Poverty, medicines and health care: It's the little things...

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ABSTRACT

Small patient charges and policies and events that may seem minor to health care professionals can have a big impact on the wellbeing of people living in poverty. Despite good intentions, policies can have unintended consequences for those who are struggling to access health care.

As Trinity Roots sing in their 2001 song, sometimes it's the little things that really matter. For people living in poverty (10.3% of the New Zealand population according to the OECD),[1] small charges for health care matter, and small indications of the awareness and empathy of health professionals about their situation matter. Small events and policies can make a big impact both on a person's health and their sense that the health system cares about them and is 'on their side'.

Little things that make a significant difference

In our recent study of people who struggle to pay prescription charges,[2] we uncovered a range of 'little things' that made a significant difference to participants.

The way the $5 prescription charge is levied

The New Zealand $5 prescription charge is levied on each item on a prescription that is dispensed. This means that a medication dose change can potentially double the cost of a medicine. One woman in our study changed from a 10 mg dose to a 12.5 mg dose of an antipsychotic drug, and therefore had to pay two $5 charges because no 12.5 mg tablet is available. She pays $5 for her 10 mg tablet, and $5 for her 2.5 mg tablet. Alternatively, the pharmacist could dispense 5 x 2.5 mg tablets, although this is clumsy and likely to lead to patients making mistakes. Surely it is not the intent of the prescription charges to dictate what dose of medicine patients should be taking, or how many tablets a person takes, although this is the effect if the patient can only afford $5.

Giving a prescription is not the same as giving a medicine

To health professionals and administrators, giving a prescription might be seen as equivalent to giving medicines. To the participants in our study, these were not equivalent. One woman said that, in the past, the hospital had given her medicines on her discharge, but now they gave her a prescription, which she couldn't always afford to get dispensed.

Loss of personal medicines during a hospital stay

Despite good procedures within hospitals, sometimes a medicine a patient brings with them to hospital gets 'lost' between admission and discharge. This can be very significant for the patients who may not be able to afford to replace them.

Compulsory treatment and provision of medicines

When patients with serious mental health problems are placed under the Mental Health (Compulsory Assessment and Treatment) Act, they are legally obliged to comply with treatment, including taking their medicines. However, they might still be charged for these, so be in a

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'Catch-22': they have to take the medicines, but they can't afford to take them. In Dunedin where our study was based, the district health board (DHB) pays for mental health medicines for these people, although we understand this is not the case for patients living in some DHB areas. One of our participants reported that even in Dunedin sometimes this process did not always occur smoothly, so patients were required to pay.

Synchronising dispensing of medicines

The new contract for paying New Zealand community pharmacists (Community Pharmacy Services Agreement) encourages pharmacists to improve adherence by synchronising the dispensing of medicines for people with long-term conditions.[3] However, people on low incomes often deliberately collect only one or two medicines at a time to avoid facing too many charges at once. Synchronising medicines would be a very good idea if they could afford to collect all their medicines at once, but when they can't, it can make adherence more difficult.

Are health professionals aware of these issues?

Do health professionals know about these issues? We didn't ask most people in our study about whether they told their prescriber or pharmacist about their difficulties paying for medicines, but some chose to tell us. One woman reported asking her general practitioner (GP) to write an earlier prescription so that she could take advantage of the free prescriptions that applied until 1 February the following year. He refused because there were potentially addictive drugs on her prescription. She reported that he was incredulous when she said that this meant she would go without them for a couple of weeks until she could afford them.

People sometimes deliberately hide their difficulties with paying from their health professionals. One woman reported that she didn't tell her doctor she couldn't afford her medicines because she felt 'I still have my pride'.

Health professionals in New Zealand shouldn't assume people can access the medicines they need. We all need to ask sensitively and to listen to patients' stories about their difficulties, to try to find ways around these, and to lobby against small (and large) changes in policies that have unintended negative consequences for people living in poverty.

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COMPETING INTERESTS
None declared.