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Medicine price awareness in chronic patients in Belgium

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ABSTRACT

Introduction: Under increasing pressure to contain health expenditures governments across Europe have implemented policies to increase responsible medicine use, e.g. by increasing co-insurance paid for by patients. In times of austerity, how do chronic disease patients perceive the medicine price they have to pay?
Method: We used a mixed methods research design. First, we distributed a close-ended questionnaire among 983 chronic disease patients in 30 Flemish pharmacies. Second, we performed semi-structured interviews with 15 of these patients. We surveyed for knowledge on the prescription medicine they bought, as well as for their needs for information and their therapeutic compliance.
Results: Although patients express a lack (and a need) of information on prices during the consultation with the general practitioner (GP), (s)he hardly addresses medicine prices. Patients often only know the medicine price when they are at the pharmacy and patients need to decide to buy the medicine or not. This often results in patients taking the medicine when considered affordable within their social and financial context.
Conclusion: It seems essential that patients are better informed about medicine prices as well as the constraints on physicians to prescribe cost-effectively. Therefore, medicine prices should be discussed more often during physician consults.

1. Introduction

To address the growing strain on the available resources for health care, governments across Europe made cuts in pharmaceutical spending. Since 2007, pharmaceuticals took up on average 15.8% of total health expenditures in Belgium. Between 2000 and 2006, the average annual growth rate per capita health expenditure in Belgium was 2.3% and this decreased to 1.6% between 2006 and 2012 [1]. It remains unclear whether this trend is solely the result of the economic crisis, or whether it reflects greater efficiency resulting from structural changes [2].

The Belgian health care system provides reimbursement for medicine consumption and covers the entire population. It applies a system of co-insurance where the patient pays a part of the cost for medicines, i.e. co-payment.

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It foresees several ways to protect the households with lower income levels. The proportion of co-payment per medicine package is limited, depending on the type of medicine and on the household income (households with lower income pay proportionally less). Additionally, since 2002, the total annual co-payment amount has been limited to a maximum bill. When co-payments accumulated over a year exceed the fixed maximum bill, all additional costs are reimbursed for the remaining year [3]. Households with lower income (and since 2013 also chronic patients) have a lower maximum bill, so they face less co-payment for their medicine use [4]. In Belgium, 28.5% of people over 15 years of age, suffered from a chronic illness (self-reported data from the National health survey Belgium, 2013) [5].

Several studies have shown that physicians tend to wrongly estimate the prices of medicines [6,7]. The lack of accessible information and a supportive software program during the consultations seem important factors that hinder price awareness in physicians [7,8]. General practitioners seem to consider medicine prices secondary to clinical effectiveness and safety [9]. They report not being influenced by patients' out-of-pocket costs when prescribing medication, unless on the patient's request [10]. Watkins et al. found several factors that could explain the intention to prescribe more expensive medicines, for example the frequency of visits from the pharmaceutical representatives [11].

The factors contributing to non-compliance are diverse and complex. The price of medication might also be an important factor for chronic patients as their total cost may rapidly become a substantial part of their budget. Several policies are embedded in the Belgian reimbursement system to protect chronic patients in low-income households. Nonetheless, increasingly such households are compelled to make trade-offs between daily living cost and health care expenditures. In this sense, the economic recession could have an exacerbating negative effect on people's health (although it also depends on the actions taken by every country individually to address the recession) [12,13]. In this study, we explored the price awareness of chronic patients and how this affects therapeutic compliance.

2. Material and methods

We used a mixed methods research design, which typically combines qualitative and quantitative research methods to address a mutual research question. In this study, we applied a sequential mixed method design. We started with the quantitative research to describe the prevalence of a certain phenomenon and looked for further explanations for these phenomena in the sequential qualitative study [14].

The inclusion criteria for patients in both studies was the current use of a cholesterol lowering medicine, an acid blocking agent and/or an antidepressant. These are three medicine groups for chronic disease treatment that have resided in the top five of most prescribed medicines for the past 15 years [15].

2.1. Quantitative study

Between July 2011 and January 2012, 1.649 questionnaires were distributed in 30 geographically dispersed Belgian (Flemish) pharmacies. Approximately 983 questionnaires were distributed by the pharmacists to the patients.

The questionnaires consisted of 17 questions, which can be divided into three parts: personal data (age, gender and prescriber), general medicine use and questions concerning compliance to treatment. For the part concerning general medicine use we asked for the name of the prescribed medicine, use of other prescribed medicines and first time use. In the second part, we asked the patients to express the need for information on a list of 16 topics that could be addressed in a consultation with the physician and pharmacist (frequency, when to take, effect, medicine price etc.). In this paper, we will only describe the results for preferences regarding medicine price. We provided five options to express the need for information regarding these topics: the physician addressed the topic himself, the patient asked for the information himself, the physician did not address it but the patient would have liked to know it, the patient did not want to know and the patient already knew. In the third part, we asked for attitudes concerning compliance (frequency and causes), impact of non-compliance on perceived health and the intention to talk about compliance with the GP and pharmacist.

Multiple logistic regression was used to examine the independent effects of patients' characteristics on preferences regarding information about their medicine(s). Odds ratios were calculated (adjusted for gender, age, medicine group and prescriber) and 95% confidence intervals were provided to demonstrate the risk estimate. We considered significance when p-value was below 0.05. All analyses were performed by using SPSS 22.0 software.

2.2. Qualitative study

We used the constructivist grounded theory approach to explore the process of taking the medication and the interaction with the physician and pharmacist during that process. Between January and December 2012, we performed semi-structured interviews with 15 patients recruited through several pharmacies and using snow-ball sampling. The recruitment of these patients was done purposively, meaning we did not look for a representative sample, but rather a diverse sample to explore a wide range of opinions and perspectives regarding medicine prices. Data collection and analysis were performed in an iterative fashion in order to obtain a diverse sample and to capture the different perceptions on medicine prices. New patients were recruited until we found that an additional interview could not add any new insights on the way medicine prices are perceived. At that moment, theoretical saturation was reached [16]. In this case, we strived for a sample with diversity in income (on average high/low), medication use (recently started – within the past 12 months- or long term user) and age. Data analysis happened in stages of open, axial and selective coding by two researchers independently [16].