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Physician Dispense Makes Sense

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Key Points

- Allowing physicians to dispense medications will expand physicians' ability to provide care, improve patients' experience, and reduce the underuse of medications.
- Montana law currently authorizes physician dispense in limited situations and should expand this capacity broadly to all physicians in Montana.
- Physician dispense does not require patients to purchase their drugs at their physician's office but merely makes the option available to them, allowing them to shop for the best price and make tradeoffs between price and convenience.

Introduction

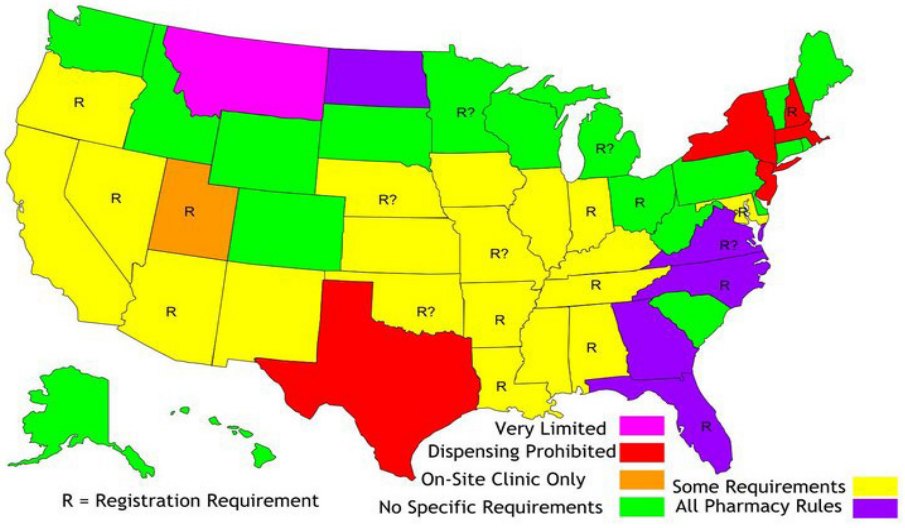
The majority of Montanans get their prescriptions from their physician then travel to a pharmacy to fill their prescriptions. Yet 45 states allow physicians to both prescribe and dispense medications, known as physician dispense, to some extent. Montana is behind the curve with no allowance for physician dispense in most of the state.

In 2018, nearly 30 percent of Americans did not take their prescriptions as recommended because of the cost (KFF, 21). Nineteen percent did not fill their prescriptions, 18 percent took over-the-counter drugs instead, and 12 percent cut their pills in half or skipped doses due to cost. Physician dispense can improve medication adherence by making prescription-filling more convenient and providing patients the opportunity to take their first dose in their physician's office with assistance from a physician or nurse. Physician dispense will expand physicians' ability to provide care, improve patients' experience, and reduce the underuse of medications.

Safety of Physician Dispense

The dispensing of medications by physicians is not new. The majority of states allow for some form of medication dispensing by physicians (**Figure 1**). Montana allows physician dispense in rural areas, so long as no pharmacies operate within 10 miles of the care facility (MCA §37-2-101). Montana physicians can also dispense free drug samples liberally or dispense in an emergency situation. (MCA §37-2-104).

Figure 1. Physician dispense laws by state



Source: "Physician Dispensing State by State Comparison," DPC Frontier

continued

A 2014 study by University of Utah faculty, funded by the state of Utah, found that the rate of adverse drug reactions (ADRs) resulting from physician-dispensed drugs were equivalent to those resulting from pharmacist-dispensed drugs (Munger et al., 8). The ADR rate was 7 percent for both dispensing scenarios, derived from self-reported patient survey results. The survey also revealed that patients "moderately agree[d]" that physician dispense improves the safety of taking medications (Munger et al., 8).

Forty-two percent of patients who reported experiencing serious ADRs from pharmacist-dispensed drugs consulted their primary care physician, 41 percent consulted a pharmacist, and 15 percent went to an urgent care or emergency room (ER) (Munger et al., 8). Among patients experiencing ADRs from physician-dispensed drugs, 64 percent consulted their physician, 28 percent consulted a pharmacist, and 6 percent went to an urgent care or ER, a significantly lower proportion than with pharmacist-dispensed drugs. The authors of the study conclude, "Prescriber dispensing of [prescription] and [over-the-counter] drugs is firmly entrenched in the U.S. health care system, is likely to increase, does not appear to increase ADRs, and may reduce urgent care and emergency department visits" (Munger et al., 9).

Health care scholars from the Curtin University of Technology and University of Western Australia conducted a systematic literature review comparing dispensing physicians' and non-dispensing physicians' practice patterns. They found that dispensing physicians tended to prescribe more pharmaceuticals than non-dispensing physicians, and that dispensing physicians prescribed fewer generics than non-dispensing physicians (Lim et al., 1). However, dispensing physicians were not found to prescribe less judiciously or to have poor dispensing standards (Lim et al., 8). The review also found that the main reason for both patients and physicians to participate in physician dispense was convenience (Lim et al., 7).

Physician dispense is not only safe, it also has the potential to increase medication adherence rates in Montana. A 2016 study in the *American Journal of Managed Care* found that the physician-led point of care medication delivery system, available to Medicare Advantage members, increased drug adherence rates for this population by 17 percent for oral antidiabetic agents, 29 percent for cholesterol medications, and 21 for blood pressure medications (Palacio et al., 1). The study included a survey of participating Medicare Advantage members, 76 percent of whom said the delivery system was more convenient than going to a pharmacy (Palacio et al., 2). Eighty-seven percent said that the model improved their ability to take their medication.

Pharmacists may reduce the marginal risk of ADRs by providing a second pair of eyes in the prescription process, but the software they utilize to check for potentially adverse drug interactions are becoming increasingly available to physicians (Held, 5:01:35). The technologies available today make it easy for health care professionals to view patients' prescription and medical records. Physician dispense is a state-level reform that can provide patients more options.

Impact on Drug Prices

How physician dispense will affect the cost of drugs to patients is unclear. Studies on the subject do not offer consistent results, largely due to the inconsistency of implementation between states and programs.

The study of Medicare Advantage's physician-led point of care medication delivery system (mentioned above) identified a trend toward reduced drug costs, but was unable to demonstrate statistical significance overall (Palacio et al., 2). In contrast, the systematic literature review (mentioned above) of physician dispense in several different countries found that dispensing physicians prescribed fewer generic drugs than non-dispensing physicians, corresponding with "modestly higher pharmaceutical costs per patient per year" (Lim et al., 5).

A 2012 study by the Workers Compensation Research Institute (WCRI) examined 23 states that allowed physician dispense in their workers' compensation systems. According to WCRI, the bulk of drugs commonly dispensed by physicians were 60 to 300 percent more expensive per pill than their equivalents dispensed at retail pharmacies (Wang, 10). Some dispensing physicians wrote prescriptions for over-the-counter drugs and charged 5 to 15 percent more than national pharmacy chains for the same drug (Wang, 12).

One reason dispensing physicians might charge more for certain drugs is lack of access to the same bulk discounts that pharmacies enjoy through their relations with wholesalers and manufacturers. Furthermore, the cost of physician-dispensed drugs might be more expensive than pharmacist-dispensed drugs because, at the pharmacy, patients receive discounts through their insurance, which represents a portion of their monthly premium. In other words, the cost of the drug is split between the amount patients pay at the pharmacy and the amount they pay for insurance.

The savings enabled by physician dispense will not always be monetary (cash savings) but can also be convenience-related (time savings, travel savings, stress savings, etc.). Patients may opt to purchase certain drugs at a pharmacy, others from their physician. Ultimately, it is important to recognize that physician dispense does not require patients

to purchase their drugs at their physician's office but merely makes the option available to them, allowing them to shop for the best price and make tradeoffs between price and convenience.

Recommendation

Allow physicians to dispense medications across the state of Montana in a manner that grants physicians maximum flexibility to perform this service.

The Montana Legislature saw a proposal as recently as 2015 to expand physician dispense by amending Title 37, Chapter 2 of the Montana Code Annotated, "Dispensing of drugs by medical practitioners unlawful - exceptions" (SB 271.).

Efforts to expand physicians' ability to dispense drugs have been contested by pharmacy cooperatives in the state (Tinsen). Their primary stated reasons for opposition are patient safety, the need for regulatory oversight, and potential conflicts of interest that may lead to patients paying more for physician-dispensed drugs than pharmacist-dispensed equivalents. However, patients who value cash-savings above convenience-savings will be able to shop for the best drug prices if physician dispense becomes the law of land. Physician dispense is unlikely to hinder patients' ability to achieve these savings, especially in the 21st century where price comparisons are easily conducted online or over the phone. It is a safe and efficacious policy for Montanans.

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Jennifer Minjarez is a former policy analyst for Right on Healthcare at Texas Public Policy Foundation. Jennifer graduated from the University of Arizona with a B.A. in economics and a B.A. in philosophy, politics, economics, and law (PPEL). Prior to joining the Foundation, Jennifer worked with a number of liberty-advancing organizations, such as the Goldwater Institute and Americans for Prosperity. She is proud to continue this work in Texas.

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