

Patients' knowledge of medication use as an equity issue in health care: Do health workers pay attention to this?

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in masters courses, specific skills courses, student grants and mentoring. The capacity building activities in EQUINET are integrated within the existing areas of work of the network or build cross cutting skills demanded across themes by institutions in the network. The papers and reports produced in these training activities are products that are used to support or target mentoring. This report has been produced within the student grant programme and is disseminated in this context. It is not a formal EQUINET discussion or policy paper.

Abstract

Equity in health does not stop at the availability of essential drugs but includes the provision of adequate information to patients for the proper use of those drugs in order to achieve a full health potential.

The major goal of this study was to measure the level of information given to patients as a component of ensuring equity in health. This was a descriptive cross-sectional survey utilizing both qualitative and quantitative methods of data collection, carried out in Uganda's national referral, teaching and research hospital. With a sample size of 549 patients interviewed, results showed that 57.9% were females, over 70% of having an educational level of up-to O-Level. Most were low-income earners comprising: unemployed (13.4%), peasant farmers (12.6%), and students (18.7%). Most patients (93.1%) were prescribed drug therapy, but 97.5% of these left the medical clinics without knowing the likely cost of medication.

Results show an inadequate knowledge of medication use with 59.02% of the patients not knowing what their conditions were, and 81.79% not knowing the right dosing schedule. Only 41% of the patients had received information about their condition, despite the large number who expressed interest in getting information about their medical conditions. The inadequate knowledge of medication was mostly attributed to the lack of communication from the medical practitioners due to the high patient load. Pharmacists in the pharmacy would help improve on patients' knowledge of medication use, however, the unrelenting lack of drugs in the hospital forces patients to go out of the hospital with half-filled prescriptions or no drugs. This poses a question on whether healthcare is equitable from the stand point of proper information about medication. If such great inequities in the provision of health care can be revealed in a national referral government hospital, one wonders about the likely situation in the referring hospitals.

1. Introduction and background the study

Patient's knowledge of medication use is not only of vital importance in the prevention of drug related problems, but also a major factor that influences treatment success and hence if provided, it offers an opportunity for one to attain a full health potential.

Equitable provision of health care not only portrays the fair and just allocation of resources in the health care sector, but also embraces the provision of information required by patients relating to the their condition and the physician's diagnosis, and the medication they are to use. Clarity of diagnostic and treatment advice correlates with adherence, which in turn leads to achievement of health. Otherwise, health will not be achieved if such information is not given in a simple clear format that can be understood by the patient. However, provision of information to patients is not only a necessary factor in treatment success but also a right.

Patients' choice is an intrinsic aspect of equity in health care. People who are ill have to believe that their health status has actually deviated from what they consider to be normal and that there's something wrong with them. This perception is dependent on a number of factors, the major ones being; previous experience, from for example, a similar illness, family members or the community. In case of children, the knowledge and experience of the mother are critical determinants.

People make a series of decisions before a treatment is self chosen or adopted: people or care givers of children have to decide whether this alteration in health status is significant enough for them to seek help or whether the symptoms will go without treatment. Once they decide that treatment is needed, people choose where to seek treatment; a hospital, private physician, pharmacist, market vendor, traditional healer, relative or some other member of the community. All these are prejudiced by a patient's knowledge of medicine in conjunction with one or more of the following factors: cultural beliefs, level of education, social-economic status, etc. In the health care system, a lot amount of time, effort, and money is spent while treating patients. This process usually involves a physical examination and history taking, and completion of laboratory work or other ancillary services. A diagnosis is then made and a medication plan is implemented.

Once patients have the prescription or have received a recommendation for products, they can decide whether to buy the drugs or not, whether they are going to buy all or some of the items recommended, and which drugs are considered essential for their illness; whether to go ahead with treatment or not; choices often influenced by the views of the family, close friends and the community, and the cost effectiveness of the treatment. Cost considerations may lead to a choice of which items to buy and which to ignore as cost effectiveness is best seen from the patients' point of view and relates to more than improved health status. Therefore, to achieve the goals sought by a health service provider, an informed decision taken by patients is desirable.

Likewise when drugs are bought, patients will then decide whether and when to take the medicines, how to take the medicines, whether to continue if side effects occur or symptoms disappear, and what to do with the medicines that remain. Therefore, failed therapies often occur as a result of many factors including medication related problems such as: lack of patient understanding of the therapy, side-effects of the medications, rejected diagnosis by patients, non-compliance and lack of filling the initial prescription due to expensive drugs. In addition, many adverse drug interactions and drug-drug or food-drug interactions may occur when actually they may be prevented by improvements in patient medication counselling and medical history documentation.

Many studies relate failure of therapy to the attitudes and communication skill of the health care providers, particularly of prescribers who are always the first to get information regarding a patient's problem and advise accordingly as to the next step based on their findings.

Numerous studies point to patients' dissatisfaction with health care provider's attitudes. Common descriptions particularly of prescribers in the private sector include the adjectives cold, uninterested, rude, aggressive, abrupt, and authoritarian. Although such descriptions don't fit many, dedicated and skilled practitioners, inappropriate attitudes toward patients are sufficiently well-documented to indicate a significant problem (Suryawati, 2003). Adherence to treatment depends on a patient's acceptance of the information about the health threat itself, and is a perception of the practitioner's friendliness, empathy, interest, and concern. For these reasons, an evaluation of patients' knowledge of medicine and its use may help screen for problems in therapy and improve therapeutic outcomes. Results of this evaluation may also be used to educate providers about problem areas in which they may be able to influence change.

1.1. Historical background of Mulago Hospital

Mulago hospital is the largest hospital in Uganda, the national referral, teaching and research hospital for Makerere University, and a general hospital for Kampala and the surrounding areas. The hospital, which started in 1962 as a venereal disease clinic in grass-thatched huts of mud and wattle, grew over time to the current capacity of over 1500 in-patients and an average of 1800 outpatients per day. The hospital has an intimate relationship with Makerere University Medical School, whose members carry out clinical duties in the hospital and head clinical departments. There are student Doctors using Mulago hospital facilities but at the same time providing healthcare services to patients. The hospital has a staff of 2300, which is about 40% of what is needed, based on staff workloads.

2. Objectives of the study

2.1. Specific objectives

- To assess the patients' knowledge of the conditions for which they are taking the medications, the quantity to be taken, and the correct dosing rate.
- To identify the factors affecting/influencing patients' knowledge of medicine and medication use in hospital patients.
- To assess whether patients are told about the usefulness of the medications they are taking, and the major adverse/side effects of the drugs they are taking.
- To determine whether patients are given chance to participate in the selection of the best therapy, since they are the ones to incur the costs of the medications.

3. Literature review

3.1. Equity in health care provision

Equity in health care provision not only relates to the equity in access to health care, but also to the provision of medication-use related information, enabling patients to make informed decisions irrespective of their social status, financial standing or educational background. Provision of equitable health care enhances patients' well-being, quick recovery and reduces mortality rates of any disease condition.

Numerous studies done in the different aspects of healthcare provision clearly show that accessibility to healthcare services is not the only determinant of health, but rather a combination of many factors. A good number of enquiries carried out in America on the causes of increased violent incidences involving discharged mentally ill patients pointed to factors which were grouped as resources, communication, and medication (Centre for Bioethics, 1997). Such inquiries revealed that ensuring that medication is taken relies on provision of access to medication and communication from the health care providers. Ensuring this network depends upon sufficient resources that include drugs, medical equipments and literature.

3.2. Income

Accessibility to health services is closely influenced by income. In a survey done in Korea in 1996, utilization of hospitals or clinics was 58.1% before an economic crisis and it decreased to 52.8% after the crisis. At the same time, utilization of pharmacy-based care increased from 37.3% to 43.1%. Results indicate that people are more likely to use lower priced services during an economic crisis (Hanjoong et al, 2003).

Access is denied to many people in the developing world; however, physical proximity doesn't mean facility access since economic constraints also bar many from utilizing some facilities (WHO, 1986). The poor encounter major problems in seeking healthcare, including: problems of bureaucracy, lengthy waiting times, and the poor attitude of health staff. Thus the rich have access; the poor don't (Rifkins, 1985). Social economic class seems to be a more discriminating factor than rural-urban residence (Harpharm, 1986).

3.3. Cost of medication

Many providers have little or no knowledge of the cost of the drugs they prescribe. Prescribing needlessly expensive brandname drugs, when a much cheaper generic version of equal strength is available has consequences to the health sector, to the community and the individual patient. When part of the cost is borne by the patient, the drug may not be purchased at all because the patient cannot afford it. When more than one drug is prescribed, the patient may be able to afford only one or two of the products listed and may choose the less important, relatively cheaper ones, such as vitamins, or buy only a partial treatment (WHO, 1997).

Price increases between the factories or importer and the patient are due to transportation costs, tariffs and taxes, and the mark-ups of distributors, wholesalers and retailers, which can easily double the ex-factory price of medicine (WHO, 2004).

The more visits made to a medical professional, the more people know about their medication and use. The cost of medication services limit the number of visits a patient makes to the health facility, which is why patients usually resort to self-medication, as it seems less costly. For example, in a study on the impact of user fees in Kabarole district, there was an overall reduction in the utilization of medical services after introduction of cost sharing which mounted to 21.3% for all cases and 12% for malaria (Kamugisha et al, 2001).

4. Methodology

We surveyed the out-patients (or their care-takers) of Mulago hospital, as their conditions don't require intensive management and/or follow-up, and their prescriptions may not be changed as frequently as in-patients' medication. This was a descriptive cross-section survey utilizing both qualitative and quantitative methods of data collection. Mulago has two wings: New Mulago and Old Mulago. New Mulago is divided into departments namely: Medicine, Surgery, Paediatrics and Obstetrics and Gynaecology. The study was carried out only in the Department of Medicine, as this is the department with the highest rates of drug use. Medical out patients wards receive an average of 519 patients daily, which was our sample size.

From the average number of patients going to MOPD (519 per day), if 15 percent the population has adequate knowledge of medicines and the reason for use, and the worst expected value is 5 percent, the sample size used (at 95% CI) was 45. Since the survey was to be done for two weeks (10 working days), the total sample size would be: 540.

5. Limitations of the study

The study is limited to only the medical wards of New Mulago hospital. This limits the number of respondents, which would give better results. Therefore the results

obtained may not give a clear picture of patients' knowledge of medication in Uganda, but may give an insight as to what is happening in government hospitals. A better solution to this would be getting more study sites; however, this would require more personnel, stationary, and facilitation. All these would require more funds.

6. Results

6.1. General characteristics of respondents

A total of 549 respondents were interviewed from the medical outpatients' department of Mulago hospital. Most of respondents interviewed were within 18 to 50 years with age ranges of 18 to 25, 26 to 35 and 36 to 50 having almost equal proportions. Those over the age of 50 were 19.3% of respondents, and 8% were below 18 years (*Table 1*).

Table 1: Respondents' Social characteristics

Characteristic	Summary measure ---n (%)
Age Distribution in years	
12 to 17	44 (8.0)
18 to 25	139 (25.3)
26 to 35	131 (23.9)
36 to 50	129 (23.5)
> 50	106 (19.3)
Female	
	318 (57.9)
Marital Status	
Divorced	58 (10.7)
Married	284 (52.3)
Single	153 (28.2)
Widow/Widower	48 (8.8)
Number Of Children	
None	99 (20.8)
1 to 3	178 (37.4)
4 to 6	120 (25.2)
7 to 10	62 (13.0)
Over 10	17 (3.6)

Of the 549, 57.9% were females indicating that most patients attending Mulago hospital are females. This can be attributed to the higher number of females in Uganda compared to the males. Most respondents were married (52.3%), with the majority having 1 to 3 children (37.4%), 38.2% had 4 to 10 children while only 3% had over 10 children.

When asked about their religious affiliations, 37.3% of the interviewed respondents were protestants, 29.4% were Catholics, 21% were Moslems, 13.3% were born-Again Christians, 4% were SDA (Seventh Day Adventists), while 0.9% mentioned other religious groups including; Jehovah's Witness, traditional African faith, and Pentecostal church (*Table 2*).

Table 2: Patients' Religious affiliations and educational levels attained

Religion	
Born-Again	73 (13.3)
Catholic	161 (29.3)
Moslem	116 (21.1)
Protestant	172 (31.3)
SDA	22 (4.0)
Other	5 (0.9)

Education Level	
None	65 (11.8)
Primary	159 (29.0)
O-Level	204 (37.2)
A-Level	74 (13.5)
Tertiary	47 (8.6)

The greatest number of patients attending Mulago hospital had attained an educational level lower than A level with the distributions being as follows: 37.2% had stopped in O-Level (this includes: S1, S2, S3 and S4), 29% had topped in primary (any class including; P1, P2, P3, and P7), 13.5 had stopped in A level (including: S5 and S6), 11.8% had never attended school, while only 8.6% had gone up to tertiary level (any higher institution of learning) (*Table 2*). Therefore 78% of patients attending the hospital are likely to have attained an educational level below A-Level (*Table 2*).

Most of the patients interviewed (20.1%) were self-employed (also commonly called businessmen), 13.4% were unemployed, 12.6% were peasant farmers, 18.7% were students while 12.1% mentioned 'housewife' as their occupation. This clearly shows that most patients attending Mulago hospital are of low economic status For those who received a monthly pay (322), the monthly income was mostly less than Shs. 100,000/=(equivalent to \$57.47) (64.3%), and only 0.9 % earned more than Shs. 500,000/=(equivalent to \$287.36). This further emphasizes the fact that patients utilizing Mulago hospital are the poor (*Table3*).

Table 3: Respondents' Economic Characteristics

	Summary Measure --- n (%)
Occupation	
Civil Servant	53 (9.7)
House Wife	66 (12.1)
Peasant Farmer	69 (12.6)
Private firm	54 (9.9)
Retired	17 (3.1)
Self-employed	110 (20.1)
Student	102 (18.7)
Unemployed	73 (13.4)
Other	2 (0.4)
Monthly Income n=322	
Less than 100,000	207 (64.3)
100,000 to 250,000	91 (28.3)
250,000 to 500,000	21 (6.5)
Over 500,000	3 (0.9)

When asked for their usual source of information regarding their illness or medication, 41.9% mentioned private clinics, 34.9% hospitals, 4.4% pharmacies, 7.3% mentioned drug shops while 1.5% in the others categories mentioned; traditional healers, shops, and a midwife in the village.

The nearest health facility mentioned was private clinic (47.2%), followed by government health unit (41.7%), NGO Unit (4.7%), pharmacy (4.4%) and drug shop (1.8%). This indicates that most of the respondents use Mulago hospital as their usual hospital and probably live within Kampala.

Results for the distance to the nearest health unit (as told by the respondent), were in agreement with the results for the nearest health unit as for most patients, it was mostly less than 10 km (89.4%) while for 1.6%, the nearest health unit was over 20Km away. When asked for their transport means (on that particular day), 78% indicated taxis, 66 (12.0%) respondents had walked to the hospital, 34 (6.2%) respondents used Boda-Boda (public motorcycles) while only 7 patients had their own personal cars. This further emphasizes the fact that most of the respondents were within Kampala and its suburbs.

The waiting time (as told by the respondents) was as follows: 61% said had waited for over 1 hour, 16.9% waited 10 to 30 minutes, 10.9% waited 30minutes to 1 hour, while 11.1% waited less than 10 minutes. The high waiting time can be attributed to the high patient load, as Mulago is both a referral hospital and a general hospital for the nearby areas.

7. Discussion

Human rights and health is emerging as a key issue in healthcare delivery. As drugs have become more effective in relieving/healing illnesses and improving patients' health, the demand on medication related information increases in line with patients' enhanced expectations of what should be provided. Patients are entitled to education on proper medication use; not only by virtue of their humanity but also by the fact that the effect of the medication (whether curative, side effects, etc.) are to be felt by the patients themselves.

Results of this study show the extent to which patients rights have been observed in the medical out-patients' wing of Mulago hospital vis-à-vis equitable provision of healthcare services, and the other factors that affect patients knowledge of medication use.

7.1. Cost of medication

Social characteristics of the patient as well as the cost of medication can determine the relationship between the patient and the health provider and thus impact on equity of health issue. When drug therapy is chosen, cost of medication becomes an important determinant as to whether patients will buy the prescribed drugs or not. In view of the fact that Mulago is a government hospital where drugs are supposed to be free, the cost of medication wouldn't be a problem. However, most of the respondents who were unhappy with the hospital services, complained about the lack of drugs in the hospital. One such patient (N.S) said:

Doctors send you to the pharmacy, and when you go there, all they have I panadol, fancidar and Chloroquine. There are always no drugs in the hospital.

Knowing that most of the patients are low-income earners (the poor) and the fact that there are no drugs in the hospital, cost of medication becomes an imperative issue. Patients have a right to know what the likely cost of medication is, and must be able to assess whether they can afford it or not before they leave the doctors room. However this has not come to the heed of prescribers. A good number of patients (97.5%) receiving drug therapy were not aware of the likely cost of their medication.

This not only shows lack of communication to the patients from the prescribers, but also lack of informed consent being exercised. A similar study carried in Mulago hospital on the extent of informed consent in Mulago hospital revealed that patients were not getting enough information and could not exercise informed consent (Sepuya, 2003). Physicians prescribe drugs, which they believe are effective, without any consideration on the cost effectiveness, especially in the low-income earners that come for their services. From a patient's point of view, cost effectiveness relates to more than improved health status.

When a patient's lack of knowledge of cost is coupled with lack of knowledge of drug names, patients are left at the mercy of pharmacy or drug shops' attendants whose interest may be in the monetary side of the bargain as there's a general shortage of pharmacists in the country.

Most patients are given drugs which do not coincide with their financial abilities. This is a big blow to the physician's desired goal as the patient won't buy the drugs. Patients are more likely to ask the pharmacy attendant to get them a cheaper alternative, or go back to the hospital so as to change to an affordable treatment. A good example is a patient (F.N), who when asked what the doctor told her about the likely cost of her medication said:

Nothing..... the doctor just wrote down but never told me cost or the name. He only said that it would cure me.

Cross-checking with the prescription, the actual drug prescribed was Artenam (an artemisinin brand from Belgium). On the market currently, the cost of Artenam ranges from 13000 (\$5.47) to 15000 Shs (\$8.62).

When asked whether she could afford medication of 10,000 Shs (\$ 5.75), her response was:

I get 3000 Shs (\$ 1.72) Daily.....I can't afford such medicine.

This could partly explain the high patient load on any doctor as patients keep on coming back for change in the regiment. Also if the option of changing a regiment at the pharmacy is taken, patients are likely to come up with drugs of low potency (especially in case of antibiotics) that may not help the patient.

7.2. Equity in health care provision

Being a national referral hospital, one expects an almost equal distribution of patients according to their social-economical status. And yet for equity, government must spend enough money to ensure that staff are trained and adequately motivated so that patients who come under their care are given sufficient information for their medication use. However, our results show that in Mulago hospital there are inadequate numbers of health workers, of different categories. At the same time, most patients seeking medical services from Mulago are of low education level and low-income earners (the poor).

Results further demonstrate a high drug utilization rate, with an average of 2.9 drugs per encounter, which is higher than the recommended 1.6 in the standard rational drug use indicators for Uganda. With this high drug utilization one expects an equal effort by prescribers to educate patients on proper medication use; however, this isn't the case. A good number of patients leave the hospital without knowing the drug name, dosage to be taken and the dosing interval, possible side effects and how to go about them, and what to do if a dose is missed.

It is therefore clear that there are high social-economic inequalities in the provision and distribution of healthcare in the country; with the rich getting their services from elsewhere while the poor are left with no option but government hospitals like Mulago. Such inequalities can be reduced by a government's initiative to improve healthcare provision and distribution by allocating more funds to the medical sector. Patients receiving medication related information see it as a privilege rather than their own right and therefore fail to ask physician questions related to their health conditions. This can be attributed to the general patients' perception of medical personnel and other factors, which may include the cultural dogma. The overall unawareness of patients' rights however can be attributed to the lack of patients' awareness programs in the country.

8. Conclusion

To wrap up the findings, results indicate a extremely low level of patients' knowledge of medication use in the out patients' department of Mulago Hospital. The inadequate knowledge of medication was mostly attributed to the lack of communication from the medical practitioners due to the high patient load, with patients not being given chance to exercise their right in medication selection with due regard to the cost-effectiveness of the treatment plan.

Pharmacists in the pharmacy would help improve on patients' knowledge of medication use. However, the unrelenting lack of drugs in the hospital forces patients to go out of the hospital with half-filled prescriptions or no drugs.

If such great inequities in the provision of health care can be revealed in a national referral government hospital as well as a teaching hospital, one wonders what the situation is in other referring hospitals where lack of medical officers has already been cited as a problem.

8.1. Recommendations and further research

In view of the above, the following recommendations if attempted and fulfilled would help reduce the inequities in the provision of healthcare, increase patients' knowledge of medication-use and the total well-being of patients:

- Government intervention to solve the unrelenting lack of drugs in the hospital through equitable distribution of resources in the public sector and more so in the health service sector.
- Government intervention to increase the number of medical officers and facilitate them in order to reduce on the patient load.
- Drug price surveys should be carried out to determine the cost of the different drugs on the market and results of such information should be made available to prescribers to help them guide patients knowledgably.
- Prescribers should be trained to encourage patients to ask questions regarding their health status or any uncertainty that might arise in the course of their communication.

- Prescribers should be re-trained to increase their communication skills to ensure that patients (who are mostly of low education level) are given appropriate instructions regarding medication use and have actually understood the instructions given.
- Considerable mass media campaigns aimed at patient education on proper medication use and patients rights through radios newspapers.

8.2. Other areas for further research

- Equitable distribution of resources in the Health Sector
- Evaluation of patients' knowledge of medicine and medication use in Uganda. This same study could be done on a large scale to get a clear picture of the situation in Uganda.
- The extent to which patients rights are observed in Uganda.
- A comparison of patients' knowledge of medicine and medication use between government health care units and private Health care unit.

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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