Response to Compliance With Hypertension Therapy:
Why Standards Are Needed

We appreciate Dr. David’s letter regarding our recent article, and agree with many of his comments. Higher costs to the patient, either in paying for a prescription out-of-pocket or in larger copayments and deductibles, are likely to reduce compliance with therapy. Receiving only 1 month’s supply of a medication may also affect compliance. There are clearly other issues beyond cost and days supply of medication that also affect compliance. Patients with comprehensive prescription medication coverage who pay little for hypertension medications and can receive supplies for multiple months (often via mail) may, unfortunately, still have poor compliance and persistence. For example, whereas patients without prescription drug coverage who were provided with free prescriptions of cardiovascular medications showed substantial increases in compliance, compliance with these free medications averaged only 72.7%, less than the standard 80% value used to classify treatment compliance. Similarly, among a population of patients in the Seychelles provided with free hypertension medications, fewer than half achieved satisfactory compliance in the first month, and the proportion with satisfactory compliance decreased with time. Among a population of Canadian hypertension patients (for whom prescription costs are likely not an issue), persistence with hypertension therapy varied significantly based on drug class and sociodemographic characteristics.

The goal of our tutorial was not to rank the most important factors affecting compliance and persistence, but to provide recommendations regarding measuring and evaluating compliance and persistence. Currently, there are not agreed-on standard methods for assessing compliance and persistence. If, as Dr. David suggests, compliance will improve by decreasing costs and providing >1 month’s supply of medication, how will the amount of compliance improvement be assessed? How will this amount compare to what might be obtained by other interventions to improve compliance? What will be the clinical impacts (short-term and long-term) to patients of each intervention, and what are the costs relative to the benefits for each? Without evidence obtained using comparable metrics and methods, these questions will remain unanswered, and the concerns raised by Dr. David will not be addressed.

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