffed by a nurse, resident, or clinical pharmacist practitioner. Several health policy visionaries have cited these venues as potential solutions to more costly options in healthcare delivery, and the future of these clinics or centers is at the heart of strategic discussions within companies and from an industry-wide perspective.

The chain pharmacy industry looks forward to promoting the safe use of medications and providing patients with the medications they need with the help of local community pharmacists they know and trust.

#### NACDS: The Voice of Chain Pharmacy

The National Association of Chain Drug Stores (NACDS) represents traditional drug stores, supermarkets, and mass merchants with pharmacies. Its more than 170 chain member companies include regional chains with a minimum of four stores to national companies. NACDS members also include more than 1,000 suppliers of pharmacy and front-end products, and nearly 90 international members representing 29 countries. Chains operate more than 39,000 pharmacies, and employ a total of more than 2.5 million employees, including 118,000 pharmacists. They fill nearly 2.5 billion prescriptions yearly, and have annual sales of over \$750 billion. For more information about NACDS, visit [www.NACDS.org](http://www.NACDS.org).

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StayWell Custom Communications (SCC) is the leader in custom health content delivered via a variety of sophisticated technology platforms. Our interactive offerings include robust web platforms, online health libraries, e-mail marketing programs, and an extensive range of multimedia tools including video, podcasts and animations. The company serves hundreds of clients representing several channels in the healthcare industry: hospitals and health systems; health plans; employers; and retail organizations. StayWell Custom also offers a comprehensive range of print and print/interactive integrated solutions to meet a broad range of clients' marketing and communication needs.

For retailers, SCC offers custom-branded consumer health and disease management communications solutions that enable pharmacies and grocers to position their stores as healthcare destinations of choice, enhancing health-conscious shopper engagement and pharmacist-patient interactions. For manufacturers, we offer a full array of disease and brand specific healthcare consumer communications and drug therapy adherence programs, which provide brand marketers with the ability to interact directly with their targeted consumer audience to drive Rx volume and build brand loyalty.

SCC recently launched the StayWell Retail Health Platform, which combines a fully customizable private label health portal with powerful, permission-based e-marketing capabilities that enable retailers to register and then continuously deliver personalized health content coupled with contextually relevant product ads and offers to their health information-seeking consumers in a variety of formats.

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StayWell, the consumer division of MediMedia USA, is one of the largest global providers of consumer health information and patient education. MediMedia distributes print and online health media to physicians, hospitals, health systems, managed care plans, retail chains, employer groups, and consumers throughout the United States and the rest of the world.

In addition to our extensive roster of clients at leading healthcare organizations, we are the publishing partner for such prestigious institutions as the American and Canadian Red Cross, Harvard Medical School, the American Heart Association, and the American Lung Association. Additional association alliances include the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, National Institutes of Health, AARP, and the American Diabetes Association. StayWell is dedicated to developing health communications solutions that are scientifically based, easy to understand and behavior-change focused. We also offer unparalleled editorial experience, commitment to accuracy and richness of presentation.

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