DIY Heart Health: accounting for the ‘use’ of over the counter statins

Aims and objectives

This project was designed to investigate lay ideas/practices concerning heart health in the context of debates about appropriate regulation of preventive drugs (i.e. sale direct to consumers; sale ‘over-the-counter’ (OTC) in pharmacies; or prescription). Our initial proposal centred on users of statins purchased direct from pharmacists, but we extended the research to consider people who had been offered prescription statins for primary prevention (see Methodology for rationale). We set out to explain how people felt about these drugs; the decisions they made about them; and how their use was articulated with other efforts to reduce cardiovascular risk, e.g. lifestyle change or health related consumption. We therefore asked:

1. How do people account for their decisions to purchase or try to purchase statins?
2. In these accounts, how does statin use/non-use fit with wider personal projects to avoid heart troubles or maintain health?
3. What do those who have purchased them say about the ways in which they use or choose not to use these products?
4. What do these accounts tell us about the emergence, uptake or transformation of the ‘self-care’ agenda and consumer identities?
5. What implications do these findings have for policy concerning the regulation of non-prescription drugs?

Methodology

Recruitment: Originally we had agreement with a major supermarket chain to recruit OTC statin users through their pharmacies nationwide, alongside our own community-based recruitment of potential or past consumers. However as we started the research, this supermarket withdrew the product due to low sales. We therefore undertook a telephone survey of 109 community pharmacists in East Sussex to explore whether low sales were the norm and whether they might offer alternative ways to recruit participants. Respondents told us that demand had always been low, but that they often referred enquiries about statins or cardiovascular risk to general practitioners, feeling that GPs would do a full risk assessment and potentially offer drugs on prescription. We therefore decided to widen our community-based recruitment to include people who were offered low-dose statins on prescription and pursue targeted recruitment of OTC statin users at a national level using an online advertisement that appeared if people searched for elements of the product’s name within Google.

We had good reason to expect that community level recruitment would work well for prescription statins, as these are very widely prescribed drugs. Sites were selected pragmatically to access people with a variety of occupational backgrounds of both working and retirement age, though two universities and two older people’s networks located variously in the South East, North West and North East of England. Following research ethics approval from both investigators’ institutions, the study was advertised to a variety of staff groups at the universities, and in the newsletters of the older people’s networks. Potential interviewees were selected, as far as possible, to provide diversity of age, gender and occupational background. We responded to all enquiries from the online advertisement, and interviewed all but one of those initial contacts (one declined).

Interviews: We undertook a total of 42 semi-structured interviews with 44 participants (2 couples), including 7 interviews with people who had bought an over-the-counter statin. Interviewees were relatively heterogeneous in demographic terms. Roughly two thirds were men, around one third had routine or manual occupational backgrounds and ages ranged from 24 to 90, although most were older than 50. Interviews explored how participants came
to be prescribed or purchase a low dose statin, accounts of uses (or in some cases rejection) of these medicines and of wider practices relating to heart health or health in general, and conversations with primary care practitioners, pharmacists and others about cardiovascular prevention. Interviews lasted approximately 30 to 80 minutes. All were recorded and transcribed in full.

**Analysis:** We conducted a thematic analysis of the interview data as an ongoing process throughout the fieldwork, involving the compilation of interview summaries and of a set of shared reflections on emergent ideas and topics of potential interest. On completion of the interviews, both investigators read all transcripts and notes, and developed a shared set of initial codes. We then individually applied these codes to a small number of transcripts to check our shared understanding and refine the coding schema, before applying to the full set.

**Findings**

Early investigation not only confirmed that use of the OTC product was low, but also indicated that pharmacists were referring potential consumers to general practitioners, either in the name of further risk assessment or to keep the cost to consumer low. Unprompted enquiries in the pharmacy about heart health appeared unusual. Our interviews indicated that people generally took action in this area after 1) routine or opportunistic testing in general practice 2) unanticipated testing alongside other clinical interventions or 3) fears around family members’ risks or experience of heart disease. Statin users were responsive rather than proactive; they focused on cholesterol more than risk or heart health; and they tended to associate the idea of preventive drugs with consulting their doctor rather than acting as independent consumers.

In investigating our second question, we analysed the ways in which statins, functional foods and healthy living practices, might be combined in chronologies of statin use. We found that though people sometimes talked of relaxing dietary restrictions, the main influences on lifestyle were the practicalities and pleasures of everyday life, not calculative approaches to cardiovascular risk. Indeed, turning to our third question, we confirmed sociological accounts of a general ‘resistance’ to medicine taking applied also to statins, and that people had expectations that improving their lifestyle might allow them to stop or reduce the statins in the future. Thus use of these drugs was layered upon other activities and was often provisional. Stories from the media or family/friends about side effects, as well as a general dislike of medication, played into these decisions.

Our fourth question focused on whether the growth of preventive approaches in health care and the new preventive drugs would redistribute responsibility for health in our society. Our data showed people accepting a degree of responsibility for heart health thanks to awareness of the contribution of various lifestyle factors. However our respondents wanted support in acting on these. For some respondents, information accessed on the internet allowed an independent approach, but for most general practitioners appeared the ideal people to share the burden of ‘care’. This finding showed the limits of the model of a health consumer content to self-medicate through pharmacies.

In answer to our final question, we sought to understand the actions of those who did buy the over-the-counter product, but also generate data that might help explain its limited appeal. Though pharmacists told us that cost was a key issue, we found that people were spending significant amounts on ‘functional foods’. Instead we demonstrated the difficulties of selling a product designed to lower risk. As noted above, cholesterol was often the focus for the patient/consumer, but pharmacy risk assessment did not include cholesterol measurement and therefore offered no way of monitoring the drug’s effectiveness. We plan further analysis on whether the appeal of this product can be linked to social, demographic or educational factors, and thus how far similar reclassifications may be justified in terms of access and reducing inequalities as well as consumer choice.