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Research Article

Incorporating cost considerations into shared decision-making: A cross-country comparison among Hungary, France, and Bulgaria

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Abstract

This study aims to compare the patients' and healthcare professionals' (HCPs) opinions about the necessity and acceptance of discussing the cost of treatment as part of shared decision-making (SDM) in three healthcare jurisdictions – Bulgaria, Hungary, and France.

The applied methodology was qualitative and non-interventional, in the form of a focus group series performed in all three countries. The focus group guideline contained a set of preliminarily formulated questions, consistent across countries, about the potential importance of discussing effectiveness, safety, and cost with physicians.

The study found that information about the cost of therapy is considered important, especially for diseases with co-payments for medicines, such as diabetes. Despite the importance of costs, patients and physicians reported avoiding discussions and decision-making that consider the cost of therapies. Patients in France are more open to such discussions but often state that after authorities decide price and reimbursement on behalf of the community, patients should not be involved, whereas in the other two countries, they are more reluctant. In all groups, it was suggested that there is a need for more properly trained healthcare professionals who can guide conversations with expertise in shared decision-making, a method that is still not widely applied.

In conclusion, shared decision-making, including cost consideration, is not widely applied in the observed countries. HCPs and patients recognize its importance but lack experience and training to properly include it in discussions.

Keywords

shared decision-making, cost of therapy, digital tools, patient perspective, healthcare professionals' opinions

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Introduction

With the advancement of technologies and faster access to medical information, the question of active patients' participation in decisions about their own therapy has started to be discussed in scientific papers (King and Moulton 2006). Shared decision-making (SDM) is a concept that gained popularity first in the USA and then in Europe (Senate and House of Representatives 2010; Coulter and Collins 2011).

The meaning of SDM is to place patients at the center of the healthcare system (Stiggelbout et al. 2012). Patients have to know their health status and the available treatment options to actively participate in decisions regarding their therapy (Barry et al. 2012). It has also been considered a possibility to reduce healthcare malpractice (Durand et al. 2015). Patients living with chronic diseases and comorbidities usually use multiple medicines, and the associated costs can become a severe financial burden (Dickert et al. 2025). Many studies show that financial burden can cause nonadherence, which later increases healthcare and societal costs, especially for older patients (Wang et al. 2021; Dusetzina et al. 2022).

SDM has also been discussed as an option not only to improve care but also to reduce the cost of therapy (Oshnima Lee and Emanuel 2013). Despite its importance, there are still barriers to discussing the cost of treatment during the patient–physician relationship (Ubel et al. 2016; Rao et al. 2022). Limited time during visits and discomfort among physicians and patients in raising questions about treatment costs are just some of the highlighted barriers. In some cases, neither the physician nor the patient is knowledgeable about the real cost of therapy (Goss et al. 2021). Digital tools and electronic healthcare records have started to be used to provide medical and cost information, but their suitability is questionable (Allen et al. 2020; Ostrer and Wang 2023).

Some studies in different healthcare settings have already evaluated the importance of SDM. In Malaysia, SDM was evaluated in terms of health coverage and its influence on price comparisons (Zaini et al. 2018). In the United States, SDM was discussed as part of the physician–patient relationship, and important questions to ask were formulated (Barr et al. 2016; Streufert et al. 2017). In Hungary, survey data suggest that while patients prefer SDM, their actual involvement in treatment decisions often falls short of these preferences (Rencz et al. 2020). In Bulgaria, SDM was discussed from the point of view of patients with chronic and incurable diseases and their physicians (Petrova et al. 2025). Such studies are limited in European countries, especially those that compare SDM perceptions among healthcare professionals and patients, which motivated our interest in the topic.

This study aims to compare patients' and healthcare professionals' (HCPs) opinions about the necessity and acceptability of discussing treatment costs as part of shared decision-making across three healthcare jurisdictions: Bulgaria, Hungary, and France.

This research was conducted as part of the HTx project. HTx existed as a Horizon 2020 project supported by the European Union, lasting for five and a half years from January 2019. The main aim of HTx was to create a framework for next-generation health technology assessment to support patient-centered, societally oriented, real-time decision-making on access to and reimbursement for health technologies throughout Europe (https://www.htx-h2020.eu/).

This paper presents the results from three countries, in addition to the already published results for Bulgaria on the same issue and project (Petrova et al. 2025).

Methodology

The study is based on the methodology described in the HTx WP5 study protocol. The same methodology has been presented in detail elsewhere (Petrova et al. 2025), but some differences between countries are noted here. The focus groups were conducted throughout 2024 across all three participating countries..

Design of the study

As a qualitative, non-interventional focus group study, data were collected within each participating country. The focus groups were conducted by researchers from the HTx project or by trained healthcare professionals.

Participants—inclusion and exclusion criteria and recruitment strategies

In line with the study protocol, patients with type 1 diabetes, multiple sclerosis, and selected rare diseases were included, as these patient groups are generally well informed about their disease and its treatment. Therefore, they can have specific needs or preferences regarding discussions of treatment costs during shared decision-making. In Bulgaria, patients with multiple sclerosis, selected rare oncological diseases, and type 1 or type 2 diabetes were recruited. In Hungary, only patients with diabetes were recruited, and in France, patients with rare diseases. HCPs participating in the focus groups were recruited based on the included patients' diseases. In total, the focus groups involved 13 HCPs and 18 patients from Bulgaria, six HCPs and five patients from Hungary, and 11 patients from France.

It was not necessary for patients and healthcare professionals to have experience with shared decision-making before the research. They were also not required to be familiar with computer-based decision support tools.

Exclusion criteria included insufficient understanding of the questions, illiteracy, age under 18 years, and diagnoses outside the selected disease areas. Physicians were either general practitioners or specialists corresponding to the patients' conditions.

The recruitment process for HCPs included a purposeful sampling approach, namely the "snowball" strategy.

This approach aimed to identify participants of interest by asking initially recruited healthcare professionals to recommend colleagues who would be suitable to participate in the focus groups, based on their professional experience with the relevant patient groups.

In Hungary, the recruitment process for patients differed from the original study protocol. Recruitment from a national patient organization was unsuccessful, so the study invitation was disseminated through other patient organizations, forums, and professional and personal networks, which resulted in successful recruitment.

Focus groups

In all three countries, the focus groups were performed in three steps: 1) an introductory part presenting participants; 2) the concept of shared decision-making and supporting digital tools; and 3) discussion of a previously set basket of questions, as follows (Petrova et al. 2025):

- Would you find information about side effects useful in a discussion with your doctor or patient?
- Would you find information on the cost of treatment useful?
- How would you feel if you had to discuss the cost of treatment with your doctor or patient?
- Does it matter to you who will bear the cost of treatment?
  - First case: when the cost of treatment is covered in full by social security, without any out-of-pocket costs?
  - Second case: when the patient must pay part of the cost, e.g., 5 percent, 30 percent?
- What is your view?
  - Can information about the cost trigger a benevolent, altruistic reaction from others ("I do not want to add huge costs to an already overstretched health system")?
  - Does information about costs make patients feel pressured to ultimately choose lower-cost care?
  - How is this different from a situation where the patient pays some or all of the costs themselves?
- If you had the opportunity to advise the HTx project on the need to discuss the cost of treatment in a shared decision-making consultation, what would you advise?
- Do you think we have left anything out of the discussion? Do you have any suggestions on how we could improve our questions for the next focus group discussion?

Data processing and data analysis

The focus groups were audio-recorded, and transcripts were produced afterwards. In each country, two researchers reviewed the transcripts to familiarize themselves with the data. The data were aggregated using narrative synthesis. National reports were written in the local languages and translated into English for the joint analysis.

Ethical considerations

The study was conducted in compliance with applicable national legislation and international ethical standards regarding the protection of personal rights, health-related personal data, and intellectual property. All researchers adhered to the relevant legal and ethical requirements throughout the study. All participants signed informed consent forms, including agreement to publish the results. The ethics committee at the Medical University of Sofia approved the study with decision 987/27.02.2024. The Scientific and Research Ethics Committee of the Health Sciences Council in Hungary approved the Hungarian study with decision BM/9100-1/2024.

Results

Main reflections from the structured questions

In Table 1, the main reflections from the focus group discussions in the three countries under consideration are presented. Information about side effects appears to be of high importance in all three countries, although lack of time during the examination was identified as the main obstacle to sharing such information. Some patients also pointed out that effectiveness and quality of life should be discussed in addition to safety information.

Information about the cost of therapy is important, especially for diseases with co-payments for medicines, such as diabetes. Despite the importance of costs, treatment decisions by patients and physicians are rarely influenced by cost, which is often avoided as a topic of discussion.

Comfort with discussing the cost of treatment is lacking for both physicians and patients. This may be due to a lack of experience and training or to prevailing dominant relationships between physicians and patients.

In the case of full coverage, the cost issue is seen as resolved, and patients expect to continue receiving medicines and healthcare "free of charge" (without any out-of-pocket payments). In the case of partial reimbursement, cost becomes an important issue. It is worth noting that patients recognize the importance of reimbursement authorities, which should be part of shared decision-making.

Altruistic behavior in cases of high-cost therapy depends on the disease and the length of the therapy. Patients express some concerns about unnecessary tests or examinations, but in general, they do not feel guilty if the cost is high due to existing health insurance. Information about treatment costs does not influence patients' opinions, as they tend to prioritize receiving the best possible treatment.

Patients who are interested in being informed about the cost of treatment should be provided with that information. The difficulty lies in defining the cost of treatment (relative cost of medicines and all costs, including the cost of treating side effects). Full cost–benefit analyses are rarely available, and during a consultation, time is lacking to address these costs.

Table 1. Main reflections from the focus group questions.

Question	Bulgaria	France	Hungary
Would you find information about side effects useful in a discussion with your doctor or patient?	Strongly positive opinion among patients. Patients ask mainly about medical aspects, such as duration of therapy, side effects, when therapy will stop, discharge timing, when the next infusion is scheduled, whether the therapy should continue in the same modality, and other common questions during anamnesis. Physicians consider it necessary in chronic diseases with side effects of therapy. Effectiveness as well as safety are the leading reasons for the choice of therapy. Effectiveness concerning progression-free survival, overall survival, and response are the leading reasons for choice, and price is outside these reasons.	Rational decision-making consultations based on efficacy, safety, and ease of use are rare; time and health literacy are the barriers. The doctor–patient relationship is still, in most cases in France, a relationship of submission of the patient to the doctor. Not all patients wish to be informed or to be part of the decision-making, but even those who would like to are rarely provided with information on relative efficacy. An explanation of which treatment is preferred is lacking, and when patients try to understand, the response is often a polite refusal.	According to doctors, it is not only useful but mandatory in the Hungarian healthcare system to inform the patient about side effects. Patients considered it essential and mandatory to discuss side effects with their doctor. Patients also noted that talking about side effects can be dangerous in some cases if the patient feels anxious. Patients said that in other countries, much more attention is paid to methods that may ultimately lead to fewer complications, which they said is less of a consideration in Hungary.
Would you find information on the cost of treatment useful?	Physicians who treat oncology patients and those with rare diseases do not inform them about the price and cost of therapy, but pharmacists do. In general, physicians and patients with these diseases consider such information unnecessary. For patients with diabetes, cost information is important, as well as for their physicians. They pointed out that they always discuss costs due to adherence problems.	The doctor–patient dialogue is not widespread, especially when it comes to discussing the cost of treatment. Participants agreed that shared decision-making is not the norm, and even in rare diseases, where patients or parents are usually well informed about the disease, treatment options are rarely discussed adequately. In this context, adding one new dimension ("cost of treatment") to information on efficacy, safety, and ease of use seems to be an illusion.	Patients felt that they could choose the best treatment for them if they had as much information as possible, including information about cost. Some patients experienced that the shared decision-making process helped them to decide between treatments because they had always been given fair and accurate information about the costs of a particular treatment or device. The doctor must also inform the patient of the cost of the treatment, and, in the doctors' view, it is up to the patient to decide whether the cost of the treatment is right for them.
How would you feel if you had to discuss the cost of treatment with your doctor or patient?	Oncology and rare disease patients feel uncomfortable and do not discuss cost, while patients with diabetes do not feel uncomfortable and ask for information. Patients are in a position of accepting information from the doctor and rely on his or her judgment.	For most doctors, there is an ethical dimension to the medical profession that dictates the choice of the best treatment for the patient, regardless of cost. According to physicians' ethics, there is a difference between treatment effectiveness and cost-effectiveness, and priority should be given to the patient's needs over any other consideration.	Opinions are divided on how doctors feel about having to talk to their patients about the cost of treatment. The need for well-trained, well-prepared healthcare professionals was raised. It was also pointed out that in many cases, doctors do not even offer more expensive treatments, almost arbitrarily deciding what the patient can afford. Healthcare professionals also emphasized the importance of a strong doctor–patient relationship and adequate patient education. They noted that unsuccessful treatment choices should not be attributed solely to patients but rather reflect limitations in communication and education. Several participants highlighted that structured patient education is currently insufficient in Hungary and that specialist services are often overstretched, limiting opportunities for in-depth discussions. Patients feel that in many cases doctors are only familiar with more common treatments and devices and have much less information to pass on about less mainstream solutions. Patients see this as problematic, as it leaves some of the burden of research on the patient.

Question	Bulgaria	France	Hungary
Does it matter to you who will bear the cost of treatment? First case: when the cost of treatment is covered in full by social security, without any out-of-pocket costs?	Opinions differ regarding full or partial reimbursement. Patients with full coverage expect it to continue and do not discuss cost. There were two situations in which patients with full coverage pointed out the importance of knowing the cost: in cases of shortages, to be able to purchase medicines themselves, and in cases of long absences from work, when they may need to administer treatment at home due to high indirect expenditures.	As a patient, I would first consider effectiveness, then side effects, and lastly price. I do not care how much it costs as long as I am cured."	Many patients said that it does matter whether they must pay out of pocket or whether social security covers the cost. GPs believed their hands were tied. They cannot consider what subsidy the patient may receive when choosing the treatment, as they must prescribe the therapy recommended by the specialist, which in many cases prescribes the active substance and may not necessarily be a reimbursed product.
Second case: when the patient must pay part of the cost, e.g., 5 percent, 30 percent?	Regardless of the level of co-payment, cost matters for patients and physicians in cases of partial coverage and becomes an object of shared decision-making. The overall opinion is that if patients are financially engaged in treatment, they will be stricter in following their therapy. Co-payment is particularly important when patients take many medicines.	The payer must be part of the decision. "We are not an open bar." When decisions are made—collectively or not, with or without the involvement of patient representatives—and a medicine is reimbursed or covered, economic aspects should not intervene in the interaction between the patient and practitioner. They should not be put into question, as doctors project their own choices, thoughts, and philosophical visions, with sometimes different opinions than the authorities.	Patients also discussed the accessibility of the new option. One opinion was that treatments should be made available to everyone regardless of financial situation, and when a modern therapy with fewer side effects and better effectiveness is available, it should be used for everyone.
Can information about cost trigger a benevolent, altruistic reaction from others ("I do not want to add huge costs to an already overstretched health system")?	Information about cost may be relevant, but treatment is more important than price. Patients do not feel embarrassed about expensive therapies. If the doctor says an expensive medicine is better, they will accept it, although this may depend on the price difference. Efficacy and safety are the most important factors, and patients trust the doctor.	Price is a key issue, and mentioning it may make a person feel guilty when treated with an extremely expensive therapy. At the same time, some decisions are made without involving the patient or providing explanations.	Some respondents indicated that patients feel altruistic. They mentioned that, given their condition, they would be cautious about undergoing unnecessary tests too often, opting for less frequent intervals whenever possible. Others believed that the social costs of treatments or devices were not usually considered. One endocrinologist noted that sometimes patients are offered automatic insulin pump treatment at a huge cost to the insurer, almost as a reward for managing their condition well. Another doctor believed that it is important to pay even a little for every medicine or device, because if patients receive it for free, it is not valued as much.
Does information about costs make patients feel pressured to ultimately choose lower-cost care?	Patients stated that they prefer higher-quality therapy but, if required to pay, may choose a cheaper option, even though health remains the priority.	Entitlement related to having paid health insurance over the years: claims that having paid into the health system for years entitles a person to the most expensive treatment. For some who have contributed to the health system for years by paying premiums or taxes, it could be considered normal to be prescribed the most expensive treatment.	Patients felt that it was important to be able to decide on their treatment themselves, taking cost considerations into account, and not to feel that the doctor was trying to influence them in one direction or another.

Emerging themes discussed during the focus groups

Several additional themes emerged during the focus groups, at times extending beyond the primary research question. However, some were considered sufficiently relevant to warrant presentation here.

Technological advancement during the HTx project led to the creation of a digital tool for shared decision-making on the cost of therapy. The digital tool was based on effectiveness and safety data. The overall perception among physicians and patients was positive because both groups consider it a source of transparent and verified information, but participants agreed, "We should not sell too

many dreams with these tools." These tools can possibly be used when there are comparable treatments that are alternatives. In fact, these tools are quite theoretical because, even if they can work, the number of situations where enough data is available is very few at the moment. This is already the case with common diseases.

The equity issue was addressed by French patients during the discussion of full or partial reimbursement. Some patients with rare diseases discussed the possibility of being treated with chimeric antigen receptor T-cell therapy (CART-T) and the lack of transparency in the selection of eligible patients. "Why were not all eligible patients treated, and who made the decision? Is there a random process? How is it explained to untreated patients?" Similar opinions were expressed by Hungarian patients, who considered that making a device or treatment free of charge is not a satisfactory solution, as it should be considered on an individual basis to determine what each patient can afford and to adjust the level of reimbursement accordingly. Many agreed that it would be ideal for reimbursement levels to be adjusted according to each individual's standard of living and financial situation.

Reimbursement policies were discussed as part of the overall cost of therapy for the patient and for society. When decisions are made – collectively or not, with or without the involvement of patient representatives – and a medicine is reimbursed or covered, the economic aspects should not intervene in the interaction between the patient and their practitioner. They should not be put into question, as doctors project their own choices, thoughts, and philosophical visions, sometimes with different opinions than the authorities in charge of negotiating prices and reimbursement. When an authority has decided that a product should be reimbursed, there is no need to have these discussions with patients. Society has decided, and discussing the matter with the patient could generate guilt when the cost of treatment is high. This corresponds with the perception of a passive patient role in physicians' communication mentioned in all three countries. Shared decision-making assumes that patients have an active attitude toward their therapy and are interested in the effectiveness, safety, and cost of treatment. Most respondents believe that the traditional relationship of prescribing by physicians and follow-up by patients is better than shared decision-making.

More broadly, the participating physicians also discussed the importance of a strong doctor–patient partnership and adequate patient education. They expressed that selecting an unsuccessful treatment option is not just the patient's responsibility; it is a failure of the doctor–patient relationship. It was also identified as an important problem that most patients living with diabetes do not receive structured education about their treatment and their disease. According to the participating physicians, the necessary conditions for comprehensive patient education are currently lacking in all of the healthcare systems under consideration. In addition, the existing network of specialists is understaffed and overburdened, leaving limited capacity to provide patient education. The need for well-trained, well-prepared healthcare professionals was raised, as well as the need for trained patients to engage in discussions with physicians.

Some discussions were related to marketing theories, such as the "price–quality heuristic," by which consumers often use price as an indicator of product quality. Patients may perceive higher-priced products as being of higher quality and, conversely, lower-priced products as being of lower quality. This theory is based on the idea that consumers do not always have complete information about a product's quality, so they use price as a signal or cue. A key question was, what do we mean by the cost of treatment? The catalogue price of medicines or technologies? Do costs cover only the price of the products, or also the cost of treating side effects and organizational costs (number of visits, laboratory examinations when needed), or is it required to conduct a complete economic analysis, i.e., cost–benefit analysis? Is the analysis always complete, available, and easy to explain to patients? Additionally, confidential drug prices reached through managed entry agreements remain a secret. All these factors add to the uncertainty surrounding the cost of treatment and may hinder discussions.

Finally, shared decision-making should be viewed within the context of medical practice. For expensive drugs, some EU member states use specific allocation criteria that limit the ability of clinicians to prescribe them. In other jurisdictions, freedom of prescription is so extensive that clinicians do not feel the need to engage in such discussions. Universal coverage and health policy for chronic and severe diseases guarantee that most patients are 100% covered and do not need to pay out of pocket. There are diseases for which decisions are taken by a specialist committee rather than by a single physician. Therefore, decisions are shared among many people.

Discussion

In this study, our primary objective was to determine whether it is necessary and acceptable to discuss the cost of treatment with patients and healthcare professionals as part of shared decision-making in three healthcare jurisdictions: Bulgaria, Hungary, and France. A similar study comparing the United States and Europe found that patients with active participation in shared decision-making have better quality of life, improved well-being, and higher treatment satisfaction (Keenan et al. 2024). We found that shared decision-making is not a common practice in the examined countries.

Despite the common methodology, there are differences in patients' readiness and HCPs' preparedness. It appears that patients in France are more eager to discuss a variety of cost aspects with their HCPs, while in Hungary and Bulgaria, a passive model of delivering care and information from physician to patient still prevails. The research highlights how useful and desirable shared decision-making is for patients (Ardito et al. 2025). It makes it easier for them to choose the treatment that is most suit-

able for them, based on the available scientific evidence and their doctor's approval, and their involvement in the decision empowers them to be real agents in the management of their own condition (Bae 2017). HCPs and patients both highlight the importance of proper education (Deng et al. 2024). This difference between France and the two other Eastern European countries can also be explained by the high per capita costs spent on many treatments for rare diseases. The debate on the cost of orphan medicinal products is intense, and people living with rare diseases might be more aware of such policy dilemmas.

Overall, we found that discussing treatment side effects is an unavoidably important part of shared decision-making for both patients and physicians (Veenstra and Hawley 2020). Based on the results, we also concluded that the discussion of treatment costs is considered very important by both groups and that both patients and physicians believe that it is up to patients to decide which treatment they can or are willing to pay for (Tracy et al. 2022). The patient group wanted treatments to be made free for everyone or, at least, that the level of treatment support should be determined based on social need, while the physicians' group was divided on this issue, and some physicians believed that patients should contribute to treatment costs. The latter view was also shared by some patients, but most considered that compulsory health insurance should ensure the best possible treatment.

Many patients agreed that it would be ideal for reimbursement levels to be adjusted according to each individual's standard of living and financial situation. As a recent development in Europe, Austria has introduced a policy capping out-of-pocket spending on prescription medicines at 2% of household income. The measure aims to improve affordability and equity by limiting patient costs and ensuring access to essential medicines. Key challenges with this new policy include verifying income, managing reimbursement processes efficiently, and mitigating fiscal pressure on public budgets (Sozialversicherung 2026).

In all groups, it was suggested that there is a need for more properly trained healthcare professionals who can hold conversations with expertise in shared decision-making, a method that is still less widespread (Deng et al. 2024).

For some patients and HCPs, there were strong objections to including treatment costs when patients and physicians need to choose a therapy, both on principle and for practical reasons. This reinforces the idea that the topic is important to address. Whenever medical decisions intersect with economic considerations, the challenge lies in approaching these situations ethically. This requires respecting patient autonomy and the right to be informed for those who seek knowledge, while also recognizing the psychological burden such decisions may impose. Financial pressures and feelings of guilt can significantly affect patients, making it essential to balance transparency with sensitivity and support (Härter et al. 2017).

The study has several limitations that should be considered when interpreting the results. First, there were differences in the number of participants across the focus groups, for both patients and physicians. Although group sizes were necessarily limited by the qualitative design, slightly larger groups might have allowed for more comprehensive insights. Moreover, the study was limited to diagnoses with predominantly chronic conditions. The findings might have been more informative if experiences and perspectives from a wider range of diagnoses had been included, together with their views on shared decision-making and discussions of treatment costs.

The selection of disease groups was also influenced by recruitment feasibility, as patient groups and support organizations were more accessible for some conditions in certain countries than in others. In addition, recruiting HCPs was challenging due to their high workload and time constraints within the healthcare system, which may have further limited participation. These limitations may have affected the diversity of perspectives and should be considered when interpreting the findings.

Another question concerns whether all authorized products should be discussed or only those available in a given country. A more effective product may exist than those included on the list of reimbursed medicines. Should this be discussed, including explanations for why it is not covered in the country, or should it remain "hidden"?

The strengths of the study are numerous. This is the first cross-country comparison of approaches and expectations related to shared decision-making that includes cost considerations across three countries. It demonstrates different perceptions of informed decision-making. In the three countries under consideration, the dominant role of physicians still prevails, and patients expect to receive guidance for their behavior. This is most evident for diseases with full coverage, where cost issues are less salient. However, a second important difference emerges in relation to equity in access. Participants expressed interest in ensuring coverage of expensive therapies for all patients without restrictions, or at least in establishing clear criteria for patient selection. These concerns were not explored in detail during the interviews.

In future studies on this topic, electronic questionnaires should be considered in order to collect a larger number of opinions and include more countries. Differences in market characteristics, reimbursement policies, and equity in access could also be incorporated into the discussion.

Conclusion

In conclusion, cost-related shared decision-making is still uncommon in the observed countries. Its importance is recognized by HCPs and patients, but limited experience and training impede its implementation.

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Additional information

Conflict of interest

The authors have declared that no competing interests exist.

Ethical statements

The authors declared that no clinical trials were used in the present study.

The authors declared that no experiments on humans or human tissues were performed for the present study.

Informed consent from the humans, donors or donors' representatives: The ethical committee at the Medical University of Sofia approved the study with decision 987/27.02.2024. The Scientific and Research Ethics Committee of the Health Sciences Council in Hungary approved the Hungarian study with decision BM/9100-1/2024.

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The authors declared that no commercially available immortalised human and animal cell lines were used in the present study.

Use of AI

No use of AI was reported.

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Author contributions

GP – design, data collection, data analysis, data interpretation, writing; MK – design, data collection, data analysis, data interpretation, writing; KT – data collection, data analysis, data interpretation, writing; MD – data collection, data analysis, data interpretation, writing; TC – data collection, data analysis, writing; YS – data collection, data analysis, data interpretation, writing; VS – data collection, data analysis, data interpretation; MDo – data collection, data analysis, data interpretation; BN – methodology, design, data analysis; ZP – methodology, design, data analysis; FH – methodology, design, data analysis; DH – methodology, design, data collection, data analysis; BA – data collection, data analysis. All authors approved the final text.

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Data availability

All of the data that support the findings of this study are available in the main text.

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