"This body does not want free medicines": South African consumer perceptions of drug quality

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Objectives Like many other developing countries, South Africa provides free medicines through its public health care facilities. Recent policies encourage generic substitution in the private sector. This study explored South African consumer perceptions of drug quality and whether these perceptions influenced how people procured and used their medicines.

Methods The study was undertaken in Durban, Cape Town and Johannesburg in South Africa between December 2005 and January 2006. A combination of purposive and snowball sampling was used to recruit participants from low and middle socio-economic groups as well as the elderly and teenagers. Data were collected through 12 focus group discussions involving a total of 73 participants. Interviews were tape-recorded. Thematic analysis was performed on the transcripts.

Results Irrespective of socio-economic status, respondents described medicine quality in terms of the effect the medicine produced on felt symptoms. Generic medicines, as well as medicines supplied without charge by the state, were considered to be poor quality and treated with suspicion. Respondents obtained medicines from three sources: public sector hospitals and/or clinics, dispensing doctors and community pharmacies. Cost, avoidance of feeling ‘second-class’, receiving individualized care and choice in drug selection were the main determinants influencing their procurement behaviour. Selection of over-the-counter medicines was influenced by prior knowledge of products, through advertising and previous use. Participants perceived that they had limited influence on selection of prescription medicines. Generic substitution would be supported if the doctor, rather than the pharmacist, recommended it.

Conclusions Our findings emphasize the importance of meaningful consumer involvement in the development of national medicines policies, and strategic campaigns targeting consumers and prescribers regarding the quality of generic and essential medicines. Where consumers perceive free or generic medicines as inferior, this could significantly undermine attempts to implement national medicines policies aimed to improve access to medicines.

Keywords Drug quality, developing countries, national medicines policies, generic medicines, consumer perceptions.
Introduction

Medicines are important, often being one of the most cost-effective interventions in health care (WHO 2004). However, pharmaceutical markets are complex, with governments having to balance public health priorities whilst also supporting investments in private sector pharmaceutical management (Bennett et al. 1997). National medicines policies, therefore, are recommended by the World Health Organization (WHO) to guide the different stakeholders in terms of their roles, rights and responsibilities in the manufacture, supply and use of medicines (Bennett et al. 1997; WHO 2001; Ratanawijitrasin and Wondemagegnehu 2002). The WHO estimates that between 1.3 and 2.1 billion people still remain without access to essential medicines (WHO 2004). In Africa, where access for vulnerable populations is especially problematic, medicines may be unavailable, unaffordable, used inappropriately and unsafe because of poor quality (Foster 1991; Newton et al. 2006; McGinnis 2008).

Two instruments, incorporated into medicines policies in order to improve access to affordable medicines, are the provision of free and/or subsidized medicines and generic medicines (Mrazek and Mossialos 2000; Dukes et al. 2003; Perry 2003). Generic medicines are defined as ‘pharmaceutical products usually intended to be interchangeable with the innovator brand product, manufactured without licence from the innovator manufacturer and marketed after expiry of patent or other exclusivity rights’ (Health Action International and WHO 2003). For these instruments to work, they have to be acceptable to both the users and providers of health care.

A growing body of literature shows that people do not use medicines in a vacuum—social, cultural, political and economic realities all contribute to how they are used (van der Geest and Whyte 1988; Foster 1991; Whyte et al. 2002; Chetley et al. 2007). Emerging evidence indicates that developing country consumers are suspicious of health services and supplies that are free (Lönnroth et al. 2001) and that brand names and prices of drugs matter (Lönnroth et al. 2001; Holloway et al. 2002; Duke et al. 2003). Such evidence also suggests that some consumers feel free and/or generic medicines may be of inferior quality.

Consumers’ views and understanding of drug quality, and the decisions they make based on these, are seldom explored. Research into drug quality is largely focused on testing the actual quality of medicines (Shaker 1997; Maponga and Ondari 2003; Syhakhang et al. 2004a). The pharmaceutical market, unlike other markets, involves consumers who are less informed about quality and value for money, and thus rely on their health care providers and governments to ensure they are getting quality medicines (Quick et al. 1997; Dukes et al. 2003). The few studies that have explored medicines quality from the consumers’ perspective in developing countries show that where the consumer has no real understanding, they tend to judge the quality of medicines on the basis of their effect (Syhakhang et al. 2004b), brand name and price (Lönnroth et al. 2001; Holloway et al. 2002), as well as recommendations of health care providers (Maiga et al. 2003). These studies have all been conducted in countries with poor regulatory capacity and limited resources for supporting policy implementation.

In contrast, it can be argued that South Africa possesses the necessary ingredients for ensuring access to affordable quality-assured medicines. It has a functioning health care system, a reputable regulatory authority (the Medicines Control Council) and the most advanced pharmaceutical manufacturing presence in Africa. The government has made concerted attempts to improve access to essential medicines through its medicines policy and Essential Drugs Programme (Department of Health 1996). It has also declared ‘access to quality, affordable medicines’ to be a right (Department of Health 2001). Activities of the non-governmental group, Treatment Action Campaign, have also improved access to essential medicines, namely anti-retrovirals (Treatment Action Campaign 1998).

The public sector, which caters for approximately 80% of the population, provides medicines for free at primary care facilities, with user charges at other levels. Medicines selection, procurement and use in the public sector are mainly through the Essential Drugs Programme, introduced in 1998 as part of the National Medicines Policy (Department of Health 1996). This sector procures medicines using non-proprietary names and has always allowed for generic substitution by pharmacists.

In the private sector, medicines are supplied by dispensing doctors and community pharmacists. Financing of medicines is largely through medical insurance. Only 14.8% of the population has access to insurance; the remainder pay out-of-pocket (McIntyre and Thiede 2007). In early 2000, generic substitution by pharmacists and price control regulations were introduced. These interventions have resulted in an increase in the use of generic medicines and an average decrease of approximately 22% in the price of medicines in this sector (McIntyre and Thiede 2007).

This article aims to fill a gap in existing literature. It reports on a study of consumer perspectives of drug quality in the context of a country with a national medicines policy and an effective regulatory system. The study was undertaken in South Africa and underpinned by a qualitative methodology. The principal research questions that were explored included consumer understandings of quality of medicines, whether this understanding affects where they would prefer to source their medicines, and whether they would use generics.

Methods

We undertook focus group discussions with consumers during December 2005 and January 2006 in the three main cities of
South Africa: Durban, Cape Town and Johannesburg. We chose this method in order to explore knowledge and experiences and give the participants the opportunity to explain why they think the way they do. We did not want to exclude people who were illiterate and we wanted to provide an informal forum for discussion and to capitalize on the interaction amongst participants (Kitzinger 1995). Ethical approval was granted by the Universities of Otago, New Zealand, and KwaZulu-Natal, South Africa.

Sample selection and recruitment
South Africa's apartheid history has resulted in people previously classified along racial lines: White, Black, Indian and Coloured. Whilst a democratically elected government has ruled for 14 years, inequalities resulting from racial segregation are still evident in the socio-economic status of the population. We wanted our sample to include people from low and middle socio-economic groups as well as youth and the elderly. We described socio-economic status according to peoples' living conditions (formal/informal housing) and employment status. Our sampling therefore followed a two-stage process. Initially, through purposive sampling, key informants were identified using local networks known to the first author. Key informants, through snowball sampling, subsequently recruited the remaining participants (Patton 2002). These recruitment approaches, especially in terms of recruiting participants from the low socio-economic groups, were chosen primarily for safety reasons. Crime in the form of car-jacking, theft, rape and assault is perceived to be out of control in South Africa (Rondganger 2007) and ‘outsiders’, because of concern for personal safety, tend not to venture, alone, into areas that are unfamiliar.

For the low socio-economic groups, key informants were either working at or close to where the first author stayed during the fieldwork. They recruited participants from where they lived, mostly squatter camps or informal housing, and/or their place of work. Four focus groups were conducted with low socio-economic participants: two in Johannesburg, one in Durban and one in Cape Town. Key informants for the middle socio-economic groups were acquaintances and/or previous colleagues of the first author. They recruited the remaining participants mainly from their places of work. Five focus groups were conducted with these participants: two in Johannesburg, two in Durban and one in Cape Town. Teenage males were recruited at a suburban shopping centre in Durban. In South Africa the elderly socialise through local community groups. Recruitment of the elderly was via these groups: one in Durban and another in Cape Town.

During recruitment, potential participants were informed about the purpose of the research. Before commencement of each focus group, time was spent explaining the nature of the research, gaining informed consent, getting permission to record the interviews, gathering demographic data on participants as well as answering any questions they had. No one declined to take part. All communication was undertaken in English. Participants were given R50 (approximately US$7) as a token of appreciation. A total of 12 focus group discussions were conducted with 73 participants. The first author facilitated the group discussions with an assistant responsible for audio-tape recording the discussions. All focus groups were held in hired, neutral venues on dates and times suitable to the participants (see Table 1 for a description of participants). Group discussions lasted between 50–70 minutes. Box 1 lists the questions used to facilitate these discussions.

Because we anticipated difficulties in contacting participants after the sessions to ensure we were reporting according to their views, at the completion of each focus group the facilitator summarized the key points discussed to provide a final opportunity for individuals to add or comment on the issues. Any sources of discrepancies, including the use of local terminology, were clarified at this time. Analysis was performed by the first author and reviewed by the other three.

Data analysis
Our analysis followed Strauss and Corbin’s grounded theory approach (Strauss and Corbin 1990). The focus group tape-recordings were transcribed and coded with the aid of NVivo, version seven. Initial coding was predominantly open. However, some substantive codes were found to mirror predetermined themes in the focus groups. The central story emerging from these groups was one of making judgements about the consequences of medicines selection and subsequent purchase and use based on the drug’s effect on symptoms. Effect of the drug was the core category in selective coding. Sub-categories reflected five different dimensions of perceived consequences of using a drug including: chance of cure, chance of individualized care, possibility of containing cost of medicines, possibility of avoiding ‘second class’ care, and choice in drug selection. These dimensions were assessed in relation to specific medicine attributes in order to analyse what attributes were of importance for respondents’ drug selection, use and ultimate understanding of quality.

The analysis was not intended to rank consequences of medicine choices in order of importance. Rather the aim was to explore how different medicine attributes were perceived as contributing to medicines quality from the consumers’ point of view.

Results
Based on the qualitative analysis, we developed a matrix linking the attributes respondents used to describe drug quality to their perceptions of the consequences of using drugs with such attributes, as described below (Table 2).

A model of the relationship between medicine attributes and consumers’ perceived consequences of medicine choices
Respondents’ medicine choices appeared to be based on explicit or implicit priorities with regard to perceived health, economic and social consequences. Five dimensions along which these perceived consequences could be understood have been identified and are shown as row headings in Table 2. Drug choices seem to be associated with perceptions of how different drug attributes relate to positive and negative consequences along these dimensions. Three particularly important variables
<table>
<thead>
<tr>
<th>Focus group (no. of participants)</th>
<th>Age range (years)</th>
<th>Ethnicity</th>
<th>Gender (M/F)</th>
<th>Work (informal/formal)</th>
<th>Education</th>
<th>Income (R7 = 1 US$)</th>
<th>Medical insurance (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Johannesburg 1 (6)</td>
<td>20-60</td>
<td>African</td>
<td>Female</td>
<td>Informal (domestic workers)</td>
<td>Primary, Secondary</td>
<td>R50–R100/day (US$7–15)</td>
<td>N</td>
</tr>
<tr>
<td>Low Johannesburg 2 (6)</td>
<td>20-48</td>
<td>African</td>
<td>Male</td>
<td>Informal (car guard, car washer)</td>
<td>Primary</td>
<td>R0–100/day (US$0–15)</td>
<td>N</td>
</tr>
<tr>
<td>Middle Johannesburg 1 (6)</td>
<td>28-63</td>
<td>African</td>
<td>Male (3)</td>
<td>Formal (clerk)</td>
<td>Secondary,</td>
<td>R3500–R7000/m (US$500–1000)</td>
<td>Y (3)</td>
</tr>
<tr>
<td>Middle Johannesburg 2 (7)</td>
<td>25-56</td>
<td>African</td>
<td>Male (5)</td>
<td>Formal (police-officers)</td>
<td>Tertiary</td>
<td>R7000–9000/m (US$1000–1290)</td>
<td>Y</td>
</tr>
<tr>
<td>Low Durban (6)</td>
<td>28-48</td>
<td>African</td>
<td>Male</td>
<td>Informal (drivers, car guards)</td>
<td>Secondary</td>
<td>R0–150/day (US$0–21)</td>
<td>N</td>
</tr>
<tr>
<td>Middle Durban 1 (6)</td>
<td>27-54</td>
<td>African</td>
<td>Male (4)</td>
<td>Formal (marketing, quality assurance, managers)</td>
<td>Tertiary</td>
<td>&gt;R9000/month (&gt;$US1290)</td>
<td>Y</td>
</tr>
<tr>
<td>Middle Durban 2 (6)</td>
<td>37-64</td>
<td>Indian</td>
<td>Female</td>
<td>Formal (teachers)</td>
<td>Tertiary</td>
<td>~R9000/month (~US$1290)</td>
<td>Y</td>
</tr>
<tr>
<td>Elderly Durban (8)</td>
<td>68-87</td>
<td>Indian</td>
<td>Male</td>
<td>Retired</td>
<td>Secondary,</td>
<td>Pensioners</td>
<td>Y (3)</td>
</tr>
<tr>
<td>Teens Durban (5)</td>
<td>16-19</td>
<td>African</td>
<td>Male</td>
<td>Students</td>
<td>Secondary</td>
<td>n.a.</td>
<td>N</td>
</tr>
<tr>
<td>Low Cape Town (6)</td>
<td>25-53</td>
<td>African</td>
<td>Female</td>
<td>Informal (domestic workers)</td>
<td>Primary</td>
<td>R50–80/day (US$7–11)</td>
<td>N</td>
</tr>
<tr>
<td>Middle Cape Town (6)</td>
<td>27-38</td>
<td>Indian</td>
<td>Male (3)</td>
<td>Formal (lawyer, marketing, office)</td>
<td>Tertiary</td>
<td>&gt;R10 000/month (&gt;US$1430)</td>
<td>Y</td>
</tr>
<tr>
<td>Elderly Cape Town (5)</td>
<td>65-73</td>
<td>Indian</td>
<td>Female</td>
<td>Retired</td>
<td>Secondary</td>
<td>Pensioners</td>
<td>Y (2)</td>
</tr>
</tbody>
</table>

**Table 1** Characteristics of participants
of drug attributes have been identified, namely: drug name, whether the drug is free or not and where it was supplied. Medicine attributes are shown as column headings in Table 2. Respondents emphasized different dimensions of drug choice attributes. However, a pattern of perceived negative and positive influences of the different drug attributes has been identified that was consistent across the focus groups.

### Relief of symptoms

The main descriptor of quality, amongst all respondents, was the effect of the medicine. Participants measured effect in terms of reduction or alleviation of symptoms with little or no side effects. Terms used to describe quality included “drug works” and “strong medicine”. The following statements capture a general theme of associating the quality of a medicine with the effect it produces on symptoms.

- “Quality is like a standard: low, medium, high. Low standard medicines equal something that doesn’t work. Is about the way it works, side-effects of it, effects of it.” (Low socio-economic group, Durban)
- “The only way I can define quality is if I drink it and see it works.” (Middle socio-economic group #2, Johannesburg)
- “Cleans my chest” (Elderly, Cape Town)
- “Strong medicine that kills the pain” (Low socio-economic group #2, Johannesburg)

Added to effect was the timeliness and duration of the effect, articulated amongst the low socio-economic groups and the elderly, i.e. the drug must produce its effect ‘now’:

- “Must kill the pain today, not tomorrow.” (Low socio-economic group #1, Johannesburg)
- “I put the original one once and it works, tomorrow you don’t have the itch and you have don’t the scales and things, it clears them.” (Elderly, Cape Town)

### Supplier/provider of medicines

Respondents got their medicines from one of three sources: public sector clinics and/or hospitals, private sector dispensing doctors and community pharmacies. In the public sector, patients have no choice in terms of who attends to them: at primary care facilities it is the nurse who first examines them; similarly, in hospitals nurses first see patients then make referrals to doctors. Medicines are dispensed by nurses, pharmacy assistants and pharmacists. Therefore, respondents used the term hospital or clinic when referring to public sector facilities; the use of the word ‘doctor’, ‘pharmacy’, ‘chemist’ or ‘pharmacist’ referred to private sector providers or practices.

Preference for a particular source appeared to be influenced by whether they perceived themselves to be receiving individualized care. There was a general perception that the state, because it provided health care for the majority of the population, did not individualize care and provided “common”

<table>
<thead>
<tr>
<th>Dimensions of consequences of medicine choices</th>
<th>Medicine attributes</th>
<th>Supplier</th>
<th>Payment mechanism</th>
<th>Drug name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Supplier</td>
<td>Public</td>
<td>Private</td>
<td>Free</td>
</tr>
<tr>
<td>Relieve symptoms</td>
<td>–/+</td>
<td>+</td>
<td>–</td>
<td>+</td>
</tr>
<tr>
<td>Individual care</td>
<td>–</td>
<td>+</td>
<td>–</td>
<td>+</td>
</tr>
<tr>
<td>Contain costs</td>
<td>+</td>
<td>–/+</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>Avoid ‘second class’ care</td>
<td>–</td>
<td>+</td>
<td>–</td>
<td>+</td>
</tr>
<tr>
<td>Choice in drug selection</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>+</td>
</tr>
</tbody>
</table>

Notes: + = perceived positive impact of particular medicine attribute. – = perceived negative impact. Empty cells mean no perceived association.
medicines that could have “expired”, did not provide much “information”, and was “free”. This perception was strongest amongst the low socio-economic participants, expressed by the view that “poor people had no choice” and had to rely on the state for their medicines. There was a sense of defensiveness in the group during this discussion, almost as though people were asking ‘why us’. The view that the public system provided inferior, second class care was reflected in comments from some of the middle socio-economic participants that they were the “fortunate people with medical insurance” who could get their medicines from the private sector. This view supports the negative perception of state care and the medicines provided. Participants suggested:

“I think one of the things to consider is obviously because of income and being on medical aid we have an opportunity not to go to sub-standard facilities, we go to decent facilities . . . .where the hygiene is good.” (Middle socio-economic group, Cape Town)

“When the doctor gives you a prescription and I go to the chemist, after one day I get better. But from the state—takes one week.” (Middle socio-economic group #2, Johannesburg)

“When I am going to the (government) clinic and drinking the medicine—no better.” (Low socio-economic group #2, Johannesburg)

People preferred to use the private sector where they expressed more trust in the providers and perceived they received individualized care with a higher chance of getting better:

“Prefer the doctor. Because they know what is happening and know what they give you.” (Low socio-economic group #1, Johannesburg)

“I want medicine that is coming from a pharmacist because he is the one that went to school that learnt about dosage, all that.” (Middle socio-economic group #2, Johannesburg)

“I don’t know how to define quality in medicine—I rely on the doctor to give me the right thing.” (Middle socio-economic group #2, Johannesburg)

“You assume that because it is from a registered pharmacist you are hoping the standard is right . . . taken that for granted, you don’t actually think of being counterfeited or anything like that.” (Middle socio-economic group #1, Durban)

“Because I would have got it from someone who knows, from chemist or hospital.” (Teen, Durban)

In the table we have described this sense of wanting, but being unable, to avoid non-individualized, inferior treatment (i.e. less than what other citizens receive) as avoiding ‘second class’ care.

Payment mechanisms for medicines

Whilst our respondents indicated that affordability was the reason for using the state sector, they also displayed a general suspicion towards free and cheaper medicines supplied by the state. Some participants used the Zulu word ‘mahala’ to describe anything that was free. People questioned why this was the case:

“Mahala is no good. This body does not want mahala medicines.” (Low socio-economic group #1, Johannesburg)

“Cheaper says to me that it isn’t as good quality.” (Middle socio-economic group #2, Durban)

“Better medicine because it is more expensive.” (Low socio-economic group, Durban)

“Most common people, we African people will go for that one, the expensive one.” (Middle socio-economic group #2, Johannesburg)

No cost or low cost was associated with lower quality by the majority of our participants. It appears that the process of judgement generally used when purchasing common consumer commodities like clothing etc., where price does inform the decision, has been adopted by our participants to assess medicines quality. This perception, common across all groups, seemed to be driven by a sense of suspicion of second class care associated with receiving free medicines—after all, it is ‘my health’ and price should not matter. However, respondents acknowledged that if they did not have money they would use the cheaper or free brand of paracetamol yet still questioned why the one was cheaper than the other:

“No, I am thinking in my mind, why this one is two rand but is the same as Panado®. If I do not have money, I will buy it.” (Low socio-economic group #2, Johannesburg)

Product name, including use of generic medicines

Under product name we focused further on the issue of generic medicines. In instances where participants felt they had a choice, as in managing a ‘simple’ ailment like a headache, they would generally self-medicate with over-the-counter medicines. In the exercise using Panado®, the original analgesic, compared with Pacimol®, the branded generic, all participants selected Panado®. Reasons for this included familiarity with a well-known brand, a name people had grown up with, people had seen advertisements for this product, had used it before, it alleviated their headache, and many had never seen Pacimol® previously:

“It (Panado®) has been recommended by a lot of people, see it advertised.” (Middle socio-economic group #1, Durban)

“Panado® is popular, used this before. It is the first time I am seeing this (Pacimol®).” (Low socio-economic group #2, Johannesburg)

“I use this one (Panado®) for my headache, not this one (Pacimol®)—it is not right for me . . . . When you take it you don’t come right. I get this one (Pacimol®) from the clinic. I buy this one (Panado®) from the chemist.” (Low socio-economic group, Cape Town)

All participants felt they had no choice with prescription medicines. This was clearly evident amongst the group of
elderly men where one member stated, to nods of agreement from the rest, that:

“Essentially it is a system of complete surrender. It has become the norm; take this medication, if it doesn’t have the desired effect come back. That is an established practice, people don’t even challenge it.”  (Elderly, Durban)

Limited choice over prescription medicines was also borne out in the exercise where we asked participants to choose between two brands of amoxicillin, a commonly prescribed antibiotic. The majority said they knew little about these medicines and would rely on their prescriber to choose:

“Doctor chooses because I am sick. I am happy because he knows what to give me to get better.”  (Low socio-economic group #1, Johannesburg)

It was also clear that participants had very little understanding of generic medicines, with some people feeling that generic medicines were inferior or fake, mainly because these medicines were cheaper or supplied for free by the state. The term “fong kong” was used by the participants in Johannesburg to describe something that was fake:

“Can I ask something from a layman’s point of view? Why are generics cheaper than originals? They make generics for the people who cannot afford the expensive one or they are just making quick money? I thought they (generics) are fong kong.”  (Middle socio-economic group #2, Johannesburg)

Acceptance of generics was evident amongst those participants who used a lot of medicines, especially for chronic conditions and where affordability was important:

“We actually go looking for generics because it is cheaper and we are huge consumers of medicines.”  (Middle socio-economic group #2, Durban)

Other factors facilitating the use of generics were if the prescriber, not the dispenser, supported its use; if sufficient information was provided by the dispenser; if there was prior experience with the use of generic medicines with resolution of symptoms; and if there were little or no side-effects:

“The other (Pacimol®) is something that you could take and could have side effects. To prevent something like that happening this (Panado®) is tried and trusted.”  (Middle socio-economic group, Cape Town)

“I would use a generic as long as I am comfortable with the explanation that I get from someone who is dispensing it.”  (Middle socio-economic group #2, Durban)

“I think if a doctor is prescribing it and he says the generic will be equally potent then I will use it. If I took a script for something and the pharmacist suggested a generic and the doctor had not told me I could, then I would be hesitant.”  (Middle socio-economic group, Cape Town)

Discussion

This study explored South African consumers’ perceptions of medicines quality. It explored the views of 73 people including teenagers and the elderly, and people from low and middle socio-economic groups from the three major cities of South Africa. The qualitative nature of the study does not allow for generalizations, and the focus group method is limited by the fact that participants may act differently in real-life situations from what they may suggest in a discussion forum. However, the study findings highlight issues that were common to all participants that may well be indicative of the perceptions of the wider population. In this sense, further research would be useful.

The study points to three key findings which, combined, contribute to undermining South Africa’s National Medicines Policy. Firstly, respondents reported that they use product attributes and the expected consequences of taking a particular medicine to assess medicine quality. Irrespective of whether the drug was a generic, an original, supplied for free by the state or purchased for a fee from a pharmacy or dispensing doctor, if the medicine relieved their symptoms then the drug was considered good quality. This finding mirrors those of Whyte et al. (2002), and of Syhakhang et al. (2004b) amongst consumers in the Lao People’s Democratic Republic. Our study adds to this knowledge through respondents highlighting time and duration of effect as additional attributes.

The second finding was that free generic medicines provided by the state sector were treated with suspicion, with respondents questioning their quality. This suspicion, however, was more in relation to participants’ general desire to avoid second class care, particularly amongst the low socio-economic groups. Lönnroth et al. studied people suffering from tuberculosis in Vietnam and how they perceived the care provided by different health care providers (Lönnroth et al. 2001). They found that when money changes hands, health workers are expected to treat patients in the best possible way to improve business; anything provided for free was questioned. Holloway et al. (2002), assessing the impact of user fees on medicines use, found that consumers in rural Nepal tended to select the more expensive brand of paracetamol, again suggesting that consumers use price or money paid as a proxy measure for quality. This was clearly shown in our study as well where participants selected the original paracetamol, Panadol®, over the cheaper branded generic, Pacimol®.

Whilst there have been studies assessing consumer perceptions of generic medicines in developed countries (Tootelian et al. 1988; Yelkur and Capella 1995; Himmel et al. 2005), such studies are limited in developing countries (Maı ¨ga et al. 2001). They found that consumers in rural Nepal tended to select the more expensive brand of paracetamol, again suggesting that consumers use price or money paid as a proxy measure for quality. Nonetheless, our findings support their results: that informed consumers will be willing to use generics (Yelkur and Capella 1995), but that many currently believe inexpensive generic drugs must be inferior (Himmel et al. 2005).

A third finding was that our respondents tended to trust the advice received from private prescribing doctors more than that of other providers such as pharmacists. Participants tended to be influenced more by their doctor, rather than the pharmacist, when deciding whether or not to use generic
prescription medicines. The current intervention to promote the use of generic medicines in South Africa recommends that pharmacists substitute at the point of dispensing unless expressly prohibited by the prescriber. If consumers are more willing to heed the advice of the prescriber over the dispenser, as our study suggests, then requiring pharmacists to substitute at the time of dispensing could potentially backfire if the prescribing practices of doctors are not targeted. Maiga et al. (2003) who explored the use of generic medicines in Mali found a similar situation. Clients visiting public sector facilities tended to get more generic medicines whilst they received more brand-name drugs in the private sector, again suggesting that private sector providers played a key role in influencing the use of generics. Such an influence needs to be recognized and incorporated into national medicines policies to ensure that consumers receive an adequate explanation of the efficacy of generics and aims of substitution.

To protect their citizens from poor quality medicines, developing country governments have to improve access to affordable quality-assured medicines, including generics (Mrazek and Mossialos 2000; Newton et al. 2006). Our finding that participants felt that free (mahala) medicines were inferior has implications for implementation of South Africa’s National Medicines Policy. In South Africa, supplying free medicines at primary care level is a government strategy to improve access for vulnerable groups. If people are not using these medicines because they perceive them to be inferior, this is cause for concern. We need to further our understanding of this relationship to ensure that the people most in need get necessary medicines. Perhaps more importantly, implementation strategies need to include public awareness campaigns showing that free and/or subsidized medicines offered through the state sector are not inferior. Chetley et al. (2007), using the example of anti-smoking campaigns, emphasize the importance of an enabling environment that encourages change. Such campaigns included combinations of legislation and regulations, price controls, information and communication strategies, advocacy, work by self-help groups as well as a number of techniques to change behaviour. These combined strategies have resulted in dramatic declines in smoking in some places, including South Africa (Chetley et al. 2007). Legislation and regulations are in place in South Africa to support the use of free and subsidized medicines. The gap appears to lie in how these strategies have been communicated to consumers.

Again, whilst further research exploring prescribers’ views on generic medicines is required, implementation of the present intervention in South Africa needs to also target health care providers to ensure that common messages are communicated to the wider public. The South African government, through the National Medicines Policy and the Essential Medicines Programme, has recommended that tertiary institutions introduce concepts like generic medicines, essential drugs and standard treatment guidelines into undergraduate medical, nursing and pharmacy curricula (Department of Health 1996). These concepts have to be actively embraced not just by students but by professional bodies and councils, so that there is a common understanding among all providers, irrespective of whether they are working in the public or private sectors (Hogerzeil 2000). Of course, South Africa is not alone in implementing a national medicines policy. Indeed, across Africa, high hopes are pinned on increased access to medicines via such policies. Yet such policies could fail in execution if inadequate attention to consumer perceptions of medicines quality affects behaviour and consumption patterns.

Policy implications

Viewed from the consumer perspective, our South African study implies possible failings in the implementation of policies that support the substitution of generic medicines by pharmacists, and provide free and subsidized medicines through the state sector. Education of health care providers regarding therapeutics must include the principles of generic medicines; public education campaigns should inform consumers about the regulation of medicines to promote trust in use of all medicines available from the public sector. Peoples’ trust in the medicines can also be promoted by ensuring that the public and private sectors are communicating similar messages about medicines and their use, especially generics. There must also be a recognition that implementation of medicine policies is affected by wider health issues such as quality of care and efficient functioning of the health system. Therefore, future implementation strategies need to ensure that there is a common understanding of the objectives of a medicines policy within the overall context of the health system, as well as improved communication and co-ordination amongst all stakeholders involved in the supply and use of medicines. These are just two of the 10 preconditions that Hogwood and Gunn (1984) have identified which must be met to ensure that successful implementation of any policy is achieved.

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