Reviewer's report

Title: "What is 50cent?" - A qualitative study of patient attitudes and medicine taking behaviours in response to a 50cent charge on prescription drugs in a publicly funded health system in Ireland

Version: 1 Date: 30 October 2012

Reviewer: Ellen Ingrid Schafheutle

Reviewer's report:

Please number your comments and divide them into

- Major Compulsory Revisions

[The author must respond to these before a decision on publication can be reached. For example, additional necessary experiments or controls, statistical mistakes, errors in interpretation.]

OVERARCHING COMMENTS

1. I think this paper reports on a very interesting and still relevant topic, which regains increasing relevance in the current worldwide economic downturn. Many studies have been published in North America (particularly large-scale quantitative ones) and also in Europe, particularly the UK, and a number of useful reviews exist.1-3 These have shown that cost paid by patients towards or for their medicines impacts on uptake or use, that it depends on the level of cost (the larger the cost, the higher the impact), that the impact differs depending on whether drugs are essential or non (less) essential), and that the cost-related (or other) reduction of essential medicines use has a negative effect on patient health outcomes (and thus ultimately on health services resources). I think within this relative richness of evidence this paper needs to usefully summary these key insights with appropriate references, very clearly identify its specific context (Ireland), identify gaps and then articulate what this study adds to our current understanding. To me one of the key issues here is that, in the UK for example (or now just England – all other UK countries abolished prescription charges in recent years) the cost for those who have to pay is relatively high (currently £7.65 per item). Nevertheless, there is concern that abolishing the charge completely would cause ‘moral hazard,’ i.e. consumption (and thus cost to the NHS) of non-essential medicines would increase. It has therefore been widely advocated that a universal nominal fee, such as 50 pence or £1 may be a much fairer approach, which would not only be acceptable but also affordable for patients, yet would not negatively impact on their use of essential medicines. This qualitative study from Ireland appears to show that this would indeed be the case, even though any impact on cost related medicines (non) adherence etc would need to be established in a much larger scale study.

2. I would also like the authors to sit less on the fence and actually say what their
policy recommendations would be. Some of these may, of course, require further research, but what are their key messages or recommendations for policy makers and researchers?

3. Please find further more detailed comments relating to each section of the paper below.

INTRODUCTION

4. It might be useful to explain the GMS in a little more detail, esp. as this will be needed so that the findings and quotes presented in the results can be understood and contextualised. In fact, it may be valuable to also explain very briefly what the entitlements and contributions of other patients are, who do not qualify for the ‘medical card.’

5. In paragraph 2 the authors need to explain what the NHS is, that this is also a publicly/ tax funded National Health Service serving the population of the United Kingdom. They further need to explain why they are specifically looking at qualitative studies from the UK (because there may be others from further afield, e.g. Australia4), possibly because funding arrangement and the delivery of health services are relatively similar? Even when just looking at the UK, these two references (hers nos 8 & 9) are not the only ones reporting qualitative findings about the impact of the prescription charge, either by these authors or others.

6. There is no reason why the authors should restrict their review of relevant literature to qualitative interview studies alone. Some survey studies have been undertaken to gather patients’ views on changes or their cost-related decisions, such as a UK survey,5 but there are other international ones.

7. If the concern is that all of the above investigated systems when patients had to pay considerably more than the 50 cent charge introduced in Ireland, there is a UK-Italian comparative study, where Italian patients pay considerably less.6

8. End of introduction: To reiterate my comment 1 above, I think the authors need to identify more clearly what we already know about how co-payments/ prescription charges impact on patients (and they have already cited some of the relevant references) and the identify clearly where the gaps are and what this study adds. This would provide a clear lead into much more clearly formulated aims & objectives.

9. Reference 15 is a very useful one, but there may be later up-to-date ones (possibly not academic papers), in particular across Europe.

METHODS

10. The authors justify why they chose one-to-one interviews over focus group discussions, but they probably also ought to justify why a qualitative approach was most appropriate (more appropriate than a survey, for example).

11. It is not entirely clear how many pharmacies were approached and how many actually agreed to participate.

12. How were the classifications of geographical location into urban deprived, urban affluent, and rural made? Are these recognised classifications? This
requires a reference.

13. In the methods it is stated that pharmacists recruited patients who came into their pharmacy. What were the selection criteria? How did the authors guard against potential recruitment bias, where pharmacists may ‘pick’ certain patients as more ‘suitable’ than others? Was any training provided to participating pharmacists to guard against such bias?*

14. Also, the authors need to acknowledge that recruiting patients in pharmacies introduces potential bias. Those who may have decided not to have their prescriptions dispensed due to cost would never actually go to the pharmacy, which is why other studies have recruited via GPs/ family physicians.*

15. The way the methods are written suggests that the pharmacist recruited the patient (but patients were free to refuse), and then the interviewer was present and conducted the interview there and then, in the pharmacy? Were patients provided any written information about the study? And without much time to decide for or against participation, how did the researchers ensure that patients were given sufficient and appropriate information to enable informed consent, and that patients did indeed have autonomy to refuse. This requires clarification.

16. It would be valuable if the authors could justify why they chose to interview patients in the pharmacy premises (other studies have interviewed patients at home). I would be concerned that patients may be less likely to speak freely and openly about cost issues and their related views and medicines use behaviours in a pharmacy (which is not ‘neutral’ ground). I would be particularly concerned about the suitability of “the seating areas of pharmacies,” which do not really guarantee confidentiality. I think this requires some reflection and justification.*

17. How many pilot interviews were conducted to test the interview schedule? And who with, i.e. what types of patients – and how had they been identified/recruited?

18. I think it would be useful to summarise briefly in the text which themes/ headings were covered in the interviews. The topic guide could also be appended with a little more detail than what is currently in Table 2.

19. How can data saturation be reached after 19 interviews, if new material (relevant to the study objectives?) arises in two later interviews?

RESULTS

20. Related to my very first comment, I think it is important that the authors structure their results such that they can focus on what is new, and also what may be context specific in Ireland. Many of the findings presented here are similar to those from other studies, esp. those reporting patients’ general views on prescription charges.7 This is not in itself a problem, as further studies can serve to confirm or contradict earlier findings, but the authors need to state very clearly what their study adds to our understanding. Many of the views of acceptance or also a sense of entitlement have been previously identified, the phenomenon of waste and moral hazard, so have the various strategies patients may employ to cope with the cost of prescription charges, such as not taking their medicines at all, prioritising between different ones, putting up with
unpleasant symptoms. Other non-cost related reasons for non-adherence (intentional and non-intentional) have also been identified in the vast existing literature on non-adherence. Contextualising and discussion of findings from this study will obviously need to occur in the discussion, but a rethink on how the results are presented, or the balance of various issues, may need to be reconsidered in light of what we know and what this study adds.

21. To me, and I have already said this under point 1, an important and novel finding relates to the views on and potential impact of a relatively low charge of 50 cents – as covered under the heading ‘recommendations.’ Indeed, a much lower prescription charge has been widely advocated in the UK (now just England) and this study could thus really contribute to our understanding of whether such a much lower charge would work in terms of raising people’s sense of value and moral hazard, thus avoiding waste, yet being low enough not to affect essential medicines use, the two together being the key aim of any charges policy (other than raising revenue).

22. There is very little detail on exemptions. Is this needed? Does it add anything new? If so, this section may want expanding; if not it could be deleted?

DISCUSSION

23. As this paper is based on a qualitative study with just 23 patient interviews, I would suggest some caution in the kind of language that is used when summarising the findings. Only a much larger study would be able to show whether a 50 cent levy does indeed have an impact on medication adherence (very beginning of discussion). Similarly, comments on what has more impact on patients’ decision (‘determinants’) need to be handled carefully – or other studies supporting these qualitative findings could be cited, e.g. Schafheutle et al.

24. In this context it may be worth referring to some of the existing (mostly North American) research on price elasticity and also reiterating that cost impacts differentially on less essential and essential medicines. The impact on less essential medicines is generally accepted if not indeed intended by a levy, whereas an impact on essential medicines should be avoided. Does it appear (form this admittedly only relatively small qualitative study) that this may be achieved by such a small levy?

25. Again due to the qualitative nature of this study, I do not think the authors should refer to ‘a minority of patients’ in this study (3rd paragraph).

26. Why is the work by Elliott et al. one of the few that is drawn on – when there is such an abundance of qualitative and particularly quantitative evidence? More discussion of the place of this study in the context of existing evidence needs to be provided, and the authors could be more specific with their policy and other recommendations.

27. A statement to say that, due to participants’ low education status, their understanding of which drugs were essential and which were non-essential was assumed to be low would require support (i.e. at least a reference).

28. The ‘novel’ hypothesis of a possibly much more effective way to control (unnecessary) demand may be by designing policies which impact on physician
prescribing practice is, I'm afraid, not novel.

29. MURs would require explanation, but I think evidence to support their benefits (and cost reduction) is not conclusive.

30. Some STUDY LIMITATIONS are included, but others ought to be reflected on and discussed, and I highlighted some potential issues with * under METHODS.

ENDNOTE

31. Essential / non-essential requires reference(s) – there are many

- Minor Essential Revisions

[The author can be trusted to make these. For example, missing labels on figures, the wrong use of a term, spelling mistakes.]

32. The use of abbreviations such as 'wouldn’t’, ‘didn’t’ etc. should be avoided throughout the manuscript

- Discretionary Revisions

[These are recommendations for improvement which the author can choose to ignore. For example clarifications, data that would be useful but not essential.]

METHODS

33. Any idea how many patients were approached but refused?

ADDITIONAL REFERENCES


**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

'I declare that I have no competing interests.'