

EDITORIAL

Drug Sampling: Perpetuating an Unjust Health Care System?

David S. Buck, MD, MPH, and David A. Wallace, PharmD

In their article, “Are Sample Medicines Hurting the Uninsured?” in this issue of the *Journal*, Zweifler and colleagues¹ raise some old and new issues with regard to the use of drug samples. Specifically, they are concerned that higher diastolic blood pressures in uninsured patients are correlated with the use of sample medications. Generally, their study raises other important concerns that underscore the need to explore beyond the immediate problem of access to adequate antihypertensive medications. They illustrate how fragmented and inadequate our current health care safety-net infrastructure is for our nation’s uninsured and underinsured citizens and how that system exposes the underserved to risks that exceed the burdens of their disease.

Although the study by Zweifler and colleagues has several methodological problems—a sampling of only 17 patients, counting Medicare recipients as being insured, basing blood pressure control on the mean of at least three readings, and not clearly defining hypertension with regard to concurrent diabetes or heart failure—it supports the premise that follow-up visits are prompted by frequent medication changes to accommodate limited supplies or that the periodic lack of medications prompts the follow-up visit.

The impact of having a fragmented safety net for health care and our dependence on sample drugs is well-known to a subset of the uninsured—the homeless—which represent an estimated 3.5 million people in the United States today.² Through our involvement in a health care safety-net organi-

zation, Healthcare for the Homeless—Houston, we are familiar with many of the issues of sample drug use. We depend on these samples to reduce our costs. We dispensed more than 4,000 prescription medications during the year with an annual cost of only \$4,620. This cost accounts for roughly 9,000 patient visits. Under such circumstances it would be unlikely that we would be able to follow Sixth Report of The Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-VI) guidelines and administer hydrochlorothiazide or β -blockers, even though such medications reduce mortality rates in hypertensive patients.^{3–5} These front-line medications are rarely distributed as samples because they are available in generic forms.

Access to health care and the treatment of hypertension are particularly challenging for the homeless, who contend with competing priorities (food, clothing, and shelter), transportation barriers, and inability to negotiate large institutional settings. Hydrochlorothiazide is generally less desirable because of the need for laboratory tests, the propensity for alcohol-related dehydration, and limited access to drinking water, although it can be very effective in some settings.⁶ Although β -blockers could have considerable efficacy in treating hypertension among the homeless because it might also improve withdrawal symptoms,^{7–9} β -Blockers cannot be stocked in our pharmacy or any other class D pharmacy in Texas. A peculiar Texas pharmaceutical law prohibits class D pharmacies, which are not required to have a full-time pharmacist, from dispensing β -blocker, antipsychotic, and many other medications. We provide sample medications whenever possible and supplement our drug supply with a class D formulary.

By using drug samples to treat the underserved, we physicians, in effect, have turned to the pharmaceutical industry to provide a solution to the health care problems we have not adequately ad-

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From the Department of Family & Community Medicine (DSB), Baylor College of Medicine, and Healthcare for the Homeless—Houston (DSB, DAW); and the University of Houston College of Pharmacy (DAW). Address reprint requests to David S. Buck, MD, 5615 Kirby Drive, Suite 610, Houston, TX 77005.

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Table 1. Establishing a Partnership with Local Politicians.

Develop a relationship with the staff member
Learn his or her name
Figure out which contact person is appropriate for your area of interest
Follow up by sending a concise letter summarizing the issues and next steps
Offer a solution to the problem (describe specific aspects with which they can help you)
Present alternatives to your proposal, when possible
Determine areas of expertise for which you might be a helpful source of information

Note: suggested by Randall Ellis, district director for Texas State representative Garnet Coleman.

dressed as a society. Such was not the purpose of medication sampling, which was designed to initiate, rather than sustain drug therapy. Because we believe in the need for collaboration between the health care services sector and political institutions, my colleagues and I are working with our state representative and other politicians to create a more integrated system of care. To date, we have (1) implemented a transportation project to improve access to health care services, (2) proposed changes in the rules that restrict class D pharmacies from dispensing β -blockers, (3) worked to improve the health care safety-net infrastructure, and (4) sought ways to link health care delivery with housing, substance abuse treatment, and general and mental health programs.

These efforts, although greatly needed, still fall short of any effective global solutions. Finding those solutions should be a mission for us all as primary care providers, because we are the physicians most involved with patients and their families, and we are ideally positioned to advocate for those patients without effective voices. To be effective advocates, however, we must find allies outside those systems that have been particularly responsive to us, such as the pharmaceutical industry. We need to overcome our feeling of disenfranchisement toward the political process (Table 1). By remaining within the safety of our own established institutions, we have, in some ways, become as ineffective as the empowered politicians who lose touch with the constituents they serve.

If we choose to continue to rely on drug samples to treat our uninsured and underserved patients, rather than choose to pursue proactively changes in the laws that limit access to health care, then we must accept that we are coconspirators in an unjust medical system.

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