The Effects of Cost Sharing on Statin Adherence

TO THE EDITORS:

The very interesting articles by Gibson and colleagues[1,2] stressed that decreasing the patient's share of costs for a maintenance-drug regimen could be an effective intervention for higher adherence, especially for lipid-lowering drug therapy, because lower statin copayments were associated with higher levels of adherence. A similar study by Schultz et al[3] on the impact of statin copayments on adherence demonstrated that the mean copayment for statins increased while the likelihood of compliance decreased. The study showed that a $15 increase to the mean copayment decreased the probability of compliance by 10%, while a $50 increase reduced the probability of compliance by 34%.

Indeed, we also believe that high copayments can be a very important financial barrier to statin adherence, because the index copayment amount can severely affect compliance with statin use. Although our expertise may be limited, we would like to offer some suggestions in the hope that our experiences may be useful to others. In Greece (a member of the European Union), where the health system policy is very different from that of the United States, copayment status does not negatively affect compliance with statin use. On the contrary, drug adverse effects, misconceptions about drug therapy, alternative medicine treatments, sterol-enriched food products, as well as other nonfinancial factors are mainly responsible for reduced compliance.[4] All insured (privately or publicly) patients, who account for the majority of the Greek population, have a standard fixed 10% share of costs (copayment) on prescribed statin therapy*; poor and uninsured patients receive 100% full health-insurance coverage and are not required to share costs (no copayment).

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In Greece, where there are remarkably few patients noncompliant with their prescribed statin medication due to financial barriers, the effect of very low copayments in maintaining compliance is indisputable. Although some may consider the initial loss of the high copayment to negatively affect health plan expenditures, the future cost savings associated with decreased cardiovascular events and procedures because of higher statin adherence, as also stated by Gibson et al,[1] will certainly more than offset the copayment loss. Without any doubt, the magnitude and importance of similar modifications and decisions regarding the share of costs and drug prescription copayments from policy makers is enormous and has extensive financial and social consequences; however, related experience coming from a small country like Greece could be very valuable. We strongly believe that the reduction of financial barriers by lowering copayments can be a clinically effective and a cost-effective benefit plan option.

*__Note:__ It is important to clarify that the 10% patient copayment is valid for severe medical conditions such as cardiovascular disease and respiratory diseases (chronic obstructive pulmonary disease and asthma), but not for all prescribed medication. The copayments are substantially higher (25%) for most other medical conditions and reach 100% for nonevidence-based medications (herbs, homeopath, complementary, and alternative medicine therapies). Copayments are fixed at 0% for special medical conditions such as cancer, epilepsy, schizophrenia, etc.

References

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