

Providing for the pharmaceutically indigent

JAMES C. McALLISTER III

Am J Health-Syst Pharm. 2002; 59:1678-9

The phrase “pharmaceutically indigent” is used at the University of North Carolina Hospitals and Clinics to describe patients who are, for one reason or another, unable to afford prescription medications. These patients would likely go without drug therapy if our institution did not provide them with access to it. This in turn would probably result in unnecessary hospitalizations and clinic visits as these patients’ conditions worsened.

In two articles in this issue of *AJHP*, Adams and Wilson describe a variety of strategies to limit the financial exposure of “safety-net” providers. In the first article, these authors describe how the principles of pharmacy benefit design and management used in the private sector form a basis for their own indigent care pharmacy program.¹ They also discuss the financial pressures on safety-net providers, the growth in the number of uninsured people, and several established programs that in limited ways help provide

the needy with prescription drugs. Such efforts, though creative, are only a beginning. Continued expansion of the pharmaceutically indigent population—especially seniors—and the double-digit annual growth in the cost of pharmaceuticals translate into serious hurdles with which safety-net providers will be confronted.

In their second article, Adams and Wilson describe formulary development and management for safety-net providers and suggest that drug therapy success is measured in clinical, economic, and humanistic terms.² The authors use the World Health Organization’s definition of an essential drug to ensure the continued commitment to providing pharmaceutical care. This approach is far less draconian than many prescription benefit strategies used by organizations in the private sector. It does, however, imply that practitioners involved in formulary management of the pharmacy benefit should have skills in ethical decision-making and

a strong grasp of the institutional mission so that formulary decisions complement clinical care.

As access to prescription drugs by the pharmaceutically indigent becomes ever more difficult, the degree to which the health care system is “broken” becomes more apparent. Private managed care organizations, which cover 34 million Medicaid beneficiaries, are withdrawing from serving state and federal health care programs. States are facing cuts in state Medicaid programs. Also, it seems that there will be little help from the federal government to increase coverage of outpatient prescription drugs. It is even less likely that safety-net providers can accommodate the growth in demand.

Each year, the University of North Carolina Hospitals and Clinics provides over \$7 million worth of prescription drugs to outpatients without reimbursement. This service is woven into our mission as the state of North Carolina’s flagship health care institution, and there is deep commitment from pharmacists, physicians, and others to continue that mission. However, those with primary fiduciary responsibility for the health care system believe that cuts in state appropriations and entitlement programs, worsening reimbursement rates, and the growing number of pharmaceutically indigent patients may compromise our ability to continue these services. It is clear that we must make changes to minimize, if not reduce, the financial hemorrhaging caused by our pharmacy assistance program.

As I consider options for continuing this program, I “search my pharmacy soul,” to paraphrase Zellmer.³ Our staff has a moral compass, is passionately committed to serving all patients, and strives not to “succumb to a corporate agenda.” This goal becomes more challenging each year, however, and in my heart I know that we cannot succeed forever without health care reform.

JAMES C. McALLISTER III, M.S., is Director of Pharmacy, University of North Carolina Hospitals and Clinics (UNCHC), and Assistant Dean for Clinical Affairs, School of Pharmacy, UNCHC, Chapel Hill, NC 27514.

Copyright © 2002, American Society of Health-System Pharmacists, Inc. All rights reserved. 1079-2082/02/0901-1678\$06.00.

The complexity of the changes needed and the potential impact of each on organizational and individual providers, payers, vendors, and patients are daunting. Changes in prescription drug coverage are complex but pale in comparison with the overall health care reform that must occur concomitantly.

As an example of the twisted logic of the current reimbursement system, it will not cover prescription drugs for many indigent patients but will reimburse hospitals for an emergency department visit or hospital admission for the same patients when their condition worsens without drug therapy. This policy signals hospitals not to provide prescriptions at their expense and signals patients that their prescribed drug therapy is nonessential.

The most important changes in the system are needed at the federal and state levels. Reform must begin with determining coverage for seniors and other often needy groups, such as children, patients infected with HIV, and patients with hemophilia. Inherent in a reform is determining what taxpayers are willing to fund, which in turn requires that the public be educated and that government and the public be prepared to deal with the consequences.

The pharmaceutical industry needs to examine its corporate conscience and be prepared to join with providers in contributing to the care of the pharmaceutically indigent. Pharmaceutical assistance programs must be standardized and be accessible throughout a patient's need for them. Drug-pricing schemes should be reengineered through collaborative discussions with providers and

payers. This will minimize cost shifting and the perpetuation of bizarre and complex discount structures.

Health care systems, too, must develop partnerships with federal and state programs, the pharmaceutical industry, and pharmacy organizations to facilitate patients' access to medications. Pharmacists must educate policymakers and providers about the cost of such programs for the indigent and collect data on the cost of treatment failures and health care costs related to unavailability of prescription drugs. Health systems and their pharmacy and medical staffs should help patients understand the anticipated shortfalls of their prescription coverage and encourage them to convey their sentiments to elected officials and payers.

Patients should be coinvestors in a reformed system by paying for a portion of their prescription costs and being compliant with therapy; this involvement will qualify them for continued assistance. Advocacy groups should work with pharmacists and physicians to educate patients about the value of medications, the importance of compliance, and the desired and undesired effects of drug therapy.

Such extensive health care reform requires a collective approach well beyond the capabilities of any single discipline. However, the profession of pharmacy can and should lead the reforms related to prescription drug coverage. I suggest that we consider the following strategies to begin a reform:

1. As individual pharmacists, focus on caring, regardless of pressures brought to bear on us by employers.
2. Substantiate our value by counseling patients, monitoring and documenting therapeutic outcomes, and intervening with providers and payers on patients' behalf.
3. Collaborate with other pharmacists to maximize compliance, validate outcomes, and facilitate transitions among acute care, clinic, and home environments.
4. Collaborate with academia broadly and consistently to study the impact of services provided (or not provided). This strategy is the only way to credibly document our value and the value of pharmaceuticals.
5. Continually explain to patients, policymakers, and payers how pharmacotherapy for all patients who need it and its management by pharmacists are good investments.
6. Demand that professional associations work with all pharmacists to communicate our message cogently, credibly, and tirelessly.

Some may consider such measures unrealistic. But continuing old strategies could eventually block all access of the pharmaceutically indigent to drug therapy. Albert Einstein said, "Stupidity is to continue to do the same thing and expect different results." Commitment and the creation of new and enduring partnerships may be our best hope for giving millions the drugs they need but might not otherwise receive.

References

1. Adams D, Wilson AL. Structuring an indigent care pharmacy benefit program. *Am J Health-Syst Pharm.* 2002; 59:1669-75.
2. Adams D, Wilson AL: Drug selection for safety-net-provider formularies. *Am J Health-Syst Pharm.* 2002; 59:1675-8.
3. Zellmer W. Searching for the soul of pharmacy. *Am J Health-Syst Pharm.* 1996; 53:1911-6.