Adherence to prescribed medication is a key determinant of treatment outcome [1–3]. Low adherence results in substantial worsening of disease, increased risk of death, and increased health care costs [4–7]. The potential burden of medication non-adherence outcomes on health care delivery makes it an important public health concern [8]. The complexity of adherence is the result of an interplay of different factors including patient views and attributes, illness characteristics, and social contexts [1, 9–12]. Moreover, factors related to the access to healthcare providers, the quality of service, as well as, drug-related factors influencing tolerance of treatment should be taken into account [13–16]. Unfortunately, low adherence to prescribed medication remains both common and difficult to detect [17]. Nevertheless, identifying the true patient’s adherence to medication and the key determinants of early discontinuation of treatment are pivotal to develop adequate interventions aimed at increasing adherence in order to improve health outcomes [18].

In spite of the availability of different methods of adherence assessment, this issue still remains a real challenge. Direct, objective measures reflecting pharmacokinetics and including measurement of the drug or its metabolite concentration are difficult to apply. On the other hand, clinical application of subjective methods, including patient-kept diaries, patient interviews and self-reported questionnaires, is much easier due to their simplicity, real-time feedback, and low cost [19–21]. Asking patients is the simplest and most frequently used method of adherence assessment. However, it has been shown that the data obtained in this way have limited credibility [17, 22]. In this issue of Medical Research Journal Michalski et al. [23] compared patients’ declarations regarding their drug intake with the results of the Adherence in Chronic Disease Scale (ACDS) in the Polish population of EUROASPIRE V study.

Based on patients’ declarations a satisfactory level of adherence (100% or 90%) was reported for 75.58% of patients treated for hypertension, 51.62% of patients treated for diabetes and 62.22% of patients treated for hypercholesterolemia [23]. However, these declarations differed significantly from the results of the adherence assessment conducted with the ACDS. The authors concluded that patients’ self-assessment of the implementation of a therapeutic plan poses a risk of overestimation; particularly when it is based on answering only a single question. Additional application of the ACDS seems to be helpful in assessing the risk of non-adherence, as well as, in defining barriers, beliefs and behaviors that determine it [23].

Objectification of patient-reported information is usually difficult, however, validated questionnaires are also considered as reliable instruments for adherence assessment [24, 25]. No standard approach for adherence evaluation has been developed. However, the application of these tools should be advocated to assess the risk of low adherence for extensive screening of patients. Moreover, well-designed questionnaires may also identify obstacles, gaps in patients’ knowledge, acceptance of a therapy plan, and the problems in cooperation between a patient and health care professionals [26–29].

References


