

Virtual Mentor

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CASE AND COMMENTARY

Patients Who Can't Afford Drugs, Commentary 1

Commentary by Amy Haddad, PhD, RN

Case

Mrs. Michaels has been under treatment for hypertension for several years. She started with a well known, brand-name drug, which effectively reduced her blood pressure. She has a steady full-time job and some employer-sponsored health insurance that includes a prescription benefit. The prescription co-payments, however, have increased dramatically, especially on brand-name drugs. On several visits, when her blood pressure was high, Mrs. Michaels told Dr. Bennett, her physician, that she had postponed getting her prescription filled for several weeks because she didn't have the money at the time. Her salary barely covers her urban living expenses, food, and transportation to her job.

Because Mrs. Michaels cannot afford to take the brand-name drug all the time, Dr. Bennett has prescribed several generic versions, as each came on the market. Unfortunately, none reduced her hypertension effectively, so she is again using the brand-name drug. One day, after another increase in her blood pressure, Mrs. Michaels told Dr. Bennett that a co-worker of hers takes the same brand-name hypertension drug. The co-worker gets a month's supply of 40-mg pills for the same co-pay that Mrs. Michaels is charged for her one-month's supply of 20-mg tablets under the same prescription benefit policy. Mrs. Michaels asks Dr. Bennett whether he will prescribe the 40-mg tablets under the pretense that it is a one-month's supply. She will split the tablets in half, so that she gets her prescribed 20 mg a day and the prescription lasts for 2 months. "You and I will know that I only take ½ tablet a day," Mrs. Michaels says to Dr. Bennett. "But the pharmacy will think that I am taking one tablet a day and getting a one-month supply." She adds, "That's the only way I can take this medicine every day, all year long. Otherwise, I have to skip it about half the time."

What should Dr. Bennett do? When trying Mrs. Michaels on generic drugs, he was able to offer her samples, but, of course, he cannot continually supplement Mrs. Michaels' prescription with drug company samples.

Commentary 1

The moral life, for health professionals and everyone else, comprises multiple and competing duties. It is not the case of deciding between wrong and right, but between or among numerous conflicting obligations all demanding our moral attention. Our days are filled with choices, largely unconscious, that indicate which

obligations or duties should, for the moment, receive priority. The case in question presents several duties in conflict, the most obvious being the duty of Dr. Bennett to Mrs. Michaels. But the physician also has obligations to his colleagues in whatever practice setting he works, the values of the medical profession, the third-party payer, and the pharmacy benefit manager. Taken further, the physician as health professional and citizen in the larger society has obligations to promote the common good. Clearly, the costs of prescription drugs is of great concern to many individuals especially those who do not have the benefit of drug coverage as part of their health insurance. As the case indicates, even those with drug coverage may have difficulty in affording the co-pays that are part of the health plan. So, the case includes much more than the basic problem of whether or not to comply with the patient's request to commit fraud (for that is basically what the patient is asking Dr. Bennett to do). Rather, imbedded in this problem of an individual patient who cannot afford a brand name drug that works best for her are institutional and societal ethical concerns.

In *The Three Realms of Ethics*, John W. Glaser proposes a model that views ethics in 3 realms: individual, institutional, and societal.¹ Most work in contemporary ethics focuses on the individual realm, so much so that the tools we use to resolve ethical problems at the individual level are, Glaser contends, inappropriately applied to concerns at the institutional and societal levels. It is worthwhile to think about Mrs. Michaels' case from the broader perspectives of institutional and societal levels because decisions in the areas of policy development, benefit design, drug detailing, and drug pricing have profound effects on structuring the particular situation in which Dr. Bennett and Mrs. Michaels find themselves.

Societal ethics deals with the common good of society. Attending to the common good requires balancing the many conflicting goods realized at this level—education, housing, recreation, health care, defense, etc. Within health care, there is also the need to balance acute and chronic care needs, administration and direct care services, and research and technology development. Although drug therapy provides great good to many people, its benefits and burdens must be weighed against other goods in health care. From a societal perspective, the growth in costs of prescription drugs must be recognized as having a significant impact on clinical outcomes. One area that should be questioned is the drug manufacturers' high expenditures on physician marketing and direct-to-consumer advertising. These costs significantly surpass the cost of research and development and are folded into the price of the products, thus creating a greater problem of drug affordability than the research and development alone. The argument made by the industry is that the education of health care professionals and patients is in their best interest. However, a counter argument can be made that this is really the responsibility of basic professional education and continuing education, not the job of a manufacturer or distributor.

It would be interesting to see a case that included the actual cost of the brand-name drug along with a break-out of 3 categories of costs allocated to each pill as a

percentage of the total cost per pill as follows: (1) the cost associated with the annual manufacturing and distribution of the drug; (2) the cost associated with recovery of the research and development investment over the life of the drug patent; and (3) the cost associated with annual professional marketing and direct-to-consumer advertising for the drug. This would give us some idea why the brand-name drug that Mrs. Michaels needs is so expensive. Since Dr. Bennett, Mrs. Michaels, the commentators, and the readers do not have access to this information, this aspect of the case and the associated societal issues cannot be fairly evaluated.

Institutional ethics deals with the good and thriving of the individuals within the institution as well as the institution as a whole within the larger community. Institutions can be as small as a family or group practice and as large as a health plan with hundreds of thousands of people. In this case, the example of a fixed co-payment per prescription that is part of the "institution" of the health plan seems to put the patient in an impossible situation. The logical way out of this impossible situation is for Mrs. Michaels to ask Dr. Bennett for an incorrect prescription to be written to achieve affordability. This kind of action is not safe for the patient, and must also involve the pharmacist in the conspiracy. It also adds to the potential risk of medication errors. The fixed dollar co-payment amount was generally designed to benefit the consumer. In this case it is working against Mrs. Michaels' benefit. Perhaps a percentage co-payment would be a more fair approach for rational distribution of the health care premium dollar. It is possible that, if enough physicians were to suggest such a change, that there might be a shift in the way the benefits are designed in the health plan. Nevertheless, the cost of the drug remains an issue for the patient regardless of whether it is at the point-of-sale or in the monthly health care premium.

Individual ethical concerns cover familiar ground in bioethics. This realm is concerned with the well-being and thriving of individuals. In this case, we would focus on the potential benefits and harms to Mrs. Michaels if she does or does not receive the drug that is presently identified as being the drug of choice for her. The facts presented in this case present a troubling assumption. The case states that the physician "has prescribed several generic versions, each as they came on the market. Unfortunately, none reduced her hypertension effectively . . ." Presented this way, it appears that it is common for patients to have difficulty achieving the same therapeutic effect from the "generic versions" of brand name drugs. However, the opposite is true. Based on the thoroughness of the FDA approval process, the reality is that it is unusual for a patient not to be able to take one of the generic versions of a brand name drug and achieve the same clinical effect. If Mrs. Michaels is one of the rare patients who cannot control her blood pressure on one of the many generic drugs on the market, then her case should be treated differently. This sort of "discrimination" is appropriate when other avenues have been exhausted and the patient stands the chance of suffering long-term harms that are the result of hypertension.

Furthermore, we would look at the harms and benefits that would occur should Dr. Bennett agree to write a fraudulent prescription. Although in the short run Mrs. Michaels may benefit from this ruse, the very act of resolving the problem so myopically diminishes not only the physician's integrity but also ignores the larger issues that created the problem in the first place. If a particular patient's case represents larger inadequacies within the health care system, and Mrs. Michaels' case certainly does, then the physician is obligated to be an advocate for changing the system for all of the physician's patients, present, and future.

References

1. Glaser JW. *The Three Realms of Ethics*. Kansas City, MO: Sheed & Ward; 1994.

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