Reintroducing prescription charges: brief option appraisal

Background

1. NHS prescription charges were first introduced in 1952. They were abolished in 1965 but then reintroduced, with exemptions, in 1968 with the level of charge increasing over time. In Wales, prescription charges were frozen in 2001 and abolished in 2007.

2. The rationale for abolishing prescription charges was to allow every individual regardless of means, to obtain all the medication they need. The burden of ill-health and prescription medicine use is not fairly distributed within the population with adults and children in the most deprived parts of Wales experiencing greater burden of disease, worse health outcomes and lower life expectancies.

3. There is evidence when a prescription charge is levied, as many as a third of people do not ask for all the medication they are prescribed leading to longer term illness and sometimes hospital admission. Economic analyses demonstrate the longer term costs of the resulting deterioration in illness outweigh the revenue derived from charging across a range of charging scenarios, and also that there are in-year costs resulting from increased emergency department visits, hospital admissions, and longer inpatient stays.

4. There is also evidence that more than a third of people with chronic conditions cut back on food to be able to pay for their medication and one fifth had cut back on bills, when only respondents with the lowest incomes were considered these rise to 54% and 33% respectively.

5. This advice provides estimated income and benefits, and anticipated costs and consequences, for two models of prescription charging **REDACTEDS35**. A further model - reintroducing prescription charging aligned to the charging system in England, has been discounted on the grounds the charging and exemption arrangements are complex, there are unjustifiable inequities in the exemption categories and there is a requirement for investment in significant infrastructure to support such arrangements **REDACTEDS35**.

6. The two charging models described below are for illustrative purposes only. The exact nature of a charging model would be developed through more detailed analyses of their impact and subsequent public consultation. However, in general any concessions to improve the fairness of a prescription charge regime (for example by offering exemptions to some groups such as children or older people, or by means testing, or capping total payments) will inevitably result in increased complexity, increased administrative costs, and reduced prescription charge income.

Assumptions

7. For the purposes of comparing the two charging models, officials have made the following assumptions. Where officials consider the charging model has a direct impact on the validity of the assumption this is set out in the narrative explaining the option.

8. The core assumptions used in this advice are:

- The number of prescriptions dispensed in Wales **REDACTEDS35** will be 84.5m;
- The frequency with which people have prescriptions dispensed will remain broadly the same as it is now (i.e. people won't request longer duration prescriptions from their prescriber);
- The average interval at which repeat prescriptions are dispensed will remain stable at around 31 days;
- Prescription charges will apply to all prescriptions dispensed in primary care by pharmacies, dispensing doctors and dispensing appliance contractors, including hospital prescriptions dispensed in the community;
- Approximately 5% of prescriptions are for children aged under 16 or between 16 and 18 and in full time education;
- Two thirds of all prescriptions are for people aged 60 and over; and
- The proportion of prescriptions used by people in different age groups remains constant across all medicines.

Key messages

- The value of the revenue raised from prescription charges is dependent on policy choices about the level of charge and whether and if so to which groups of patients or medicines, exemptions apply. A universal charging system would raise significant revenue but with the costs disproportionately falling on older people and those living in areas of high socioeconomic deprivation.
- There are likely to be significant short-term costs associated with establishing and communicating even a straightforward charging system. This would negate as much as 50% of the income in some models.
- Evidence supports the view that free prescriptions encourage people to obtain and take the medicines they need to protect their long-term health.
- Prescription charges discourage people from seeking healthcare they need and impact on other life choices, this is disproportionately felt by those with lower incomes.
- Prescription charges raise revenue for the NHS but overall are likely to result in a net cost to the NHS as result of utilisation of other healthcare resources this effect is not limited to preventing future use of health services, there would be a near immediate impact on some services like emergency departments and hospital admissions.
- A high proportion of the income generated from introducing charging for specific medicines could be achieved through alternative approaches including encouraging self-care and reducing prescribing by GPs continuing the trend which shows prescribing of these medicines has been reducing over time.

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Consideration of charging models

Universal charging with no or limited exemptions

9. Under a universal charging system it is assumed everyone who has a prescription dispensed would be charged a flat fee for every prescription item. For illustrative purposes a flat rate fee of £2 per prescription has been assumed with no cap applied to the total charge per patient. A small number of exemptions could be implemented based on age or the medicine prescribed and these are explored below.

Income assumptions

10. A universal charging system (at £2 per item) with no exemptions would generate approximately £169m in charge income per year. This would represent around 1.7% of the current HSS MEG of around £10.1billion.

Impact of exemptions

11. Exempting some groups would reduce charge income as follows:

- Children aged 16 and under - £8.5m reduction per year.
- Adults aged 60 and over - £111.5m reduction per year.
- Prescriptions for contraception - £0.8m reduction per year.

Distribution of payments

12. Age - On average every person in Wales receives 27 prescriptions per year giving rise to an average annual cost per person per year of £54. However, people aged 60 and over represent only 27% of the population but receive 67% of prescriptions this means the average number of prescriptions per person per year in this age group would be 66, giving rise to an annual average cost per person per year of £132. As people get older prescription use increases with around 50% of people aged 75 and over taking at least five or more medicines. Not having a cap on total prescription charges (because it would be administratively costly to implement one) means there would be no upper limit on payments and a person (of any age) receiving 10 medicines on repeat prescription would be required to pay £240-£260 per year. This would impact significantly on a small number of younger people with rare diseases like cystic fibrosis or who had received an organ donation, where a large number of medicines need to be taken to manage their condition.
13. Multiple deprivation – prescription use increases with each quintile of multiple deprivation. In the most deprived quintile 54% of adults are prescribed at least one regular medicine and 32% are prescribed three or more. In the least deprived quintile these proportions are 45% and 20% respectively. The average number of prescriptions per person per year in the bottom two quintiles of multiple deprivation is 26.8 meaning people living in those areas would be charged £54 per year or £5 (9.2%) per person per year more than someone living in the least deprived 40% of the population. People whose ill health meant they could not work would be significantly disadvantaged by this approach.

Benefits

14. A universal system is relatively straightforward to implement, charges would be levied on all prescriptions and deducted from reimbursement paid to dispensing contractors.

15. Income levels would be significant representing around 16% of total NHS medicines spend and around 25% of primary care medicines spend.
16. Charges would for some people, be a deterrent to having a prescription dispensed at all. This would lead to a reduction in demand for primary healthcare (GP appointments) and could be expected to lead to an increase in self-care. However, officials estimate prescriptions for over the counter medicines (excluding analgesics and other medicines commonly used for prescription indications) represent only 2% of total prescriptions (between 1m and 2m items per year) meaning the deterrent effect is likely to have limited impact on prescribing of these items.
17. The median cost of a prescription medicine is around £2.17; a 15% reduction in demand for prescriptions would reduce medicines spend by around £27m per year.

Disbenefits

18. The distribution of prescription medicines use means the costs of charging would be disproportionately borne by people with multiple co-morbidities, by older people, and by those living in the most deprived communities.
19. The deterrent effect would impact on all medicines; up to a third of people would not have some or all of their prescriptions dispensed, others would not present for treatment or would present later only when their condition deteriorated, and symptoms became intolerable. In some cases, this could require more intensive treatment including more expensive medication and/or hospitalisation. People would be more likely to present at hospital emergency departments (where medicines would be supplied without charge). For instance, the most commonly prescribed medicine is atorvastatin which reduces cholesterol and is used for primary and secondary prevention of heart attacks and strokes, but often does not produce short-term noticeable health benefits to individuals, so this may be one item that people choose not to pay for which would increase future NHS costs.
20. Income assumptions are highly susceptible to changes in people's prescription seeking behaviour. The deterrent effect of charges would lead to fewer prescriptions being written. Furthermore, GPs are already being encouraged to increase the interval between prescriptions. Charging would accelerate moves to increase intervals as more people ask for longer prescription durations, reducing the number of prescriptions issued and the income derived from charging.
21. There would be considerable costs associated with consulting and communicating the change to the public although these would represent only a small proportion of the potential charge income (estimated at around 1%).

<u>Charges for "low-cost" medicines used for minor, common ailments</u>

22. Under this model a charge would be payable for a specified list of medicines which are used exclusively or primarily for minor, common ailments and which could be purchased in a limited quantity from a pharmacy or a supermarket.
23. Indication data are not available so determining which prescriptions attracted a charge would be based solely on the medicine. This would mean the list of medicines would necessarily be limited.
24. Approximately 10% of prescriptions in Wales are for medicines where the legal classification allows them to be purchased without a prescription (8.7m items). However of these, many are used for the treatment of conditions which could not be considered suitable for self care (for example calcium supplementation for osteoporosis prevention in older people and sip feeds for people with malabsorption conditions). The figure also includes around 1.5m prescriptions for paracetamol preparations which are not

considered to be in this category (because the vast majority of prescriptions are for treatment of chronic pain in conditions like osteoarthritis with an average quantity of more than 100 tablets per prescription).

25. Officials estimate the maximum number of prescriptions which would attract a charge would be no more than 2m per year and would include medicines used primarily for conditions including hayfever, diarrhoea, and dry eyes.

Income assumptions

26. A charge of £2 per item with no exemptions would generate approximately £4m in charge income per year.

Impact of exemptions

27. In the absence of any data to support a different approach, officials have assumed the distribution of medicines use by age across all prescriptions applies to these medicines. If that assumption is correct exempting some groups would reduce charge income as follows:
    - Children aged 16 and under – at least £0.2m reduction per year.[1]
    - Adults aged 60 and over - £2.7m reduction per year.

Distribution of payments

28. Age – 67% of charges (£2.7m) would be paid by people aged 60 and over. Children would pay at least £0.2m in charges but this is likely to be higher because the nature of these conditions may be more likely to affect children and parents may be more likely to seek treatment for their children than themselves.
29. Multiple deprivation – prescription use and therefore charges would be 9.2% higher amongst the 40% of people living in the most deprived communities than the 40% living the least deprived communities, however given the low level of income derived from charging under this model the difference in absolute terms is low.

Benefits

30. Whilst more complex than a universal system of charges, this option is relatively straightforward to implement, charges would be levied on all prescriptions for a list of specified medicines and deducted from reimbursement paid to dispensing contractors.
31. Charges would for many people, be a deterrent to having a prescription dispensed at all. This would lead to a reduction in demand for primary healthcare (GP appointments) and could be expected to lead to an increase in self-care. Some items may have a retail price below the level of the charge and we can expect prescriptions for these items to decrease over time as people learn to self-care. This would reduce prescription charge income but this would be offset by a reduction in medicines spend of around the equivalent value.
32. This model would deter fewer people from having prescriptions dispensed for more serious health conditions minimising many of the risks to longer term deterioration in health.

[1] It is plausible that use of these medicines represents more than 5% of total medicine use because the nature of these conditions may be more likely to affect children or parents may be more likely to seek treatment for their children than themselves.

Disbenefits

33. Estimated charge income is low and there are likely to be as yet unquantified costs associated with defining which medicines attract charges.
34. The distribution of prescription medicines use means the costs of charging would be disproportionately borne by older people, and to a lesser extent by those living in the most deprived communities.
35. Charges could result in people requesting medicines which were exempt from instead of those which incurred a charge. Depending on how prescribers respond to such requests, this could lead to a change in the mix of medicines prescribed with a move to less safe, more expensive medicines.
36. There would be considerable costs associated with consulting and communicating the change to the public although these would represent a significant proportion of the potential charge income (estimated at around 25- 50%) negating most of the benefit in year one.