Giveaway Drugs: Good Intentions, Bad Design

A community clinic director is frustrated by well-meaning drug company programs.

BY BUCK TAYLOR

It’s like Christmas every day," said Casey one hot Tuesday morning last July, while waiting to see our clinic physician. Looking confused, I followed her finger to the uniformed backs of the FedEx and UPS drivers waiting for signatures at the front desk. The padded envelopes and boxes from exotic-sounding senders such as Novartis and Aventis, hailing from far-off locales in New Jersey and Delaware, bring a measure of excitement to our clinic, which serves the low-income population in Bozeman, Montana, 120 miles north of Yellowstone National Park.

The three-month supplies of pills that arrive from the east are saving Casey’s life. Casey has been a patient in the clinic that I direct for as long as I can remember. She has a ruddy complexion and late-night disc-jockey voice. She has lived hard and it shows. She takes Glucophage for diabetes, Prevacid for stomach ailments, and Zestril for high blood pressure. These drugs cost about $165 a month, but her income is at the lowest level of our clinic’s sliding fee scale. To afford these drugs on her own, she would have to stop paying rent or utilities; before seeking care in our clinic, she had simply gone without them.

The cost of the freshly arrived clinic medications to Casey? Free. The cost to the clinic for helping Casey and four hundred other patients to procure them—and the ancillary costs to the patients themselves? Therein lies the rub.

Charitable Drug Programs

All major U.S. drug manufacturers offer a medication assistance program (MAP) to benefit low-income people with chronic conditions who cannot afford the medications prescribed by their doctors. Drug sales representatives market the programs to private physicians. Those providers, though, are more apt to use drug samples, which drug reps readily dispense to them, than have their staff spend large amounts of time with MAP bureaucracies.

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In fact, the main users of these programs are safety-net providers, including private free clinics and federally subsidized community health centers like ours.

The MAPs provide a genuine benefit to our patients and enhance our mission of patient care. At the same time, they also help to burnish drug companies’ public image. The industry’s trade group—Pharmaceutical Research and Manufacturers of America (PhRMA)—publishes a compendium about the programs for providers and tracks annual utilization figures. The drug charity programs are good for all of the players.

Our interaction with these programs on behalf of Casey began in the exam room when she started coming to us. Our doctor diagnosed her multiple illnesses and prescribed treatment, then learned that Casey could not afford to buy the needed medications. Clinic staff then spent time determining which company made the drugs that were prescribed for Casey. This is key information, because each of this country’s 174 MAPs has its own application form and requirements. Next they had to figure out how to get the forms. Some drug companies allow providers to download forms from Web sites, then mail them back; others arm their sales reps with forms to distribute during on-site visits, although clinics like ours do not see many sales reps. A few companies require us to order the forms directly from them.

Time-Consuming And Off The Mark

Once we secured the right applications for Casey, the real work began. She needed three drugs from three different manufacturers’ MAPs—a typical patient scenario. I sat in one day as our medical assistant engaged in this process. The application from Bristol-Myers Squibb, maker of Glucophage, required estimates for total monthly household income and a listing of liquid assets. This form was fairly easy to complete, but between December 2001 and June 2002 it was entirely revamped—not an unusual occurrence. Forms are revised or replaced when companies merge, drugs are removed from assistance programs, or a company contracts with a new entity to run its MAP.

Casey’s second medication, Prevacid, is made by TAP Pharmaceuticals, which asked more limited financial questions but inquired about the applicant’s marital status. Casey chuckled at this, wondering if she would be ineligible for the drug if she got divorced. The form also asked about U.S. residency status. She is a U.S. citizen, so this question did not affect her. But I find the query curious, because all the forms I’ve seen require a So-
cial Security number, which automatically disqualifies undocumented residents—an at-risk patient group often seen in clinics like ours that serve inner-city and migrant populations. Finally, the form from AstraZeneca, makers of Zestril, was two times as long as the others. The financial section asked about the patient’s portfolio in stocks/bonds, certificates of deposit, savings, checking, IRAs, and annuities. This is amusing, since most of the roughly 400 clinic patients in these drug charity programs fall into our “B” sliding-fee category, meaning that they have an individual annual income of less than $8,860.

Although our most needy patients, like Casey, usually qualify for MAPs (indeed, her applications were all successfully processed), staff members play a guessing game with the others, because eligibility criteria differ among programs and seem arbitrary at times. For instance, some companies issue guidelines for financial eligibility but state that patients are considered case by case. One drug firm requires a clinic staff member to phone in after a form has been completed to receive preapproval before the paperwork is forwarded. Recently this company refused to believe that our patient was living on $253 per month and denied the application based solely on an over-the-phone judgment. This example is not the norm, but it illustrates the unpredictability that our staff members face.

As if the burden of applying for one thousand free meds for four hundred patients is not onerous enough, most companies require a new application every three months. All three of Casey’s MAPs expire at different times. This means that she must return to fill out new paperwork as often as every sixty days. She schedules time off work, then coordinates with her husband to use their one (dilapidated) car to travel eight miles each way to the clinic. For patients of limited means, the forms can’t be completed until they can muster up a ride to our office.

After the paperwork, we wait. Once an application is mailed to a manufacturer, there is no predicting when a medication will arrive. Turnaround time can be as quick as two weeks, although the norm is two to three months. (In rare cases, the drugs don’t show up at all because the patient wasn’t eligible or the paperwork wasn’t received.) A clinic medical assistant once submitted applications on the same day for the same drug for two separate patients. The first patient received her pills in two months, the second in five.

While waiting for the free drugs to arrive, we do our best to supply the medications for our patients. Sometimes we have a month’s worth of samples we can give them, but what can we do when shipments of free meds we’ve applied for take five months to arrive? Clinic staff work hard to estimate when to resubmit patients’ refill forms before the last three-month supply runs out, but drug companies’ erratic mailing schedules often render these efforts futile. As Casey says, “When you’re
poor, lots of kind folks want to give you something. It just seems like they put up lots of barriers to actually getting it.”

Gratitude Tempered By Frustration

Despite these problems, we and our patients are thankful to be on the receiving end of drug companies’ charity programs. When I told Casey that I was going to write about her experience, she said to be sure not to upset the applecart. She is concerned that people like her will lose access to free medication if I am overly critical.

I appreciate that inefficiency and cumbersome paperwork may appear to be a small price to pay for obtaining pro bono medicines for our patients. We are fortunate in that our clinic can afford the staff time—roughly forty-five to sixty minutes to process each MAP drug request (at $11 per hour of medical assistant time). But for smaller, volunteer-based free clinics that, unlike us, do not receive federal support, tackling the MAP process can be simply too overwhelming.

Pharmaceuticals have become an essential element of modern medicine. We are dependent on them for delivering what is now considered basic care. If it is true that, as one recent study predicts, drug spending in the United States will double in the next five years—especially for the chronic diseases we often see in our clinic—Casey and the other marginalized patients we serve will have even more difficulty accessing needed medications without drug company charity programs. Unlike people receiving prescription drug benefits under Medicaid or private insurance (and maybe soon the elderly, if Congress enacts a Medicare drug benefit), uninsured and working-poor patients like Casey have limited to no means of acquiring expensive drugs. Pharmaceutical companies recognized this by creating such charitable programs in the first place. Yet the industry’s failure to make a more serious commitment to improving the current system will undermine its charitable spirit.

Designing A User-Friendly Program

How can the drug companies make their charitable programs more readily accessible to providers and needy patients? To start, a standardized form that could be downloaded from the Internet would realize large savings, especially to providers like us who are dependent on tight revenues to serve the poor. Most drug manufacturer forms ask similar questions, just in 174 different ways. Some discussion among drug companies, PhRMA, and patient advocacy groups has been directed toward this goal, but companies still do not support a standardized form.

Next, standardizing eligibility and reapplication requirements among drug charity programs would create greater efficiencies on the provider end. Patients
like Casey rarely have the opportunity to move up on the sliding fee scale, especially in a three-month time span, so requiring a new form every year instead of every quarter would be more practical for most of our patients. Last, combining less frequent patient reapplication requirements with a better mechanism for predicting eligibility approval and medication shipping dates would greatly reduce both clinic costs and the frustrations of providers and patients. These steps would also help to avoid medication gaps for patients taking lifesaving drugs when the clinics don’t have the samples to give them during the wait.

I was pleased to note the announcement in fall 2002 of the Pharmaceutical Consortium of Assistance Programs, a small group of drug companies that will work to streamline patient assistance programs through Web-accessible application forms and a three-day turnaround time. However, these efforts so far involve only a tiny fraction of the industry, and the group’s press release implies that its focus is on reducing administrative costs for the small and midsize companies that have joined the organization.

Our clinic for Montana’s medically underserved is part of the nation’s fragile health care safety net, which millions of Americans rely upon. Collaboration between providers like us and drug companies is crucial to continuing service to the increasing numbers of patients living on the edge of our health care system. Designing user-friendly giveaway programs that are more sensitive both to needy recipients and to the time-pressed, resource-poor providers who serve them would bring a more festive “Christmas” to our clinic year-round, while increasing drug companies’ charitable reach.