

Access to prescription drugs among noninstitutionalized elderly people in west Texas

K. TOM XU, SCOTT R. SMITH, AND TYRONE F. BORDERS

Health care insurers face increasing demands to provide elderly beneficiaries with prescription drug coverage. Although older Americans have a great need for pharmaceutical products, universal access to prescription medications and pharmaceutical services is not ensured through government programs. Medicare, the nation's largest health insurance program, does not currently cover prescription drugs for all its beneficiaries. Access to prescription drugs became a campaign issue in the presidential election of 2000, and this fostered a national debate about whether prescription drugs should become part of the Medicare entitlement program. Although the elections raised public awareness about the problems of drug access and affordability facing the elderly, there is limited knowledge about patterns of access to prescription medications and pharmaceutical services. Policymakers need evaluative information about factors contributing to unequal access that may be amenable to policy interventions.

The national Medical Expenditure Panel Survey found that 87% of

Abstract: The determinants of realized, perceived, and potential access to prescription drugs among an elderly population were studied.

Data were derived from telephone interviews of 3498 noninstitutionalized elderly persons living in west Texas. Access indicators examined were whether the respondents were taking prescription drugs, had perceived problems in obtaining prescription drugs, had comprehensive prescription drug insurance, and had a usual pharmacy. On the basis of the behavioral model of health services, multivariate logistic regression analysis was performed to determine whether predisposing, enabling, and need factors were associated with each access indicator.

Approximately 14% of the patients were not taking prescription drugs at the time of the interview. Of the patients who were taking prescription drugs, about 16% reported

having problems obtaining prescription drugs and 24% primarily used a single pharmacy. Nearly 36% did not have comprehensive prescription drug coverage. Among the four indicators of prescription drug access, lack of prescription drug insurance was the most prevalent barrier. Employer-provided insurance improved access more than any other type of coverage. Elderly consumers taking more medications reported more problems accessing prescriptions than those taking fewer medications.

Among the indicators of access to prescription drugs among noninstitutionalized elderly people in west Texas, lack of prescription drug insurance was the most prevalent barrier.

Index terms: Ambulatory care; Data collection; Drug distribution; Geriatrics; Health-benefit programs; Prescriptions

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Americans age 65 years or older purchased at least one prescription medication in 1996, compared with 60% of those under 65.¹ The Office of Actuary in the Centers for Medicare and Medicaid Services reported that the share of total personal health expenditures for hospital services fell

between 1980 and 1997, while the share of prescription drug spending rose from 5% to 8%.^{2,3}

In 1991, the per capita annual spending for prescription drugs by elderly people was estimated to be nearly \$500, but approximately 45% of this population did not have pre-

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scription drug coverage.⁴ According to estimates from the 1998 Medicare Beneficiaries Survey, average spending for prescriptions was \$546 for beneficiaries without drug coverage and \$999 for those with coverage.⁵ Since many elderly persons live on a limited monthly budget, some must ration their use of prescription drugs, make special financing arrangements, substitute other treatments, or postpone treatment.⁶ These strategies reduce individuals' compliance with a treatment regimen and may compromise their health status.

To study the determinants of access to prescription drugs, we applied the behavioral model of health services developed by Andersen.⁷ This model has been widely used to examine access to health services but has rarely been applied to efforts to understand access to prescription drugs.⁸ Our study sought to identify the determinants of realized, perceived, and potential access to prescription drugs, focusing on insurance type, intensity of medication use, system factors, and skepticism about medical care.

Methods

Study design. The study analyzed data collected from the Texas Tech 5000 Survey conducted by the Department of Health Services Research and Management at Texas Tech University Health Sciences Center. The Texas Tech 5000 Survey was based on a telephone listing of 65,000 households in west Texas, a largely rural and ethnically diverse region. A detailed description of the study design can be found in a companion study published elsewhere.⁹

The current study used the data from the first two phases of the survey. The eligible sample for the first phase consisted of 6942 people 65 years of age or older. Of those sampled, a total of 5006 people responded, yielding a 72.1% response rate. The sampling frame for phase 2 was

based on respondents in phase 1. Excluding individuals who refused to participate in future interviews, were deceased, or were too ill to participate, and those whose telephones were disconnected, the net sample size for the second phase was 4141. Of the 4141 persons eligible to participate in the second phase, 3696 responded, yielding an 89.3% response rate. The overall response rate for those who participated in both phases was 53.2%.

Data. Data for individuals were derived from the Texas Tech 5000 Survey. County-level information about the availability of pharmacies and pharmacists was obtained from the Texas State Board of Pharmacy.

Access indicators. Because access to pharmaceutical services has been understudied relative to access to medical care, standard indicators of pharmaceutical service access have not been developed. We thus selected indicators of realized, perceived, and potential access to prescription drugs that complement typical indicators of medical care access. The realized-access indicator, showing whether an elderly individual was taking any prescription drugs at the time of the interview, is conceptually similar to measures of realized medical care access, such as whether an individual has visited a physician or has been admitted to a hospital.¹⁰ Use of prescription medications was coded as a binary variable, with 1 indicating use and 0 representing no use.

The perceived-access indicator, which reflects the patient's perception of the difficulty of obtaining prescription drugs, is similar to measures of the difficulty of obtaining an appointment for medical care, such as those described in the Consumer Assessment of Health Plans Study.¹¹ Difficulty in obtaining prescriptions was categorized by respondents as a "big problem," "a small problem," or "no problem at all." Preliminary analyses of the data showed that this variable was highly skewed, with a

large proportion of respondents answering "no problem." Therefore, the variable was dichotomized into "no problem" and "have problems."

The potential-access indicator, showing whether a respondent's insurance covered all potentially needed prescription drugs, is comparable to indicators of access to potentially needed medical care, such as comprehensive health insurance.¹⁰ This indicator was coded as a binary variable, with 1 representing prescription drug insurance covering all needed prescriptions and 0 representing no such insurance. To avoid the confusion between this indicator and type of insurance, such as Medicaid or private insurance, which are treated as enabling factors, we will refer to this indicator as comprehensive prescription drug coverage.

A fourth measure—also an indicator of potential access—was whether the respondent had a usual pharmacy. This indicator examined the continuity and service aspects of access to prescription drugs and is comparable to having a usual source of care in the studies of access to medical care. We hypothesized that having a usual pharmacy would improve the coordination of prescription drug use and, through centralized record-keeping, make it easier to detect potential adverse drug events. The survey participant was asked how many pharmacies he or she usually visited; answers were categorized as one, two, or three or more. Strong skewness was observed in this variable; a majority of the respondents indicated primarily using only one pharmacy. Hence, this variable was dichotomized into one pharmacy and more than one pharmacy.

Independent variables. The behavioral model theorizes that access is determined by a person's predisposing, enabling, and need factors. In this study, predisposing factors were race or ethnicity, age, sex, employment status, and health beliefs. Respondents were categorized as non-Hispanic

whites, Hispanics, and people with other racial backgrounds (primarily blacks). Although most people over 65 years of age are retired, some respondents were still employed. Consequently, a binary variable was created to indicate whether a respondent was employed.

Skepticism about medical care was measured with four questions included in the National Medical Expenditure Survey. Previous studies have shown that skepticism toward medical care is associated with fewer physician visits, lack of a usual physician, lower use of hospital care, and lower health care expenditures.¹² Respondents were asked whether they agreed with the following four statements:

1. I can overcome most illness without help from a medically trained professional.
2. Home remedies are often better than drugs prescribed by a doctor.
3. If I get sick, it is my own behavior that determines how soon I get well again.
4. I understand my health better than most doctors do.

The responses were categorized as strongly agree, agree, neutral, disagree, and strongly disagree. In the analysis, these responses were classified as agree, disagree, or neutral.

Nine enabling factors were included in the analysis. Since the majority of elderly people are retired, monthly income may not be a meaningful measure of an individual's ability to purchase prescription drugs. As a result, we adopted the respondent's highest income in his or her lifetime as a surrogate indicator of purchasing power. Because the elderly respondents in the sample had Medicare and it does not typically cover prescriptions, we asked whether respondents had additional insurance. The additional insurance types were Medicaid, other federal insurance, employer-provided insurance, and other supplemental insurance. The additional insurance types

were not mutually exclusive because some respondents had multiple insurance plans purchased by themselves or through family members. Four dummy variables representing these insurance types were created.

Other enabling factors included whether respondents had a usual source of care (no usual source of care, a usual physician, or a usual site), whether they lived within the city limits, whether they had concerns about transportation costs, and whether they had concerns about travel distance. Place of residence was categorized as urban, rural, or frontier county. Rural was defined as a nonmetropolitan county or a county with fewer than 50,000 persons. Frontier was defined as a nonmetropolitan county that had fewer than seven persons per square mile.¹³

System-related enabling factors were also included. Examples of system-related enabling factors in the behavioral model are the numbers of physicians and hospital beds per 1000 population. Because the present study focused on access to prescription drugs, measures of the potential accessibility of pharmaceutical organizations and providers were included. A list of pharmacies and pharmacists practicing in the 105 counties covering the sample area was obtained from the Texas State Board of Pharmacy. Business addresses of the pharmacies were used to identify their locations. The county population was obtained from the Texas Department of Health. The numbers of pharmacies and pharmacists per 1000 population in each county were calculated. Although they are likely to be positively correlated, pharmacy density and pharmacist density measure different aspects of the availability of pharmaceutical services. Pharmacy density is the average number of business establishments in each county, an indicator of the availability of prescription and nonprescription drugs. Higher pharmacist densi-

ty, however, indicates the availability of skilled personnel for providing services.

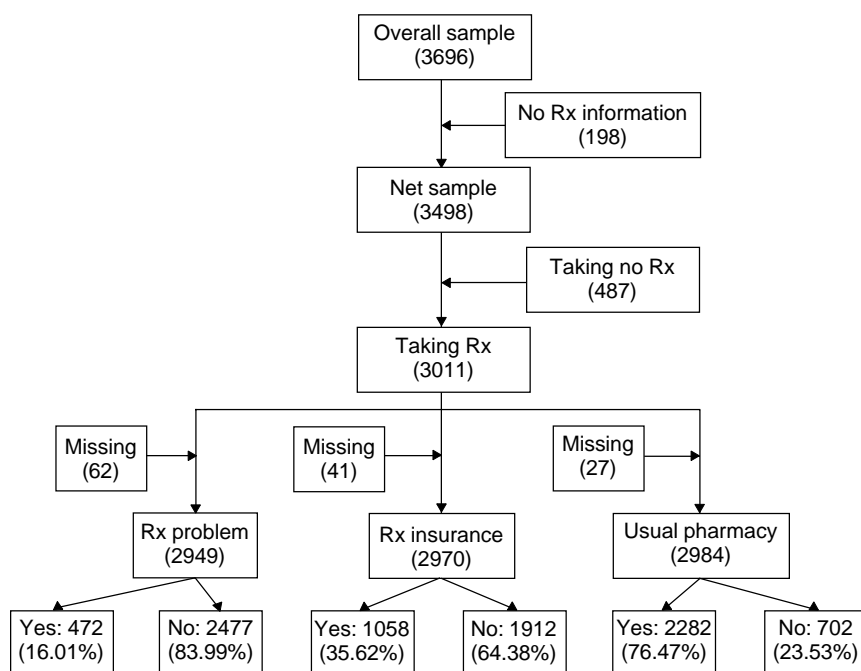
Several need factors were included. First, the 12-Item Short-Form Health Survey was used to measure physical (PCS12)- and mental health (MCS12)-related quality of life.¹⁴ Higher PCS12 and MCS12 scores indicate better physical and mental health, respectively. We were interested in whether elderly persons who used more medications reported more access problems. The variables measuring medication use were the total number of prescription drugs and the total number of nonprescription drugs used.

Analysis. Descriptive analysis was first performed to identify with which aspect of access—potential, perceived, or realized—the elderly people had most problems. Multivariate analysis was performed to identify factors associated with access to prescription drugs. Logistic regression was used because all four dependent variables were dichotomized. The independent variables were the predisposing, enabling, and need factors.

Results

Figure 1 illustrates the selection process and the distribution of responses for the indicators. Most respondents were taking prescription drugs at the time of the interview. Among the elderly patients who took prescription medications, over 80% did not report problems with obtaining prescriptions. Over three quarters of the respondents who took prescription drugs had a usual pharmacy. However, only about one third of the respondents who took prescription drugs had comprehensive prescription drug coverage. The characteristics of the 3498 elderly people for whom prescription drug information was available are shown in Table 1. For categorical and binary variables, sample frequencies and proportions are reported. For con-

Figure 1. Selection process for study sample and distribution of responses for indicators.



tinuous variables, means and standard deviations are shown.

Multivariate analysis results are shown in Table 2. Estimates of odds ratios (ORs) are reported for each of the four logistic regression models. Overall, enabling and need factors were found to be significantly associated with access to prescription drugs. Health beliefs were not found to affect comprehensive prescription drug coverage or having a usual pharmacy. Moreover, beliefs that a person's own health behavior determines health and that a person understands his or her own health better than physicians were not found to affect any indicators of access. However, the belief that a person can overcome illness without a medical professional's help was found to lower the odds of taking prescription drugs by about 26% ($p < 0.05$) and the odds of having problems obtaining prescription drugs by about 19% ($p < 0.10$). Believing that home remedies are better than prescription drugs was significantly associated with not taking any prescription drugs (OR = 0.628).

Enabling factors, especially insurance in addition to Medicare, were significantly associated with all four indicators of access to prescription drugs. Having Medicaid, although not affecting the other three access indicators, was found to increase the odds of having comprehensive prescription drug coverage by over 60% ($p < 0.01$). Other federal insurance affected only one indicator, having a usual pharmacy (OR = 0.660). Employer-provided insurance affected all four indicators. In particular, having employer-provided insurance more than quadrupled the odds of having comprehensive prescription drug coverage ($p < 0.01$). Employer-provided insurance also increased the odds of taking prescription drugs by about 35% ($p < 0.05$) and decreased the odds of having problems getting prescriptions by 32% ($p < 0.01$). In the effects on these two indicators, having supplemental insurance was associated with higher odds of taking prescription drugs (OR = 1.301) and lower odds of having problems getting prescription drugs (OR = 0.820). In contrast to having

employer-provided insurance, having supplemental insurance was found to reduce the likelihood of having comprehensive prescription drug coverage (OR = 0.650). Having any other insurance (except for supplemental insurance) in addition to Medicare reduced the odds of having a usual pharmacy ($p < 0.01$).

Among all the independent variables, having a usual source of care had the most dramatic positive impact on the odds of taking prescription drugs (OR = 6.042). However, having a usual source of care seemed to be associated with lower odds of having a usual pharmacy (OR = 0.488). Compared with urban residents, rural residents were less likely to have problems getting prescription drugs. However, compared with urban residents, frontier county residents had much lower odds of taking prescription drugs (OR = 0.593), lower odds of problems getting prescription drugs (OR = 0.699), and lower odds of having a usual pharmacy (OR = 0.638). No differences in prescription drug coverage were found between rural and urban respondents.

Although neither pharmacy density nor pharmacist density influenced the odds of taking prescription drugs, higher pharmacy density increased the odds of having a usual pharmacy by over 1.6 times ($p < 0.01$). Higher pharmacist density was significantly associated with lower odds of having problems getting prescription drugs (OR = 0.727). Higher pharmacy density was associated with lower odds of having comprehensive prescription drug coverage, whereas higher pharmacist density was related to higher odds of having such coverage.

After adjusting for other potential confounders, more prescriptions were associated with more problems in getting prescription drugs (OR = 1.083) and lower odds of having a usual pharmacy (OR = 0.889). However, having more prescriptions was

Table 1.
Characteristics of Sample

Variable	Value
Predisposing factors	
Race, no. (%)	
Non-Hispanic white	2980 (85.19) ^a
Hispanic	368 (10.52) ^b
Other races	150 (4.29) ^c
Age, no. (%)	
65 yr	309 (8.83) ^d
66–70 yr	1073 (30.67) ^e
71–75 yr	937 (26.79) ^f
76–80 yr	664 (18.98) ^g
≥81 yr	515 (14.72) ^h
Sex, no. (%)	
Male	1069 (30.56) ⁱ
Female	2429 (69.44) ^j
Employment status, no. (%)	
Not employed	2968 (84.85)
Employed	530 (15.15)
Health-related beliefs, no. (%)	
Cannot overcome illness without medical help	2309 (66.01)
Can overcome illness without medical help	1189 (33.99)
Home remedies are not better than prescription drugs	2209 (63.15)
Home remedies are better than prescription drugs	1289 (36.85)
Own behavior does not determine health	1094 (31.28)
Own behavior determines health	2404 (68.72)
Do not understand own health better than physicians	1589 (45.43)
Understand own health better than physicians	1909 (54.57)
Enabling factors	
Highest income in lifetime, mean ± S.D. \$×10,000	3.867 ± 2.606
Insurance, no. (%)	
Medicaid	367 (10.49)
Other federal insurance	336 (9.61)
Employer-provided insurance	1141 (32.62)
Supplemental insurance	1755 (50.17)
Usual source of care, no. (%)	
No usual source of care	222 (6.35)
Usual physician	2186 (62.49)
Usual site	1090 (31.16)
Where living, no. (%)	
Outside city limit	562 (16.07)
Inside city limit	2936 (83.93)
Urban county	1947 (55.66)
Rural county	1145 (32.73)
Frontier county	406 (11.61)
Issues related to transportation, no. (%)	
Not concerned about transportation costs	1903 (54.40)
Concerned about transportation costs	1595 (45.60)
Not concerned about travel distance	2509 (71.73)
Concerned about travel distance	989 (28.27)
Availability of pharmacies and pharmacists	
No. pharmacies per 1000 population, mean ± S.D.	0.35 ± 0.14
No. pharmacists per 1000 population, mean ± S.D.	0.73 ± 0.34
Need factors, mean ± S.D.	
Monthly prescription drug expenditure, \$	102.27 ± 128.91
Monthly nonprescription drug expenditure, \$	16.48 ± 46.55
No. prescription drugs	3.09 ± 2.32
No. nonprescription drugs	1.46 ± 1.33
PCS12 ^k	40.56 ± 11.80
MCS12 ^l	54.92 ± 8.57

^a2000 U.S. Census figure for elderly population (≥65 years of age), 83.67%.

^b4.86%.

^c11.47%.

^d5.80%.

^e26.80%.

^f24.67%.

^g19.92%.

^h22.80%.

ⁱ41.18%.

^j58.82%.

^kPCS12 = physical health domain of 12-Item Short-Form Health Survey (SF-12).

^lMCS12 = mental health domain of SF-12.

associated with higher odds of having comprehensive prescription drug coverage (OR = 1.041). More nonprescription drugs increased the odds of taking prescription drugs (OR = 1.238) and having problems getting prescription drugs (OR = 1.105) and reduced the odds of having a usual pharmacy (OR = 0.886). The number of nonprescription drugs, however, was not associated with the odds of having comprehensive insurance. Healthier elderly persons were less likely to take prescription drugs ($p < 0.01$) and less likely to report having problems getting prescription drugs if they took any ($p < 0.01$).

Discussion

Access to prescription drugs among the elderly is one of the least-studied dimensions of access to health care. Pharmaceutical products are vital in the treatment of chronic conditions and diseases in the elderly population. Consequently, evaluating access to prescription drugs and identifying barriers have significant policy implications for improving the care for the elderly.

Previous studies of the elderly population's access to prescription drugs have mainly focused on prescription drug insurance. This study explored other indicators of access to prescription drugs. Using the behavioral model, we investigated potential, perceived, and realized access to prescription drugs. Among all four indicators of access, prescription drug insurance was the biggest barrier, as indicated by our finding that more than one third of the elderly patients did not have comprehensive coverage. We also found that only a relatively small percentage (14–16%) had problems in realized access (taking prescription drugs) and perceived access (no problem obtaining prescription drugs). Among individual characteristics, enabling and need factors were significantly associated with access to prescription drugs. In particular, insurance, such as employer-provided insurance, in ad-

Table 2.

Results of Multivariate Analyses of Realized, Perceived, and Potential Access to Prescription Drugs

Variable	Odds Ratio			
	Currently Taking Prescription Drugs (n = 3498)	Have Problems Obtaining Prescription Drugs (n = 2949)	Have Comprehensive Insurance (n = 2970)	Have a Usual Pharmacy (n = 2984)
Predisposing factors				
Non-Hispanic white				
Hispanic	0.720 ^a	1.052	0.969	0.864
Other races	0.755	1.066	1.761 ^b	0.930
65 yr				
66–70 yr	1.049	1.206	0.922	0.843
71–75 yr	0.999	0.895	0.854	0.899
76–80 yr	0.965	0.831	0.926	1.105
≥81 yr	0.814	0.701	0.786	1.100
Male				
Female	1.525 ^b	0.957	0.957	1.353 ^b
Not working				
Working	0.763 ^c	1.037	0.692 ^b	1.139
Can overcome illness without medical help	0.737 ^b	0.812 ^a	0.995	1.091
Home remedies better than prescription drugs	0.628 ^b	1.080	0.957	1.002
Own behavior determines health	0.952	0.953	1.052	0.943
Understand own health better than physicians	0.900	1.122	0.998	0.969
Enabling factors				
Highest income in lifetime	1.661 ^a	0.705	1.362	0.859
Medicaid	0.957	1.151	1.591 ^b	0.927
Other federal insurance	1.191	0.899	1.120	0.660 ^b
Employer-provided insurance	1.349 ^c	0.675 ^b	4.053 ^b	0.565 ^b
Supplemental insurance	1.301 ^c	0.820 ^a	0.650 ^b	0.866
Have no usual source of care				
Have usual source of care	6.042 ^b	0.978	1.386	0.488 ^c
Live inside city limit	1.080	0.986	1.208	0.753 ^c
Concerned about transportation costs	0.894	1.179	0.863 ^a	1.034
Concerned about travel distance	0.861	1.473 ^b	0.850	1.054
Urban county				
Rural county	0.890	0.703 ^b	0.987	1.022
Frontier county	0.593 ^b	0.699 ^a	1.063	0.638 ^b
Number of pharmacies per 1000 population	1.491	1.451	0.556 ^a	2.579 ^b
Number of pharmacists per 1000 population	1.027	0.727 ^a	1.256 ^a	0.802
Need factors				
Number of prescription drugs	NA	1.083 ^b	1.041 ^c	0.889 ^b
Number of nonprescription drugs	1.238 ^b	1.105 ^c	0.952	0.886 ^b
PCS12 ^d	0.941 ^b	0.973 ^b	1.006	1.002
MCS12 ^e	0.970 ^b	0.972 ^b	1.010 ^c	0.998

^ap < 0.10.

^bp < 0.01.

^cp < 0.05.

^dPCS12 = physical health domain of 12-Item Short-Form Health Survey (SF-12).

^eMCS12 = mental health domain of SF-12.

dition to Medicare and the intensity of prescription use, affected all four indicators of access.

Among the predisposing factors, we found that skepticism about medical care, namely a perception that one could overcome an illness without medical assistance, was associated with lower odds of taking prescription drugs. Skepticism about medical care has been shown to be associated with the utilization of medical care services¹² and satisfac-

tion with health care.¹⁵ However, persons who did take prescription drugs and believed in their ability to overcome illness without medical help perceived fewer problems obtaining prescription drugs. This might be expected, as those who are taking prescription medications have gained access to the pharmaceutical care system.

Private insurance, in addition to Medicare, plays an important part in determining elderly people's access

to prescription drugs. Employer-provided insurance was the most favorable type in improving access. Interestingly, Medicaid improved only potential access but not the other indicators. In a recent survey of Medicare beneficiaries, even among elderly people with both Medicare and Medicaid, nearly 1 in 10 indicated that they spent more than \$100 per month on prescriptions.¹⁶ Elderly Medicaid beneficiaries were not more likely to take prescription

drugs, to have fewer problems in getting prescription drugs, or to have a usual pharmacy than elderly non-Medicaid beneficiaries. Consequently, it can be inferred that Medicaid insurance for elderly patients improves only *potential* financial assistance to access. Medicaid prescription coverage may not be sufficient to ensure adequate realized access to prescription drugs.

It is of concern that patients who took more medications had more problems accessing prescription drugs than those who took fewer medications. This is particularly important in light of previous research showing that polypharmacy is associated with noncompliance and poorer health outcomes.¹⁷ The complexity of multidrug regimens and elderly patients' chronic conditions may require more management efforts, coordination, and consultations calling for pharmacist involvement. Pharmacist recommendations have been demonstrated to reduce inappropriate prescribing,¹⁸ improve cardiovascular outcomes,¹⁹ lower cholesterol levels,²⁰ and positively affect blood pressure control.²¹ The involvement of pharmacists has also been found to improve elderly patients' medication compliance²²⁻²⁴ and overall adherence to therapy.²⁵ In sum, additional pharmacist involvement in care may be needed to further improve access to prescription drugs.

The results of this study may assist pharmacists in working with the elderly. Factors such as Hispanic race, health beliefs, and insurance status affected access to prescription drugs. By recognizing the potential role these factors have in access to medications, pharmacists who work with the elderly may be able to remove or lower some of the barriers. In addition, some pharmacists may need to adapt their routine counseling practices by asking elderly patients more questions about insurance problems, personal beliefs about health and overcoming illnesses, and the use of

home remedies as substitutes for prescription medications.

This study has several limitations. Because the study involved telephone surveys, all the prescription information was self-reported. The survey covered only people with home telephones; institutionalized elderly people and those who did not have telephones were not included in the sample. However, only about 4% of households in Texas do not have telephones. Because pharmacy-specific information was not collected, we were unable to establish the extent to which specific pharmacy or pharmacist characteristics contributed to access to prescription drugs. Although the four indicators have been used independently in other studies, the current study is the first to treat them as different dimensions of access to prescription drugs. Consequently, this approach warrants further research to establish validity. The study did not take into account the appropriateness of medication use; it is possible that some medications were inappropriately prescribed or used. Finally, the study was more explorative than conclusive. Although the study used a sample from Texas, it is possible that the results can be applied to states that have characteristics similar to those of west Texas, such as New Mexico and Arizona.

Access to prescription drugs among elderly patients needs to be addressed in designing programs to improve elderly patients' health, to increase compliance with therapy, and to diminish inequality in care. In the current study, although a significant proportion of patients had potential problems in accessing prescription drugs, realized and perceived access did not present any significant problems. Among the indicators of access, lack of prescription drug insurance was the most prevalent barrier. Special attention to insurance coverage of prescription drugs among elderly people is needed, especially among

those who use multiple medications concomitantly. Further research should be conducted to establish whether our results can be generalized to other subpopulations of the elderly.

The inclusion of prescription drug coverage in Medicare, if ever realized, would have profound impact on elderly patients' access to prescription drugs. Potential access would be greatly improved, and, theoretically, realized access would also increase, leading to better compliance and health outcomes. However, to what extent the realized access could be improved through better potential access is unclear. As our study demonstrated, although Medicaid improved potential access, no improved realized or perceived access was observed.

Conclusion

Among the indicators of access to prescription drugs among noninstitutionalized elderly people in west Texas, lack of prescription drug insurance was the most prevalent barrier.

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