Report of the Task Force on the Availability of Cardiovascular Drugs to the Medically Indigent

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Requests for reprints should be sent to the Office of Scientific Affairs, American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231-4596.
Executive Summary

Summary of Findings

The American Heart Association has played an important role in decreasing mortality from cardiovascular disease and stroke through its research support, scientific programs, and health education efforts. This attack on cardiovascular disease has been extremely successful in reducing morbidity as well as mortality, but many obstacles remain. Although education in primary prevention will have a beneficial effect in the long term, for the immediate future people who have, or will have, cardiovascular disease can benefit only if they have access to appropriate medical care and to new, often expensive, medications. Lack of access to medical care and inability to buy costly medications are major problems that are more likely to affect poor people, who also suffer more cardiovascular diseases, than the affluent.

To accelerate the benefits of modern accomplishments to control cardiovascular illnesses in medically indigent people, the AHA formed the Task Force on the Availability of Cardiovascular Drugs to the Medically Indigent. The task force investigated problems related to access to health care and, specifically, availability of cardiovascular drugs. The recommendations of the task force were based on the findings detailed in this report and in response to societal issues that affect the health and well-being of a significant segment of the US population.

Interest in universal access to health care has been changing rapidly since the task force was formed, and there is growing support among physicians of this country for some type of program. Thus, it seems likely that Americans with cardiovascular diseases who are not receiving adequate treatment because they have no health care insurance or are underinsured will be provided with appropriate medical care in the foreseeable future. However, because such a large-scale program cannot be established quickly, the task force urges the Board of Directors to implement the following recommendations in order to provide as much relief as quickly as possible.

Recommendations

The task force recommends that the AHA

1. Join with the American College of Physicians, the American Medical Association, and other professional organizations and voluntary health agencies to promote universal access to health care, including coverage for prescription drugs
2. Notify its members who are health professionals of all programs that supply cardiovascular drugs free of charge or at reduced cost to patients who cannot pay
3. Encourage affiliates in states whose health departments provide medications to inform all health professionals that those programs are available. Encourage affiliates in states where this help is not available to support their health department's development of such programs
4. Consider wide dissemination of information about these programs to all US physicians through the National High Blood Pressure Education Program and the National Cholesterol Education Program of the National Heart, Lung, and Blood Institute
5. Explore with the Public Affairs Policy Committee the possibility of initiating a federally funded program that provides free cardiovascular drugs to poor people who are not Medicaid recipients
6. Work with appropriate groups, for example AHA councils and committees (Research Committee and Education and Community Programs Committee) and the Agency for Health Care Policy and Research, to explore ways to stimulate research in the most effective treatments for cardiovascular disease and to stimulate education and community programs about preventive measures and issues of compliance
7. Actively participate in conferences organized by other associations regarding this issue and initiate and sponsor AHA conferences at both the national and affiliate levels
8. Urge affiliates to review the status of the lack of availability of cardiovascular drugs in their communities and its impact on cardiovascular disease, mortality, and morbidity among all population groups, including minorities, poor children, and the elderly
9. In the implementation of recommendations of various AHA task forces, particularly those addressing issues of minorities, children, and the elderly, focus attention on the high prevalence of the poor, uninsured, and underinsured in these populations, in which morbidity and mortality from cardiovascular diseases are high
10. Present this report and its recommendations to the national media through the AHA Office of Communications
11. Review the impact of these recommendations in 1 year through a subcommittee of this task force

Introduction

The mission of the AHA is to reduce morbidity and mortality from cardiovascular diseases and stroke. Without question, much has been accomplished in the fulfillment of this mission. For example, research accomplishments have pointed the way for the development of increasingly effective drugs, invasive procedures have been improved, noninvasive approaches have been developed, and the role of diet in some cardiovascular diseases has emerged. The result of these advances has been a progressive fall in morbidity and mortality from all cardiovascular diseases. The AHA has contributed uniquely to this improvement in the public health through its research support, its scientific programs for health professionals, and its health education programs for everyone.
For cardiovascular death rates to continue to fall, every person must be educated in primary prevention and every patient with a cardiovascular disease must have access to appropriate medical care, including not only physician follow-up but all necessary medications. With regard to the latter, the steady rise in the cost of cardiovascular drugs has made it increasingly difficult for many patients to follow therapeutic programs without interruption. Because most cardiovascular diseases are more prevalent in the poor than the affluent, the burden of these illnesses falls disproportionately on those who are less able to afford them.

To address the general issue of access to health care and the specific issue of the availability of cardiovascular drugs to the medically indigent, this task force was formed. The task force reviewed a large number of documents (see References) before developing its recommendations.

The recommendations of the task force are based on an assessment of the data concerning the prevalences and costs of cardiovascular diseases, the demographics of health care coverage in the United States, and barriers to proper care because of low socioeconomic status.

US Cardiovascular Disease Prevalence and Cost

Prevalence

Cardiovascular diseases affect more than one in four Americans, or an estimated 69 million, and continue to be the major cause of death in the United States.1

Hypertension

- It affects about 61 million Americans.
- It is more prevalent in poor people than in the affluent (National Center for Health Statistics, personal communication [unpublished data from Health Interview Studies], September 1990)
- It is more prevalent in blacks than in whites.1
- It is the major risk factor for strokes and contributes significantly to heart attacks. It is the major cause of end stage renal disease in blacks.
- Medications account for an estimated 20% of the national cost of hypertension, in contrast to other cardiovascular diseases, for which these costs represent a lower fraction of the total (Figure 1).

End Stage Renal Disease

- It is a major public health problem that is fatal without dialysis or kidney transplantation.
- Its most frequent causes are hypertension and diabetes.
- Blacks are disproportionately affected: although they represent 12.3% of the US population, they comprise 28.3% of end stage renal disease patients.2
- Adequate treatment of hypertension has been shown to slow the rate of decline in kidney function in patients who already have damaged kidneys.
- Medicare End Stage Renal Disease programs fund much of the cost of dialysis and kidney transplantation. In 1988 Medicare's contribution to that cost was 67%, representing $3.7 billion.

Stroke

- 500,000 Americans are afflicted each year.1
- 2,980,000 Americans have had strokes.
- It is estimated that in 1992 stroke will result in $2.6 billion in lost productivity.
- It is more prevalent in poor people than in the affluent (National Center for Health Statistics, personal communication [unpublished data from Health Interview Studies], September 1990)
- It is more prevalent in blacks than in whites.1
- Stroke accounts for one half of all patients hospitalized for acute neurological diseases.

Coronary Heart Disease

- It is caused by atherosclerosis of the coronary arteries.
- It is the leading cause of death in the United States.
- An estimated 6 million Americans have either had a heart attack or have angina pectoris.
- The AHA has estimated that 1.5 million heart attacks will occur in 1991; of these, 34% will be fatal.
- Known risk factors for coronary heart disease are hypertension, cigarette smoking, elevated blood cholesterol, and diabetes. Stopping smoking and reducing the blood cholesterol level have been shown to reduce the risk of heart attack. In large clinical trials, controlling hypertension has had a variably beneficial effect on heart attack rate.
- It is more prevalent among poor people than among the affluent (National Center for Health Statistics, personal communication [unpublished data from Health Interview Studies], September 1990)

Congenital Heart Disease

- About 8 of every 1,000 children are born with congenital heart disease.3
- By 1995, an estimated 300,000 persons under the age of 21 will have heart defects; 38% will have undergone one or more corrective procedures.
- One fourth to one third of the more than 4 million people who are born each year live in poverty, so the burden of congenital heart disease falls disproportionately on the poor.

Other Forms of Heart Disease

- Rheumatic fever and rheumatic heart disease affect an estimated 1.3 million children and adults.1
- Bacterial endocarditis occurs most often in people with damaged heart valves and other structural heart defects and in intravenous drug users. In 1988 20,000 people were hospitalized with this serious cardiac infection, and it was the cause of death of fewer than 2,000.
FIGURE 1. Estimated cost of major cardiovascular diseases by type of expenditure for 1992. From Heart and Stroke Facts.1

- Kawasaki disease is a mucocutaneous lymph node syndrome that occurs in children. In 20% either the coronary arteries, the heart muscle, or both are damaged. It is usually self-limiting, but the course can be shortened by giving intravenous gamma globulin. Over 1,500 cases each year are diagnosed in the United States.4

Cost

The AHA estimates that the total 1992 cost of cardiovascular diseases will be $108.9 billion, with heart disease costing $47.9 billion, stroke $16.7 billion, hypertension $14.8 billion, and all other cardiovascular diseases $29.5 billion. These figures include the costs of physician and nursing services, hospital and nursing home services, medications, and lost productivity resulting from disability (Figure 1).1

In addition, each case of end stage renal disease caused by hypertension and requiring hemodialysis costs $25,000 per year. In 1987 hypertension accounted for 38% of new end stage renal disease in blacks and 22% in whites. It was the most frequent cause of end stage renal disease in blacks, while for whites the most frequent cause was diabetes. In 1990 the total end stage renal disease program cost $5.4 billion (federal, state, and private sources).2

The Health Care Financing Administration (HCFA) reported the typical hospital admission charges for selective heart disease conditions as follows: stroke, $28,411; heart attack, $7,588; and high blood pressure, $856.5

The expected cost per case for 5 years for coronary artery disease events as reported in the Framingham Study is as follows: acute myocardial infarction, $51,211; angina pectoris, $24,980; unstable angina, $40,581; sudden death, $9,078; and non–sudden death, $19,697.6

Demographics

The Insured

- 181 million Americans have some form of private health insurance.7
- 30 million are covered by Medicare Part A, and about 98% of these also have Part B.
- 24 million have Medicaid coverage, but inclusion criteria are very restrictive and coverage is limited.
- The percentage of the poor population covered by Medicaid has decreased significantly during the past two decades.
- 27.5 million veterans receive help from the Department of Veterans Affairs.
- 1 million Native Americans are covered by the Indian Health Service.

The Uninsured

- 31–37 million Americans have no health care coverage; of these, 55% are employed adults, 32% are children, and 13% are unemployed adults.
- The number of uninsured is growing.
- The percentage of minorities who are uninsured exceeds the percentage of minorities in the United States.8

The Underinsured

- For many people the amount of insurance coverage is inadequate to cover the cost of medical care. An estimated 50 million Americans have some form of insurance but lack sufficient coverage for major hospital and medical expenses.7
- Women, dependents, the unemployed, the poor, and persons aged 55–64 are most likely to be underinsured.9

Lack of Access to Medical Care

The cardiovascular health of poor people is worse than that of the more affluent, at least as far as hypertension (Hypertension Detection and Follow-up Program data) and congenital heart disease are concerned.3 Poor people also see a physician less frequently10 and use fewer preventive and health maintenance services. The Congressional Budget Office has estimated that the uninsured receive one third less health care on the average than the insured.11
In 1986 a Robert Wood Johnson survey found that at least 19 million American adults reported financial impediments to receiving needed health care. The survey also reported the following:\textsuperscript{12}

- Blacks had fewer ambulatory visits than other groups, despite higher rates of chronic illness.
- The uninsured had 27\% fewer ambulatory visits than the insured.
- Nearly 16\% of people with a chronic or serious illness had not had an ambulatory visit in the year before.

**Lack of Access to Medications**

Cardiovascular medicines can be costly (Table \textsuperscript{113}). In fact, as knowledge has advanced, medications have become more specifically targeted and more effective but, unfortunately, much more expensive. Because patients may have more than one cardiovascular disease, the cost of treating such complicated problems can be extraordinary. For example, a patient with coronary heart disease, hypertension, renal insufficiency, and hypercholesterolemia inadequately controlled by diet will probably take a \( \beta \)-blocker, an angiotensin converting enzyme inhibitor, a potent diuretic, and a cholesterol-lowering drug for a total monthly cost of approximately $100. These medications are in addition to other less costly drugs, such as digitalis and hydrochlorothiazide. For poorer people, medication costs are an important impediment to the best therapy modern medicine has to offer. Three recent reports clearly show the cost of antihypertensive drugs to be an obstacle to optimal therapy:

- Shulman et al.,\textsuperscript{14} in an interview survey of a representative, random sample of housing units in Georgia, found that for patients with uncontrolled moderate to severe hypertension, low income was a barrier to obtaining medicines, refilling prescriptions, and attending office visits.
- Roccella,\textsuperscript{15} coordinator of the National High Blood Pressure Education Program, in comparing results of several large surveys conducted by the National Heart, Lung, and Blood Institute reported that in recent years both patients and physicians have found costs to be an impediment to appropriate treatment.
- McMahon, Johnson, and Duncan\textsuperscript{16} found the cost of drugs to be an obstacle to continuous therapy of hypertension.

Below are two typical examples of types of cases that exemplify this problem, according to Neil Shulman, MD, chairman, Board of Trustees, International Society on Hypertension in Blacks.

1. A single, 45-year-old woman who earns $8,000 annually as a waitress exhibits an initial blood pressure of 170/120. The annual cost of the necessary blood pressure medication is approximately $900. She can neither afford the medication nor afford to take time off from work for doctor visits or lab tests.

2. A 54-year-old domestic worker who reports an annual income of $9,500 exhibits blood pressure ranging upward from 160/114. The annual cost of the required blood pressure medication is approximately $850. The patient cannot afford prescription refills and therefore skips taking the necessary medication for 2–3 days at a time in an attempt to extend the prescription (N. Shulman, personal communication, 1991).

In both of these instances, the patients do not meet the eligibility requirements for Medicaid because they are not disabled, are not over 65, and report incomes that are too high. If either, however, were to suffer a stroke, heart attack, or kidney failure, she would become eligible for Medicaid. This catch-22 phenomenon affects millions of our society’s working poor.

**Plans for Universal Access to Medical Care by Other Countries**

All industrialized nations except the United States and South Africa provide health care for virtually all their citizens through public programs.\textsuperscript{17–19} These health insurance plans are financed by general revenues provided by federal or provincial governments or combinations of employee health insurance and community-based plans.\textsuperscript{20,21}

Canada spent $1,483 per capita for personal health services in 1987. In the United States that figure was $2,051. Other countries spending large amounts were Iceland ($1,241), Sweden ($1,233), Switzerland ($1,225), Norway ($1,149), France ($1,105), and West Germany ($1,093).\textsuperscript{19}

**Proposed US Programs**

The American College of Physicians has urged “some type of coordinative, comprehensive program on a nationwide basis citing the urgency of the need to address the issue of universal access to health care and providing the factual underpinnings of the present problem.”\textsuperscript{17,21}

The AMA has published a 16-point program, “Health Access America,” which is designed to improve access to affordable quality health care.\textsuperscript{22} The May 15, 1991, issue of the *Journal of the American Medical Association* (265:19:2491–2567) was exclusively devoted to papers concerning caring for the uninsured and the underinsured.

Physicians for a National Health Program (PNHP) have proposed a program that would fully cover everyone under a single, comprehensive, public insurance program.\textsuperscript{23}

**US Programs Providing Access to Medication**

**Community Programs**

The National Association of Community Health Centers (NACHC) is headquartered in Washington, DC, and serves members across the country. The NACHC consists of 550 community health centers and health centers for migrant workers and 100 health projects for the homeless that operate in 2,100 clinic sites in the United States. To date the NACHC has provided primary health services including phy-
### TABLE 1. Average Wholesale Price for Some Commonly Used Cardiovascular Drugs

<table>
<thead>
<tr>
<th>Drug**</th>
<th>Dose (mg/day)</th>
<th>Average wholesale price in dollars*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100 Tablets</td>
<td>Month</td>
</tr>
<tr>
<td>β-Blockers</td>
<td></td>
<td></td>
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<tr>
<td>Tenormin</td>
<td>50</td>
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<tr>
<td>Inderal LA</td>
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<td>81.50</td>
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<td>propranolol</td>
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<td>2.41-4.51</td>
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<tr>
<td>Lopressor</td>
<td>100</td>
<td>39.31</td>
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<tr>
<td>Visken</td>
<td>10</td>
<td>49.50</td>
</tr>
<tr>
<td>Centrally acting agents</td>
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<td></td>
</tr>
<tr>
<td>Catapres</td>
<td>0.4</td>
<td>50.55</td>
</tr>
<tr>
<td>clonidine</td>
<td>0.4</td>
<td>3.40-9.19</td>
</tr>
<tr>
<td>Wytsensin</td>
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<td>44.33</td>
</tr>
<tr>
<td>Aldomet</td>
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</tr>
<tr>
<td>methyl dopa</td>
<td>300</td>
<td>8.22-20.96</td>
</tr>
<tr>
<td>Tenex</td>
<td>1</td>
<td>47.50</td>
</tr>
<tr>
<td>Calcium-channel blockers</td>
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<tr>
<td>Cardizem</td>
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<td>Cardizem SR</td>
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<td>Angiotensin converting enzyme inhibitors</td>
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<td>Capoten</td>
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<td>Zestril</td>
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<td>Diuretics</td>
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<tr>
<td>Dyzide</td>
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<td>Maxzide</td>
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<td>Vasodilators</td>
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<td>Antiarrhythmics</td>
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<td>Quinaglute</td>
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<td>Mexitil</td>
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<td>Procain SR</td>
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<td>Antihyperlipidemics</td>
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<tr>
<td>Mevacor</td>
<td>20</td>
<td>165.18</td>
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<tr>
<td>Lopid</td>
<td>1,200</td>
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*Average wholesale price as obtained from Redbook 1990, Annual Pharmacists Reference. This is the price the pharmacist pays; the retail price is variably higher.

**Trade names are capitalized; generic names are lower case.
sician services, nurse services, laboratory work, preventive and emergency services, transportation, preventive dental services, and pharmaceutical services to more than 6 million indigent people. Most are minorities living in urban areas. The recipients, all of whom are either uninsured or underinsured, pay on a sliding fee scale. In addition to providing medical services, the NACHC also advocates health programs for the indigent.

County-level health agencies also provide services to the indigent. In Alabama, the county health department in Montgomery has developed a hypertension program in cooperation with private physicians. If a patient exhibits high blood pressure, he or she is referred by the physician to the county health department. If the patient has no health insurance and reports an income within a specified percentage of the poverty level, he or she is given the necessary medication. There is no limit to the number of times a patient may receive the medication.

State Programs

State health departments in all 50 states were asked whether they had programs in which indigent persons were provided with cardiovascular services or drugs. Of the 32 states that responded, 17 currently have some type of program for the indigent.

Alabama. The Alabama Department of Public Health has a hypertension control program that provides services to 10,000 patients. These services are expanding and are currently available in 59 of 67 counties for hypertensives at 150% of the poverty level or below. Patients are charged up to $3.00 for a visit, based on income. The health department and private physicians jointly treat 80% of the patients. Such patients bring in prescriptions for medications provided on the health department’s formulary. They receive the medications along with monitoring and patient education. To remain eligible, these patients must return to their own doctor at least every 6 months. Another 20% of patients receive a full-care visit, including electrocardiograms, blood chemistry, physical examination, medications, monitoring, and patient education directly through the health department. There is no limit to the number of times a patient may receive medication.

Arizona. The Arizona Health Care Cost Containment System (AHCCCS) is a Title XIX Medicaid demonstration project funded jointly by the federal government, the state of Arizona, and the counties of Arizona. The AHCCCS replaces the traditional fee-for-service system existing in other states by using competitively awarded prepaid capitated risk, sharing contracts with prepaid health plans to provide quality health care while containing costs. The AHCCCS contains costs by enrolling eligible members in contracted prepaid health plans and paying a fixed monthly payment for each enrollee. Cardiovascular drugs are a covered benefit under this program. The prepaid health plans contract with physicians, hospitals, and pharmacies to provide all AHCCCS-covered services to members.

Arkansas. The Arkansas Department of Health has a small program that provides prophylactic penicillin or substitute antibiotics for the prophylaxis of rheumatic fever in children with rheumatic valvular heart disease; no other cardiovascular medications are provided.

Connecticut. Connecticut’s Pharmaceutical Assistance Contract for the Elderly program enables the elderly as well as disabled individuals over age 18 to purchase medication at low cost. The income eligibility for singles is $13,300 or less, and $16,000 or less for married couples. There is no registration fee for the program, and members are charged a copayment fee of $4.00 per prescription.

Florida. The Florida Department of Health and Rehabilitative Services, through county public health units, provides comprehensive services to indigent clients in all 67 counties of the state. These services include blood pressure assessment, cardiovascular risk factor evaluation, lab testing, educational intervention, referral, and follow-up. Accessibility to services is targeted to medically underserved clients, with priority given to women of childbearing age, children, and adolescents. There is extensive Medicaid coverage for cardiovascular drugs, but non-Medicaid-eligible clients do not have the same accessibility to pharmacy services across the state. Some county public health units provide cardiovascular drugs for non–Medicaid-eligible clients, but the level of pharmaceutical services is dependent on local funding.

Georgia. The Georgia Department of Human Resources, Division of Public Health, has a Stroke and Heart Attack Prevention program that has been in place for several years. The program is conducted in 126 of Georgia’s 159 counties through public health clinics. Patients are referred by their private physicians to public health physicians or nurses if they have no insurance or third-party payer and cannot afford medication or follow-up care. Patients receive an assessment and diagnosis and, if needed, drugs for little or no cost depending on ability to pay. During 1990, 103,598 patients were screened, 16,212 were provided with education about nutrition and fitness, and 8,700 received prescription drugs. The majority of patients are treated jointly by the health department and private physicians. The health department has a Task Force for Access to Health Care in Georgia.

Hawaii. The Hawaii Prepaid Health Care Act, which was passed in 1974, requires private firms to offer health insurance for employees who work at least 20 hours a week. In 1990 the State Health Insurance Program, sponsored by the Department of Health, was launched to provide coverage for the “gap group” who do not qualify for Medicaid or the employee-sponsored health insurance; this medically indigent population comprises 3–5% of Hawaii’s total population. The Hawaii State Department of Health has several programs to help this segment
obtain medical care and cardiovascular drugs. Medical care is available to the indigent on a sliding fee schedule from private, nonprofit organizations, for example hospital-based outpatient clinics.

Idaho. The Idaho Department of Health does not provide cardiovascular services or drugs to the indigent.

Illinois. The Illinois Department of Public Health currently does not provide cardiovascular services or drugs to the indigent. However, the Illinois Department of Revenue has a Pharmaceutical Circuit Breaker Program that pays for medication for persons who qualify (they must be over age 65 and have an income of less than $14,000). A toll-free number is available to offer assistance.

Kansas. The Kansas Department of Health and Environment has 14 clinics for the medically indigent that offer a variety of services. While the types of services differ by clinic, most have physicians and nurses on site full-time and most use samples from pharmaceutical companies. Persons who have no insurance or cannot pay the deductible as well as some state Medicaid patients are eligible.

Kentucky. The Kentucky Department of Health Services provides nonpharmacological cardiovascular services in the form of education and counseling for hypertension and cholesterol patients throughout the state. These services are delivered through local health department staff, mainly by nurses, nutritionists, and health educators. These services are provided at a nominal charge of $1–$5, but no one is refused services if they are unable to pay. At this time medications are not provided through the Department of Health Services.

In 1985, the Kentucky Medical Association developed a program called Kentucky Physicians Care, in which the association works with physicians in the state to provide office visits free of charge to patients who report incomes at 100% of the federal poverty level but who are not eligible for Medicaid. Kentucky residents can call a toll-free number for information about the program and, if eligible, are referred to one of the program’s volunteer physicians. The initial visit and an average of four follow-up visits are provided free of charge. To date the program has referred 37,000 patients to physicians. In July 1989 the association invited pharmaceutical companies to become involved in the program by supplying cardiovascular drugs. Pfizer volunteered to participate and has donated $40,000–$50,000 worth of drugs (average wholesale cost) to the program. The Kentucky Pharmacists Association also became involved by dispensing Pfizer drugs free of charge to patients in the program. The patient takes his or her prescription to a participating pharmacist, who dispenses the drug to the patient. Each month the pharmacist sends a summary of dispersed prescriptions to the Kentucky Medical Association, which verifies patient eligibility and sends the summary to Pfizer. The pharmaceutical manufacturer then sends the pharmacist drugs to replace those that were dispensed. All of Pfizer’s prescription drugs are included in the program.

Louisiana. All of the 10 state-run general hospitals provide medical services and cardiovascular drugs.

Maryland. The Medical Assistance Program covers prescription services. All prescriptions, with a few exceptions such as less-than-effective drugs, are covered for recipients. Most recipients copay a fee of $0.50 per prescription if they are eligible for federal categories and $1.25 per prescription if they are in categories for which costs are paid solely with state funds. The Pharmacy Assistance Program covers prescription drug costs for persons with limited income and assets exceeding the Medical Assistance limitations. This program only covers prescription drug services. The recipient copayment is $4.00 per prescription, and coverage is limited to anti-infectives and maintenance drugs used to treat chronic conditions, for example cardiac drugs used on a long-term basis, anticoagulants, hemorrhheologic agents, hypotensive drugs, vasodilating agents, and erythropoetin.

Michigan. The Michigan Department of Public Health has a Children’s Special Health Care Services Program, which covers persons up to age 21 who have crippling cardiovascular conditions. Medical eligibility is the qualifying criterion for specialty care services and drugs. For higher-income families (250% of poverty level and more), there may be family financial participation. Michigan offers two prescription drug assistance programs for adults: in one program annual credit is available to eligible elderly whose out-of-pocket prescription drug spending exceeds 5% of income (spending is capped at $600 per year per qualified applicant); a companion program provides limited emergency assistance to those with extraordinary out-of-pocket expenses for prescription drugs.

Minnesota. The Minnesota Department of Human Services has two programs in place and another in the planning stage. The Medical Assistance program provides health care coverage for families with children, pregnant women, and aged, blind, and disabled persons who are unable to pay for necessary health care. The Medical Assistance program is partially funded by federal Medicaid. The Minnesota Medical Assistance program provides prescription drugs to its recipients. In 1990 approximately 280,000 recipients received $65 million worth of cardiovascular drugs. The prescription price paid by the Minnesota Department of Human Services is the lowest of the three: average wholesale price minus 10% plus a $4.10 dispensing fee, maximum allowable charge plus dispensing fee, or the usual and customary fee. The General Assistance Medical Care program helps low-income persons who are not eligible for other state or federal assistance programs pay for medical care. The program, which is funded by the state and counties, provided $8.8 million worth of prescription drugs to 42,000 recipients.

The Department of Human Services completed a feasibility study in April 1991 for a state-funded prescription drug assistance program. The program is intended to aid Minnesotans with high out-of-pocket
expenses for prescription maintenance and life-sus-
taining medications. It is designed to assist persons
who are ineligible for Medical Assistance or General
Assistance Medical Care, do not have private or
employer-sponsored health insurance coverage for
prescription drug expenses, and have family incomes
equal to or less than 185% of the federal poverty
guidelines. Two groups who are most likely to meet
the eligibility criteria are 1) low-income noninstitution-
ized seniors who have Medicare only or private
Medicare supplemental insurance that excludes drug
coverage, and 2) low-income noninstitutionalized dis-
able workers. Pharmacy claims submitted by partic-
ipating pharmacists for program enrollees are paid by
the state.

Mississippi. The Mississippi State Department of
Health has a hypertensive drug program that has
been in place for approximately 8–10 years. Patients
are referred to the health department through their
physicians for counseling and monitoring visits and
hypertensive drugs if needed. Fourteen hypertensive
drugs are available. The drugs are provided on a
sliding fee scale depending on the patient’s ability to
pay. Patients qualify if their income is at or below
180% of the poverty level. The state funds the costs
of the drugs but receives the drugs at a reduced price
from pharmaceutical companies. Approximately
10,000 patients have been served through this pro-
gram this year.

Mississippi also has another program, the Heart
Program, that funds the travel costs associated with
sending physicians from the University of Mississip-
pi’s Medical Center to different parts of the state to
perform chest x-rays and electrocardiograms on heart
patients whose income is at or below 180% of the
poverty level.

Missouri. The Department of Health is prohibited
from supplying prescription drugs free of charge but
does provide other services, including blood pressure
and cholesterol screenings and primary prevention
programs. Depending on the site, a nominal process-
ing fee may be charged. Anyone in Missouri can
receive these services.

New Jersey. Under the New Jersey Pharmaceutical
Assistance to the Aged and Disabled program, an
enrollee shows a pharmacy a card and is charged a
nominal copayment fee for prescription drugs.

New York. The State of New York Department of
Health has a program, the New York State Medical
Assistance Program, in which cardiovascular services
and drugs are available for reimbursement when
prescribed for a Medicaid-eligible individual by a
licensed medical practitioner. With the passage of
certain provisions of the Omnibus Reconciliation Act
of 1990, State Medical Assistance programs are
required to provide coverage for nearly all medica-
tions marketed by a pharmaceutical company that
has entered into a rebate agreement with the federal
Health Care Financing Administration. By and large,
al most major pharmaceutical firms have filed such an
agreement, and thus all important cardiovascular
medications are covered in New York. New York
also has the Elderly Pharmaceutical Insurance Cov-
erage (EPIC) program, which provides comprehen-
sive coverage to senior citizens with lower incomes
and catastrophic coverage to seniors with somewhat
higher incomes. Enrollees in the comprehensive cov-
erage program pay a modest premium ($20–$76 per
year) and save more than half the cost of prescrip-
tions. Those in the catastrophic coverage program
pay either a higher premium or a deductible to
purchase prescriptions at reduced cost.

Oklahoma. The Oklahoma State Department of
Health provides blood pressure screenings and moni-
toring in association with private physicians. They
also provide health education to individuals and
groups at worksites, with emphasis on lifestyle, nu-
trition, smoking cessation, exercise, and the need for
regular medical services. They do not furnish medi-
cations for the control of hypertension.

Oregon. Oregon does not have a program for the
indigent at this time.

Pennsylvania. Pennsylvania has a Pharmaceutical
Assistance Contract for the Elderly. Annual program
costs exceed $210 million and are expected to rise at
a rate of 12% annually. The program, which serves
over 410,000 state residents, is limited to persons
over age 65 with less than $12,000 annual income for
single persons and less than $15,000 annual income
for a couple. All who qualify can obtain any medica-
tion prescribed by their physician from the most
convenient pharmacy. State funds from the Pennsyl-
ylvania lottery are used to reimburse pharmacists.
The program, which has been deemed a model for other
states, receives no federal or industry funding, and
may be a target for budget cuts by the state.

Rhode Island. Rhode Island’s Pharmaceutical As-
sistance to the Elderly program (RIPAE) is admin-
istered by the Department of Elderly Affairs. The
program pays 60% of the costs of prescription drugs
used to treat heart problems for eligible persons.
Persons who are 65 or older qualify if their income is
$12,000 or less for singles or $15,000 or less for
married couples.

The Department of Health, Division of Family
Health, maintains a contract with Rhode Island
Hospital for the provision of pediatric cardiology
services. A sliding fee scale is used for both the
services (diagnostic and treatment) and prescription
drugs.

South Carolina. The South Carolina Department of
Health and Environmental Control does not pro-
vide clinical services or drugs for cardiovascular
patients, indigent or not. Their chronic disease pro-
gram has a primary prevention focus, with major
efforts centered on smoking, exercise, and diet.

South Dakota. The South Dakota State Depart-
ment of Health provides most cardiovascular drugs to
eligible Medicaid recipients. This coverage includes
injectable and orally and transdermally administered
currently approved drugs. Any new products ap-
proved by the Food and Drug Administration are automatically included for coverage.

Tennessee. In 1989 Tennessee passed the Community Health Agency Act, which established Community Health Agencies in each region of the state. The Community Health Agencies coordinate health care services for the indigent; some have pharmacy programs in which area pharmacies are contracted to dispense medications at a reduced cost, depending on the patient’s ability to pay.

Texas. The Texas Department of Health has a State Primary Care Program in 72 counties with high unemployment. The program is an ambulatory program that serves persons with heart problems whose income is at or below 150% of the poverty level and who are not eligible for Medicaid or Medicare. The health department arranges for a doctor’s visit, with patients charged a sliding fee (up to $5). Medication is also provided on a sliding fee scale (usually $1–$2). The health department’s annual budget for this program is $8.5 million, with $1 million allocated to drugs. Approximately 75,000 patients have been served, and 200,000 have been referred to Medicaid or Medicare.

Vermont. The Division of Children with Special Health Needs has a cardiovascular program for persons under age 21 who have congenital heart disease. The program does not have any income requirements for eligibility; however, to qualify enrollees must not have a third-party payer. The state covers the total cost of the cardiovascular drugs; antibiotics and prophylactic drugs are not covered.

Virginia. The Virginia State Department of Health funds a program in Richmond in which the Richmond High Blood Pressure Center provides physician and lab services by soliciting physicians to volunteer their time and lab services. The High Blood Pressure Center gives patients vouchers that can be taken to the pharmacy. Patients pay for the drugs on a sliding fee scale. The cost of the drugs is assumed by the pharmaceutical companies.

West Virginia. The West Virginia Department of Health and Human Resources does not currently have a program for the indigent.

Wisconsin. The Wisconsin Department of Health and Social Services does not currently have a program for the indigent other than Medicaid and Medicare programs.

Wyoming. The Wyoming Department of Health, Division of Preventive Medicine, participates in a Strept Program, which supplies penicillin.

Pharmaceutical Companies

Following are descriptions of programs, developed by pharmaceutical companies, that were available to the task force. This list is not comprehensive; other pharmaceutical companies may have similar programs of which the task force is not aware.

CIBA-GEIGY. CIBA-GEIGY does not have a formal program for the indigent but has established a task force to study the issue. Presently, the company provides drugs on a case-by-case basis but anticipates a formal program in the near future. A program has recently been instituted that is designed to hold down the cost of medication. The company guarantees that the retail price of CIBA-GEIGY’s new angiotensin converting enzyme inhibitor, Lotensin, will not increase for an individual patient. The product is currently priced below other angiotensin converting enzyme inhibitors. The program is not specifically directed toward the indigent but will protect patients from a price increase caused by any factor, including the need for dose titration.

G.D. Searle and Company. Searle’s “Patients in Need” program was begun in 1987. All Searle-manufactured cardiovascular drugs are provided free to anyone who is not insured. Requests must be made by the physician. The patient is given a certificate for free medication that can be redeemed at any pharmacy. Searle pays the pharmacist for the charges. There is no limit on the number of times a physician can make a request for a patient. As of May 1989, 65,000 heart disease patients had received 200,000 prescriptions for medication at no cost. The program’s retail value is estimated at $30 million, but Searle has assigned no monetary limits to the program.

Genentech, Inc. In June 1988 Genentech created the Uninsured Patients Program to assure availability of Activase to patients without medical insurance. Under these circumstances, Genentech will replace Activase used to treat patients who meet the following criteria:

- Annual family gross income of less than $25,000
- Not eligible for Medicaid
- Not eligible for Medicare
- No private insurance coverage
- Not eligible for other assistance programs

If the patient meets these criteria, the hospital completes a qualification form and attaches accompanying documentation that is used to verify the patient’s family’s annual gross income, diagnosis, and the dosage of Activase administered. Genentech’s reimbursement department reviews the information submitted to determine the patient’s eligibility. If approved, Activase replacement is shipped to the hospital within 30 days. Upon receipt of the replacement, the hospital credits the Activase charged to the patient’s account. To date, the Uninsured Patients Program has provided 2,981 vials of Activase, free of charge, to 1,484 patients who were treated in 1,067 hospitals across the United States.

Knoll Pharmaceuticals. Knoll distributes medication (e.g., Isoptin and Rythmol) in three ways: 1) free samples are given to physicians who pass them along to patients; 2) physicians can request a package of free medication from Knoll by completing a form or writing a prescription (turnaround time is 3–4 weeks; Knoll limits each physician’s requests to two per month); and 3) patients may obtain a certificate from their physician and take it to a pharmacist to receive 30 free tablets. There is no limit on the number of times the patient may use the certificate. The retail
cost of the certificate program to Knoll is approximately $300,000–$400,000 per month.

Marion Merrell Dow, Inc. Marion Merrell Dow, Inc., has no formal program but provides cardiovascular drugs to the indigent on a case-by-case basis.

Pfizer Inc. Pfizer supplies drugs on a case-by-case basis to physicians who contact the company. Pfizer is also involved with the Kentucky Medical Association program described earlier in this report.

Sandoz Pharmaceuticals Corporation. Sandoz has a program, run in conjunction with the National Organization for Rare Diseases, to provide Sandimmune (cyclosporin) to those who do not have insurance and/or cannot afford the ongoing financial burden.

SmithKline Beecham. In SmithKline’s “Indigent Patient Program,” the physician contacts the SmithKline representative, who then processes the request through the home office in Philadelphia. The drugs are sent back to the physician to dispense to the patient. This assistance is available on a one-time only basis to the patient.

Winthrop Pharmaceuticals Division of Sterling Drug Inc. Winthrop has no formal program but provides drugs on a case-by-case basis through its public affairs office.

American Heart Association Programs

The AHA does not currently have any access-to-medication programs targeted to the medically indigent. Following are descriptions of programs that the AHA implemented in the past.

Digitalis. In 1929 the AHA decided to distribute a standardized digitalis preparation. The New York Heart Committee prepared tablets of the leaf of digitalis with the desired characteristics and distributed them through AHA cardiac clinics. This action prompted the production of the drugs by commercial houses. By 1932 several products of equivalent potency were available, and the AHA deemed it unnecessary to continue distribution.

Penicillin. In 1953 the AHA issued a statement that secondary prevention of rheumatic fever was possible through provision of penicillin. Approximately 20 affiliates began programs in which penicillin was provided to rheumatic fever patients to prevent subsequent attacks. The affiliate programs, some of which were conducted with state health departments, continued until 1965. A description of the New York State Affiliate’s program is as follows: The affiliate, with the approval of the state pharmaceutical association, received bids from several drug houses and contracted with the lowest bidder to provide bottles with a specified number of tablets containing 250,000 units of penicillin at costs of less than 0.4¢ per tablet. Prescriptions for a month’s supply or more were made on request. Patients took the prescriptions to their pharmacies, where special packages were available from a wholesale druggist designated by the affiliate to receive the drugs obtained by the AHA. Any physician in the state could participate in the program by sending an application for each patient. The form included a checklist of rheumatic fever data and the current diagnosis. Upon receipt of the request, the AHA sent the prescription blanks for penicillin by return mail.

Recommendations

The Task Force recommends that the AHA

1. Join with the American College of Physicians, the AMA, and other professional organizations and voluntary health agencies to promote a national program of universal access to health care, including coverage for prescription drugs

2. Notify its members who are health professionals of all programs that supply cardiovascular drugs free of charge or at reduced cost to patients who cannot pay

3. Encourage affiliates in those states whose health departments provide medications to inform all health professionals that such programs are available. Encourage affiliates in states where this help is not available to support their health department’s development of such programs

4. Consider wide dissemination of information about these programs to all US physicians through the National High Blood Pressure Education Program and the National Cholesterol Education Program of the National Heart, Lung, and Blood Institute

5. Explore with the Public Affairs Policy Committee the possibility of initiating a federally funded program that provides free cardiovascular drugs to poor people who are not Medicaid recipients

6. Work with appropriate groups, for example AHA councils and committees (Research Committee and Education and Community Programs Committee) and the Agency for Health Care Policy and Research, to explore ways to stimulate research in the most effective treatments for cardiovascular disease and to stimulate education and community programs about preventive measures and issues of compliance

7. Actively participate in conferences organized by other associations regarding this issue and initiate and sponsor AHA conferences at both the national and affiliate levels

8. Urge the affiliates to review the status of the lack of availability of cardiovascular drugs in their communities and its impact on cardiovascular disease, mortality, and morbidity among all population groups, including minorities, poor children, and the elderly

9. In the implementation of recommendations of various AHA task forces, particularly those addressing issues of minorities, children, and the elderly, focus attention on the high prevalence of the poor, uninsured, and underinsured in these populations, in which morbidity and mortality from cardiovascular diseases are high
10. Present this report and its recommendations to the national media through the AHA Office of Communications

11. Review the impact of these recommendations in 1 year through a subcommittee of this task force

References


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