

Is limiting rather than abolishing prescription charges the answer?

The annual review of prescription charges has come around again and this week the charge in England increases to £6.65. This is happening against a background of a Health Select Committee inquiry into NHS charges. Ellen Schafheutle took part in the consultations



One way of maintaining revenue and having a cost barrier against inappropriate use would be to lower the prescription charge to £1 or £2 per item and to make a larger proportion of the population liable to pay

As reported in *The Pharmaceutical Journal* of 4 February (p125 and p128), the House of Commons Health Select Committee has taken evidence on NHS charges (see www.parliament.uk/healthcom). Following the submission of written evidence in December 2005, representatives from health professional bodies, think tanks and patient charities were invited to give oral evidence during January and February.

The inequity of the current system of prescription charges and exemptions has been raised on numerous occasions over many years. However, this was the first opportunity to feed these views, supported by some of the existing evidence, into policy making in England in a considered and systematic manner. A separate consultation process is also

taking place in Scotland, following the failure of a bill to abolish prescription charges.¹

Evidence on the impact of prescription charges on patients in the UK and their medicines use is limited. I am supported as a post-doctoral fellow by the Health Foundation and the NHS Research and Development programme to study this topic. Research conducted by myself and colleagues at the University of Manchester generally supports much of the anecdotal evidence that there are, indeed, inequities in the current system.²⁻⁵ Particularly affected are people suffering from non-exempt chronic conditions and those on low incomes or long-term sick leave, who find themselves just above the threshold for exemption under the low-income scheme. This research has shown that non-exempt patients on below average household incomes are more likely to experience problems affording their medicines.^{4,5} To cope with the cost of prescription charges they are more likely to use a number of cost reduction

strategies, such as not going to see their GP (to avoid the prescription), not getting a prescription dispensed or prioritising among a number of different prescribed items.

Abolition of prescription charges

The simplest way of addressing patients potentially going without necessary medicines would be to abolish prescription charges completely. Indeed, this is the way Wales is going, where prescription charges are being phased out. The charge currently stands at £3, having been reduced from £4 on 1 April. For England, this would mean a loss of revenue from individual charges as well as prepayment certificates, which currently contribute some £450m to the income of the NHS. This equates to about 5.5 per cent of the net cost of all dispensed items.⁶ However, there is also concern that abolishing prescription charges would not merely mean a loss of NHS revenues. Exempt patients behave differently from those paying prescription charges, in that

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they are more likely to consult a GP for the treatment of minor ailments and so obtain a medicine, otherwise available to buy over the counter, free of charge.^{7,8} Removing the cost barrier for all could, therefore, result in increased workload for GPs and, consequently, increased use of NHS resources.

Potential changes to policy

As in Scotland, the Health Committee in England may, therefore, decide against a complete abolition of prescription charges — at least in the short term — while keeping a close eye on developments in Wales. So what are the options the Health Committee should consider? A crucial feature of any review will be to improve access by addressing some of the current inequities and barriers to access. If this is to be done without losing the current level of revenue from prescription charges there are a number of options.

The earlier discussion about concerns that an abolition of prescription charges would lead to an increase in the use of GP and other health services in order to obtain medicines free of charge is an important one. In fact, one aim of having prescription charges in place is to deter the use of non-essential medicines. Nevertheless, this effect is rather limited in the current system, because it only applies to the 13 per cent of dispensed items that are not exempt. The remaining 87 per cent of items are dispensed free of charge.

One possibility for pursuing both goals of maintaining revenue and having a cost barrier against inappropriate use that would apply to more people or items would be to make a larger proportion of the population liable to pay prescription charges. This could be achieved through a lower charge (eg, £1 or £2 per item). The largest group of currently exempt people that would be affected by such a change are people aged 60 years or over. It is interesting to note that in terms of exemption on the grounds of older age alone the UK is slightly unusual in comparison with many countries in Western Europe.¹ Exemptions, or at least reduced payments, do exist in many countries, but they either relate to pensionable age or the age limit is higher than that in the UK (eg, in Ireland, those over 70 years of age are exempt from prescription charges).

Ensure access to essential medication

A crucial feature of any revised policy of prescription charges will be to devise a system that ensures that there is no financial (or other) barrier to patients accessing essential medication. Essential drugs have been defined as those that prevent deterioration in health or prolong life and would generally not be prescribed in the absence of a definitive diagnosis.⁹ Not taking such medicines appropriately may result in adverse health outcomes

which, in turn, may lead to increased use of health services and, thus, increased use of NHS resources. Unfortunately, we do not have any UK evidence that this is the case. However, large scale studies from Canada⁹ and the US¹⁰ have demonstrated this negative effect on health outcome and resource use, particularly in vulnerable groups, such as those on low incomes or with chronic conditions, or both. Hence, those using essential medicines (mostly those with chronic conditions) need to be protected against undue cost and problems of affordability.

Advances in the availability of treatments and the much increased availability of evidence on the long-term benefits of many treatments mean that the list of medical conditions that qualify for prescription charge exemption is out-of-date. Even though this has been long and widely accepted, the list has not been reviewed since it was drawn up in 1968, and lack of consensus has been cited as a reason. However, it may be that the mere

approach of having a list is flawed. First, this system of medical exemption is unfair because those qualifying are exempt from paying for any prescribed medication, whether related to their qualifying condition or not. Second, and more importantly, maintaining any list of medical conditions perpetuates the problem of leaving some (if less or different) people with chronic conditions excluded from medical exemption. A different approach, to both address the

inequity of blanket exemption and ensure that essential (chronic) medication is accessible without a cost barrier, would be to draw up a list of essential drugs qualifying for exemption. New additions to this list could be linked to recommendations provided by the Institute for Health and Clinical Excellence (NICE), thus ensuring regular reviews.

Improve prepayment certificates

If recommended by the Health Committee in England, a consultation on possible reforms to the policy on prescription charges is likely to be a time consuming process. There is, however, one protective mechanism that already exists which could, if improved, achieve some of the objectives much more quickly and until a more in-depth review has been completed. A crucial feature of any revised policy will be to prevent cost and affordability issues from affecting adherence to essential medicines and thus, health outcomes. Prepayment certificates are in place to achieve this, but there are a number of problems. Research conducted by myself and colleagues at the University of Manchester has shown that not all people that could benefit from the use of a prepayment certificate are aware of their existence.³ Furthermore, many

of the patients most vulnerable to affordability issues find it difficult to manage the lump sum payment of £33.90 for four months (£34.65 from 1 April) or £93.20 for 12 months (£95.30 from 1 April). Another important issue is the episodic nature of some conditions, such as asthma. These patients may be well and require little medication for extended periods, yet at other times may require additional short-term courses of treatment.¹¹ The timing of such increased periods of medication is relatively unpredictable, making it difficult to anticipate when a prepayment certificate would be worth its while.

It should be relatively straightforward (and quick) to improve the way prepayment certificates are administered or paid for. One possibility would be to allow payment by instalments, as is possible for television licences, for example. The idea of issuing retrospective prepayment certificates once a certain number of charges had been paid is one reform that is currently being considered by the Health Committee in Scotland. This would introduce a true cap on prescription charges, addressing many of the shortcomings we have identified in our research, and making them fairer and more accessible.

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Prescription charges should not act as a barrier to patients accessing essential medication