

REVIEW OF
**nhs prescription charges
and exemption arrangements**

IN SCOTLAND

consultation

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REVIEW OF NHS PRESCRIPTION CHARGES AND EXEMPTION ARRANGEMENTS IN SCOTLAND

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SECTION 1: INTRODUCTION AND CONSULTATION ARRANGEMENTS

Summary

1.1 This document has been prepared as part of the Executive's Partnership Agreement commitment to review prescription charges for people with chronic medical conditions, and for young people in full time education or training. This commitment recognised that the current exemption arrangements, which date back to 1968, contain anomalies and are no longer fit for purpose.

1.2 The Executive's Health Department undertook a literature search to gain an overview of prescription charge and exemption policies in other countries to help inform consideration and debate on the matter. The key facts from the overview are provided at Section 3 and a copy of the full Executive Summary is at Annex A.

1.3 This document:

- Sets out the background and policy context to NHS prescription charge and exemption arrangements in Scotland
- Discusses options for change to facilitate debate on possible system reforms

Consultation Objectives

1.4 The issue of prescription charges and exemptions is complicated. Changes to the current arrangements will have complex financial and social consequences. The best outcome is likely to involve a combination of changes implemented over a period of time.

1.5 The purpose of this consultation document is to encourage debate on a range of options. Thereafter, the preferred options will be subject to a regulatory impact assessment. The consequences of the proposed changes will be carefully considered and the Executive will then decide on the changes to be made, and how and when they might best be implemented.

1.6 The options, and way in which they are implemented, must:

- not deter patients from obtaining medication which is important for their health or to relieve suffering
- be affordable to patients at the time of need
- be practicable to deliver
- contribute to the efficient and effective provision and use of primary care services
- support the Executive's policies and priorities, which include:
 - promoting health
 - supporting self-care
 - tackling problems of poverty and low income

The Executive's Position

1.7 The Executive continues to believe that the principle of patient contribution to the cost of NHS prescriptions is right, provided it is underpinned by effective exemption arrangements. Such a scheme helps reduce the level of less urgent demands on GPs' time, places a value on medicines that patients require, and makes a valuable contribution to NHS finances.

1.8 However, it also believes that people should not be deterred from obtaining their medication because they cannot afford to pay for their prescription, and that those who have a substantial need for medication for which they pay a contribution should have access to an affordable system of payment.

1.9 As the Partnership Agreement recognises, the Executive also believes that we should widen access to full time education and training. Removing prescription charges from all full time students and people on Modern Apprenticeships could remove a potential financial barrier to participation.

Chronic conditions

1.10 There has been significant debate about the current exemption arrangements on medical grounds. Two anomalies are:

- The list of exempt conditions excludes common chronic conditions such as asthma but includes others, such as diabetes. It does not take any account of the volume of medicines that a patient may need.
- The exemption extends to all of the patient's prescriptions and, therefore, can include medication for other ailments completely unrelated to the chronic condition in question. For example, a patient with diabetes and asthma will obtain all their asthma medication free whereas someone with asthma alone will have to pay for the same medication.

1.11 Reform of the list of chronic conditions may be administratively complex and may not remove all of the perceived inconsistencies in the system. The key issue in this regard is that people who have substantial medication needs, including those who suffer from a chronic or life-threatening condition, should not face an open ended financial obligation, nor be deterred from obtaining their medication on the basis of affordability.

Options

1.12 This paper puts forward a range of options and possible variants. The Executive wishes an open consultation on these options and does not therefore specifically endorse or rule out options at this stage. The Executive's initial view is, however, that the best outcome is likely to involve a combination of changes managed in over a period of time.

1.13 Options which could be considered include:

- Extend the exemptions available under the NHS Low Income Scheme.
- Consider whether there are other proxy measures of low income which could be used to trigger exemption from prescription charges
- Review the current exemption list of chronic conditions
- Review the extent of any exemption for chronic conditions, such as restricting such exemptions only to prescriptions relating to the chronic condition

- Reform the current pre-payment system towards a monthly payment scheme so that participation need not require a large up-front payment.
- Provide exemption for all full time students and people on Modern Apprenticeships.

1.14 The focus of this consultation is on the Scottish Executive's Partnership Agreement commitment, against a background of ensuring consistency with the Executive's policies of promoting health, supporting self-care and reducing inequalities. However, as we have made clear, there are a number of interactions within the current regime of prescription charging and exemptions. The current rules include consideration of:

- Age-related exemptions
- Income or benefit related exemptions
- Condition related exemptions

1.15 The Executive recognises that it may be difficult to provide narrow responses to the consultation and will therefore be happy to consider replies which are not strictly limited to chronic conditions and young people in education and training.

Responses to this consultation

1.16 Written responses to this consultation paper are invited by 30 April 2006:

By e-mail to:

prescriptioncharges@scotland.gsi.gov.uk

or by post to:

Ms Charmian Runciman
 Scottish Executive Health Department
 St. Andrew's House
 1ER
 Regent Road
 Edinburgh
 EH1 3DG

1.17 If you have any queries please contact Mark Dorrian on 0131 244 2597.

1.18 We would be grateful if you could clearly indicate in your response which questions or parts of the consultation paper you are responding to (using the consultation questionnaire if appropriate) as this will aid our analysis of the responses received. **We would also be grateful if, in responding, you would complete the Respondee Information Form that is attached to the covering letter or at the back of the electronic version of this document.**

For future engagement:

1.19 If you wish to access this consultation online then please go to <http://www.scotland.gov.uk/view/views.asp>. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is, if you prefer to submit your response by e-mail to prescriptioncharges@scotland.gsi.gov.uk

SEConsult

1.20 An email alert system for SE consultations (SEconsult) was launched in 2003. This system will allow stakeholder individuals and organisations to register and receive a weekly email containing details of all new SE consultations (including web links). SEconsult will complement, but in no way replace SE distribution lists, and is designed to allow stakeholders to 'keep an eye' on all SE consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We encourage you to register as soon as possible.

Access to consultation responses

1.21 We will make all responses available to the public in the Scottish Executive Library by 26 May 2006 and on the Scottish Executive consultation web pages by 5 June 2006, unless confidentiality is requested. All responses not marked confidential will be checked for any potentially defamatory material before being logged in the library or placed on the website.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT

January 2006

SECTION 2: BACKGROUND

NHS prescription charges and exemptions

2.1 Prescription charges were first introduced in 1952 for patients in the community and, except for a three-year period between 1965 and 1968, have been levied ever since. The flat rate prescription charge has historically been viewed by UK Health Departments as a reasonable amount to be paid (by patients who can afford to do so) for prescribed drugs and/or appliances.

2.2 The current flat rate prescription charge in Scotland is £6.50 per item dispensed. It has risen by 10 pence increments since 1999-00. For patients who need many or frequent prescriptions, a more affordable option is to purchase a pre-payment certificate (PPC). PPCs can be cost effective where a patient needs more than 5 items in a four month period (for which the charge is currently £33.90); and where the patient needs more than 14 items in a twelve month period (current charge £93.20).

2.3 Prescription charges are intended as a contribution towards the cost of the NHS, on the basis that some form of co-payment sends a clear signal that this is a valued service. The £6.50 charge and PPC rates do not therefore relate directly to the cost of the prescribed item or the cost to the NHS of supplying it.

2.4 In Scotland in 2004-05, the cost of providing pharmaceutical services from community pharmacies, and by dispensing doctors and appliance suppliers was £982 million. Of this, £859 million was the cost for medicines and appliances, and £123 million was spent on remuneration for pharmacists, dispensing doctors and appliance suppliers. For the same period, prescription charges, including the sale of pre-paid certificates, totalled £44.4 million, which is 4.5% of the cost of pharmaceutical services and around 1% of NHS Boards' total revenue budget.

2.5 There are NHS prescription charge exemption arrangements designed to protect those who are most likely to have difficulty paying charges. It is estimated that around 50% of the population qualifies for free prescriptions under the current exemption rules. However, because this group includes the elderly, who are high 'users' of medicines, over 90% (68 million) of items dispensed in Scotland are supplied to the patient free of charge.

2.6 A person can qualify for exemption or remission of charges for three main reasons – age, financial status or medical condition. The following is an analysis¹ of the volume of exempt prescription items that these and other categories of exemption account for.

Under 16	5%}	
Aged 16, 17 or 18 in F/T education	1%}	59%
60 years or over	53%}	
Income, tax credit, and Job Seeker related		15%
Medical exemption certificate (including maternity)		7%
Pre-payment certificate		5%
Contraceptives		1%
General*		13%

* Includes where the exemption category unknown or where more than one exemption category has been ticked on the form.

¹ Based on an average of 2002-03 to 2004-05 (inclusive) dispensed prescription data provided by NHS National Services Scotland.

2.7 The list of chronic medical conditions that confer exemption from charges was agreed with the medical profession in 1968. The criteria for placing conditions on the list at that time were that they must be easily recognisable, lifelong and life threatening. All required regular, prescribed medication. It is also the case at present that anyone who qualifies for exemption because they have a chronic condition does not have to pay for *any* prescriptions – whether the prescription relates to the chronic condition or not.

2.8 A fuller summary of the current prescription charge and exemption policies, including the list of those medical conditions that currently exempt the patient from paying any prescription charges, is at Annex B.

Policy Context

2.9 The Executive's policy position remains that patients who can afford to do so should make a contribution to the costs of prescribing and dispensing; it provides a means by which patients can place a value on the medicines that they require, contributes to efficient prescribing practices and helps to reduce the level of less urgent demands on GPs' time.

2.10 However, the Executive has also acknowledged that the current charge and exemption arrangements as a whole contain anomalies. It was this recognition that led the Executive to make a commitment under the Partnership Agreement to a review of prescription charges for people with chronic medical conditions, and young people in full time education.

2.11 Since making that commitment there have been a number of developments that are relevant to the review, namely:

- The Executive's October 2005 publication of *Delivering for Health* that sets out a programme of action for NHS Scotland to the end of this decade.
- The phased abolition of prescription charging in Wales has raised the possibility of complete abolition of charges here in Scotland.
- The Scottish Parliament's Health Committee has considered a Member's proposed Abolition of NHS Prescription Charges (Scotland) Bill.

Charge Abolition

2.12 The Executive has not supported the Bill to abolish prescription charges and considers that, on the basis of the evidence presented to the Committee, the case against abolition is in fact strengthened. Annex C sets out in more detail the possible implications of abolishing prescription charges in Scotland. However, the evidence did highlight the position of those on low incomes and the possible consequences of any difficulty or inability they may have in paying for some of their medicines. Therefore, rather than focusing on abolition of charges across the board, which would benefit both those in the higher and lower income brackets, the Executive is taking the opportunity of this review to address the affordability of medicines with particular emphasis on those with higher medication needs.

Delivering for Health

2.13 One of the overarching themes of *Delivering for Health* is a shift in the balance of care from a reliance on episodic, acute care in hospitals, to an approach where the focus is on promoting good health and preventative medicine, through support for self care, and through greater targeting of resources on those at greatest risk. *Delivering for Health* also emphasises the need to give priority to tackling health inequalities. A key driver in delivering these policies will be the primary care team, with more health care being provided locally in GP practices and community pharmacies. It is very important to consider possible changes to the charges and exemption regime in this context and to ensure that any changes are consistent with, and support, the strategic direction set by *Delivering for Health*.

The Position in Wales

2.14 The Welsh Assembly Government's policy is to make prescriptions free of charge in Wales by 2007. In 2001, prescription charge exemption was extended to all young people up to the age of 25, and charges were frozen at £6 per item. As of October 2004 the charge fell to £5 and then to £4 in April 2005. A further £1 reduction is planned for April 2006.

2.15 The Executive is not aware of analysis undertaken prior to implementation of the policy to consider its financial impact. The Welsh Assembly has allocated annual budgetary increases to its Health and Social Care Department so that NHS Wales has not had to absorb the loss of prescription income. That budget is planned to reach £32.2 million in 2007 and takes no account of any possible increased costs or savings - to date there is no hard evidence of either and this is not expected to emerge until the charge has actually been abolished.

2.16 The most contentious issue arising from implementing the policy so far has been surrounding cross-Border activity, whereby patients resident in Wales but registered with a GP in England are unable to access a Welsh prescription and thereby benefit from the reduced charge (when it is dispensed in Wales). The situation for patients resident in England but registered in Wales means that conversely they are able to benefit. At the time of producing this document the Welsh Assembly Government has still to resolve this issue. From a Scottish perspective the point to bear in mind is that in developing any new charge and exemption arrangements it will be necessary to address and resolve possible cross-Border issues.

SECTION 3: REVIEW OF THE USE OF CO-PAYMENTS IN OTHER COUNTRIES

3.1 The Scottish Executive undertook a review of the use of co-payments in other countries to provide an evidence base and source of reference for this consultation phase. It examined and compared how much patients contribute to the cost of their medication and what exemptions and reduced payment policies are in place in Western Europe, North America, Australia and New Zealand.

3.2 The report of the overview states the position as at January 2006

3.3 In summary, the health systems in the countries surveyed are varied, and so too are how much patients pay towards their medication, exemption and reduced payment policies. The fact that each country is operating from a different baseline means that direct and precise comparisons between the different arrangements could be misleading. However, the key points to emerge from the review are:

- Patients in all countries surveyed pay some form of charge towards their medication, except the Netherlands, though this policy is currently being reformed to introduce patient co-payments, and some parts of Italy
- Overall, the system in Scotland/UK is generally more generous than most other countries. The amount patients pay towards their medication in most of the countries surveyed relates to the cost of the drug dispensed, with patients paying a percentage of this cost. In Scotland/UK the charge is not related to the drug price but is a fixed payment of £6.50 per item. Additionally, the exemption scheme in Scotland/UK entitles approximately 50% of the population to have all their prescriptions free of charge.
- Although variation in the price of drugs and differences in charging policy makes it difficult to compare Scotland/UK against other countries, in general, for very low cost drugs, patients in Scotland/UK pay a higher charge, but face lower costs relative to other countries for medium to high priced drugs.
- No other country surveyed takes the approach of the UK countries that anyone who qualifies for exemption on the grounds of having a medical condition is exempted from charges for *all* prescriptions whether or not the prescription relates to the medical condition.
- Not all countries surveyed included exemption on medical grounds
- The majority of countries surveyed offer reduced payments or exemptions for older people and people on low income. In addition, most offer help for high users of services or medication in the form of reduced payments or a cap on the total payment in a given period of time. In terms of older people, most of the age thresholds relate to pensionable age or are higher than in Scotland/UK e.g. over 70 in Ireland.
- There is little evidence from other countries of exemption policies for students and people in training

3.4 The review also concluded that there is insufficient research, particularly in the UK, to assess the degree to which prescription charging would adversely affect health status due to reduced take-up of prescriptions, or, for that matter, the degree to which non-compliance with taking medication for *any* reason would have this effect.

3.5 A copy of the report's summary is at Annex A which includes references to the sources used. The following Section 4 draws from the main report as appropriate. A full copy of the report (over 40 pages) can be obtained by contacting Ms Charmian Runciman (0131 244 2231).

SECTION 4: DISCUSSION AND CHANGE POSSIBILITIES

4.1 REVIEW OF EXEMPTIONS RELATED TO MEDICAL CONDITIONS

The Executive has a Partnership Agreement commitment to review prescription charges for people with chronic medical conditions. This commitment recognised that the current exemption arrangements, which date back to 1968, contain anomalies and need to be reviewed.

4.1.1 There are two approaches to exemptions based on clinical conditions. One is to maintain a list, as at present, of chronic conditions which qualify for medical exemption. The other is to provide exemption against a list of medicines that are deemed 'essential' for the listed conditions, or for the treatment of chronic conditions more generally. One of the consequences of the latter approach could be to change the current position whereby the medical exemption extends to prescriptions that are not related to the chronic condition in question.

4.1.2 The review of the use of co-payments in other countries found 7 countries², in addition to the UK countries, where some form of medical exemption exists. In addition, 7 other countries had some form of reduced payment based on medical needs. It also found that the UK is the only country surveyed where medical exemption entitles patients to all prescriptions free of charge.

4.1.3 In Scotland, the medical exemption arrangements are condition-based and in effect apply to people not exempt on grounds of age. In themselves, they take no account of the patient's ability to make a contribution to the cost. The exemption applies regardless of the frequency and number of different medicines needed for the condition and leads to anomalies such as inclusion of those with low thyroid function who require usually only one type of medication but exclusion of those with high blood pressure or asthma who may be on several different forms of medication or inhaler. Thus, for those patients whose condition is not listed but who nevertheless have significant requirements for medication, there is no special provision, unless they are exempt on other grounds.

4.1.4 Change possibilities (CP) for revision of the current medical exemptions could include the following.

CP 1: Review the criteria by which chronic conditions are defined and consider the therapeutic categories of drugs that are essential to their treatment, where that consideration is carried out by an expert group.

4.1.5 In order to remain fair and effective, the criteria or definitions will require regular review for possible adjustment. However, the finally determined lists may still leave out conditions or medicines that some patients feel should be included. The place of drugs that are used to treat side effects of main treatments would be particularly challenging to codify, and would require further expert judgements to be made.

CP 2: Link exemption to the drug and not the condition.

4.1.6 This would require a similar expert group to define criteria for including drugs for exemption from charges and for ongoing review of the exempted list. It would mean that, unlike the present system, drugs not linked directly to the condition would be subject to a charge: however, to recognise the possible indirect link, the charge could be at a concessionary rate. Under this option it would be possible to widen the range of conditions that attract exemption (and possible concessionary rate) by extending the exempted drug list. The same issues as expressed in 4.1.5 would apply.

² Ireland, Luxemburg, Austria, Belgium. France, Portugal and Sweden.

CP 3: Convert the medical exemption category to a 'high prescription user' category

4.1.7 This option is discussed at paragraph 4.2.16 onwards.

Views are sought on:

1. Whether exemption from all charges should continue to be given on medical grounds alone, and if so, whether the list of conditions should be reviewed.

2. Whether, where exemption is given on medical grounds, that exemption should relate only to drugs for the treatment of the medical condition in question, rather than (as at present) covering all drugs whether or not they relate to the condition that gives rise to the exemption.

3. Whether it makes more sense to provide exemption based on a list of drugs, or based on a list of conditions.

4.2 ECONOMIC NEED – AFFORDABILITY

The Executive believes that people should not be deterred from obtaining their medication because they cannot afford to pay for their prescription, and that those who have a substantial need for medication for which they pay a contribution should have access to an affordable system of payment.

This section considers the issue of prescription charge affordability and income based systems.

Background

4.2.1 The review of the use of co-payments in other countries revealed that the majority of countries surveyed have reduced payments or exemptions for people on low income, and/or had either caps for how much people pay for prescribed medicines, or reduced payments for high users of prescription medication.

4.2.2 In Scotland, like the rest of the UK, exemption from prescription charges is available to patients receiving income support, income based Job Seeker's allowance, working family and child tax credits, and people who qualify for full help under the NHS Low Income Scheme. These criteria are effectively proxies for low income as they are all means tested benefits.

4.2.3 The NHS prescription charge in Scotland is a flat fee for each prescription and, unless the patient purchases a pre-payment certificate (PPC), there is no monetary cap to what they pay as the number of prescriptions required by the patient increases. This can result in financial pressures for those who are high users of prescription medication and who fall outside the current exemptions system.

4.2.4 However, whilst PPCs offer a cost effective way of meeting and capping charges, the initial cost may present difficulties for some patients. Patients are not always made aware of the PPC system and, in any case, may not know in advance when a PPC might be of benefit, particularly if they are at the beginning of an episode of illness which may become chronic or last longer than expected.

Change Possibilities

4.2.5 The approaches that could variously or collectively address these affordability issues include:

- revising the list of low income proxies that attract exemption
- modifying the PPC scheme to be more readily affordable
- introducing a concessionary rate for higher users of medicines
- placing a cap on the charges payable by anyone over a given period of time
- lowering the flat fee for all

Exemptions on Income Grounds

4.2.6 The current income related exemptions are based on means testing criteria that are applied at a UK level.

4.2.7 The policy on the NHS Low Income Scheme (LIS) and other income related schemes is that the same eligibility criteria should apply throughout the UK so that equity of treatment for all claimants is assured. This unified approach also enables claims, and the associated entitlement for NHS charge exemption, to be processed centrally and cost effectively by the Prescription Pricing Authority (PPA) in Newcastle.

4.2.8 It would, however, be possible to extend the current NHS Low Income Scheme (LIS) to cover a wider section of the population in Scotland without administrative changes being required at PPA.

4.2.9 At present, depending on the outcome of the means test under the LIS, applicants will receive either a HC2 or HC3 form. The HC2 entitles the holder to exemption from a number of NHS charges including NHS prescriptions. The HC3 entitles the holder to help with health charges except those for prescriptions. In 2004-05, over 70,400 people in Scotland applied for help under the LIS. Over 41,200 received full help (HC2) whilst 21,500 (and their dependants) qualified for partial help (HC3): 7,700 did not qualify. Therefore:

CP 4: Extend exemption from paying prescription charges to all persons holding a LIS HC3 certificate – which would extend charge exemption in Scotland to over 21,500 people and their dependants.

Pre-payment certificate scheme

4.2.10 The issue of affordability is already addressed to a degree by the availability of pre-payment certificates (PPCs). These certificates can be cost effective where a patient needs more than 5 items in a four month period (the current charge is £33.90); and where the patient needs more than 14 items in a twelve month period (current charge is £93.20). However, whilst this is effectively a form of financial capping, there are some issues within the current PPC arrangements.

- The patient needs to be aware of the scheme at the beginning of their treatment episode. GP surgeries and community pharmacies should carry publicity material for PPCs, but this may not always be the case, patients may not notice it, or it simply may not attract the patient's attention.
- At the beginning of a treatment episode, neither the patient nor their health advisers may be able to anticipate whether the patient will benefit from a PPC and it is not possible to purchase one retrospectively.

- The patient needs to have available funds of at least £33.90 (for the 4 month PPC) in order to purchase a certificate and gain the cost benefit.
- The cost effectiveness increases further when the patient is able to buy the twelve month certificate, but this requires patients to have £93.20 available as a one-off, upfront payment.
- Patients at the lower end of the income scale may find the upfront financial layout at either level a barrier to using the PPC scheme.

4.2.11 To increase public awareness of the PPC scheme, the Executive is currently in the process of revising its publication and distribution arrangements for patient information on both prescription charge exemption and other NHS charge exemptions. These will extend distribution to more public places, e.g. libraries and citizen advice centres etc., as well as GP surgeries and community pharmacies; and will provide for 6 monthly restocking of the material.

4.2.12 However, in addition to these steps, the change possibilities that to varying degrees could address the issues relating to PPCs include:

CP 5 - issue a PPC retrospectively to patients whose prescription charges over a set period amount to the value of a PPC, (i.e. based on current charges, once 5 prescriptions have been charged in a 4-month period) or to offset the cost of the PPC by the amount paid over a preceding set period.

4.2.13 This would benefit both patients in the early stages of a chronic illness, where they have not previously required regular scripts, and those who have acute illnesses requiring frequent prescriptions over a short period of time.

4.2.14 Such an arrangement would require patients to retain and present evidence of previously paid charges, which could be administratively bureaucratic and would require built in safeguards to prevent system abuse. An alternative would be to administer the scheme by means of an electronic record. This is discussed further at paragraph 4.2.19 below.

CP 6 - restructure the minimum period for which the PPC applies.

4.2.15 Any intention to make the PPC more affordable at the point of need would require a lowering of the initial payment linked to a reduction in the period covered. Working pro-rata to the current rates, a two month period could be bought for £17.00. Taking this measure to its extreme, a monthly capping system roughly equivalent to the current PPC pricing could augment or replace the current PPC system. A possible option based on this thinking is at paragraph 4.2.21 to 27.

4.2.16 An alternative arrangement would be to provide patients with the ability to pay for their PPC by instalments and so reduce the upfront costs. This would require the patient to enter into a financial commitment but would benefit those patients who are high users and are not exempt on other grounds.

Views are sought on:

1. Whether prescription charge exemption should be extended to HC3 holders.

2. What changes to the PPC system would address current barriers to its use, particularly by those on low income, and maximise patients' benefit.

Capping and concessionary fees for higher users

4.2.17 Introducing a monetary cap at which the patient either pays a concessionary fee, or ceases to pay a fee for a pre-determined period of time, requires the use of a patient specific record or other documentation to record transactions.

4.2.18 At present, patient records are held at GP surgeries and - in many cases – the community pharmacy that the patient regularly visits. Currently these records are not designed to capture prescription and dispensing activity data in a way that would enable the activity to be used for cost abatement purposes. Neither is it currently possible to monitor prescriptions dispensed by different pharmacies and so 'track' the number of charges the patient has to make. Nevertheless, these do not present a barrier to the possible future development and introduction of new charge capping and concessionary rate arrangements.

4.2.19 The increasing use of the CHI (Community Health Index) unique patient identifier on prescriptions³, coupled to the introduction of patients' electronic health records⁴ and the advent of electronic transmission of prescriptions (ETP) will increasingly provide a database on which patient charge tracking systems can be developed. The ETP facility in Scotland is planned to start roll-out in the latter part of this year 2006. Additionally, it is clear that many of the countries surveyed in the review of the use of co-payments in other countries have systems that enable patient charge capping and the application of reduced co-payments and we might learn from their systems.

4.2.20 A possible option based on capping and concessionary rates for higher users would be to:

CP 7: Introduce a monthly charge cap with the limit set in line with the current cost of pre-payment certificate but with a more affordable entry point.

4.2.21 The current monthly equivalent of the PPC is around £8.00 (based on the annual PPC cost). Under this option, adopting this as the cap level would mean that a patient would pay a full £6.50 for the first script of the month then a reduced rate (i.e. £1.50) for the second script in the same month and thereafter no further charges that month. This would effectively bring them into the pre-payment system in the first month.

4.2.22 For example, a patient who obtained a script for antibiotics for cystitis in week 1 of the month would pay £6.50, but if they required a second script in week 2 due to unresolved symptoms, they would pay £1.50 for this. A third script for thrush due to the antibiotics in week 3 would be free. If they then had a further attack of cystitis in the following month, they would again pay £6.50 for the first script, and so on.

³ Full uptake of the CHI number across Scotland to be achieved by June 2006 (Delivering for Health – Section 3)

⁴ Under the eHealth Strategy (Delivering for Health – Section 3)

4.2.23 Patients on regular medication would also benefit under these arrangements. They normally receive enough medication for 2 months at a time, i.e. 6 times a year. Under this arrangement a person who currently requires 2 regular items every 2 months, and therefore does not benefit from the PPC system, would pay £8.00 every 2 months instead of £13.00 as at present. (2X £6.50). For a person on 3 types of medication, issued every 2 months, they too would pay £8.00 every 2 months instead of £33.90 per 4 monthly PPC.

4.2.24 In addition, patients on medication which currently attracts 2 prescription charges because of dual contents, e.g. hormone replacement therapy (HRT), would be liable for a maximum charge of £8.00 instead of paying £13.00 as at present.

4.2.25 Thus most patients on regular medication would be paying £4.00 per month on average over the year. For patients with acute illnesses, the maximum they would pay in a year if they had more than 1 script each month would be £96.00, and if they had 1 or less than 1 script a month, they would pay £78.00 or less over the year. This is comparable to the current cost regime.

4.2.26 An alternative to CP 7 would be to be:

CP 8: Introduction of a concessionary rate for those patients who require regular repeat prescriptions or acute prescriptions frequently – either with or without some form of capping.

4.2.27 Under this option the full prescription charge would be applied to only one item on any multi item prescription, with a lower charge for the rest. This would financially benefit patients who either regularly or occasionally require multi-item prescriptions. For example, for a patient who regularly requires 3 items every 2 months and with a concessionary rate of (say) £4, the cost in a 4 month period would be £29 (£6.50 + £8, twice). This would be less than the 4 current monthly PPC and with a lower initial outlay.

Flat Fee

4.2.28 An administratively straightforward way of making prescription charges more affordable to patients might be to:

CP 9: Introduce a lower flat rate charge that would be payable by all, except those with low income or age exemption.

4.2.29 A possible consequence of reducing the flat rate fee for all (other than those currently exempted on income and age grounds) is that more people would seek a GP appointment in order to reduce the cost that they might otherwise expect to pay for over the counter medicines. Annex C reports the possible cost consequences of this 'increased demand' factor in relation to a total abolition of prescription charges. It can be assumed that the estimated cost consequences of reducing the flat fee will be less, but that it will be relative to the level of reduction. Reducing the flat fee for all (as qualified above) would lead to a reduction in charge income to NHS Boards.

Views are sought on:

1. Whether there should be a reduced flat fee for all (with current income based exemptions) and, if so, the level at which affordability to the patient and cost to the NHS can be balanced.

2. Whether there should be a monetary cap to the charges that a patient is required to pay over a set period of time, after which prescriptions should be free within this period of time.

3. Whether there should be a concessionary rate for patients who require frequent prescriptions, and whether the concession should be triggered by the costs incurred over a set period of time.

4. Whether there are other changes in the arrangements for pre-payments or caps that are not listed above and which would maintain charge income in general for NHS Boards.

4.3 ABILITY TO PAY

The Executive has a Partnership Agreement commitment to review prescription charges for young people in full time education or training. This commitment recognised the Executive's wish to widen access to full time education and training.

Young people in full time education or training

4.3.1 The review of the use of co-payments in other countries found little evidence of exemption for young people in full time education.

4.3.2 People in full time education and aged 16 to 18 inclusive are already exempt in the UK. However, those entering full-time tertiary education where undergraduate courses last up to 4 years fall outside this age category for at least part of their course. Not only do they have to find fees and living expenses, but they also have little time to earn any income. Prescription charges, although a relatively small part of their expenditure, can seem prohibitively high. Exemption on income grounds can be difficult to obtain for the full length of the course resulting in repeated claims and excessive bureaucracy.

CP 10: Extend exemption to (a) persons up to the age of 24 or (b) all persons, in full time education or training.

CP 11: Introduce concessionary charges for persons aged 19 or over in full time education or training.

CP 12: Improve system for exemption on income grounds for persons aged 19 and over in full time education or training.

4.3.3 The category of 'people in full time training' covers a very broad spectrum. It will include people on apprenticeships where either or both their training and salary costs are met by their employer, and those on full time vocational training as part of the paid process for obtaining a necessary qualification.

4.3.4 Any extension to the current exempted group (16 to 18) to include full time students or others in full time training will bring benefits to the persons concerned but reduce the level of charge income to the NHS, although people in this category are generally young and low medicine users so the loss would be relatively small.

Views are sought on:

- 1. Whether there is a case for extending the current ‘full time student’ threshold to cover tertiary education.**
- 2. Whether exemption should be extended to all persons in full time education or training, regardless of their ability to pay.**
- 3. Whether there should be concessionary charge arrangements for full time students or trainees above set age thresholds.**
- 4. Whether there are other changes in the charging system that could remove the need for special arrangements for full time students or trainees?**

Age Exemptions

4.3.5. In Scotland, persons aged 60 or over, and under the age of 16 are exempt from prescription charges. The review of the use of co-payments in other countries found that many of the countries surveyed had exemptions or reduced payments for older people or pensioners, however the age threshold tended to relate to pensionable age or was higher than that in Scotland e.g. those over 70 in Ireland.

4.3.6 Eight of the countries in the review had some form of exemption or reduced payment for children and younger persons, but the threshold for this varied. As reported above, Wales now has a young people’s age exemption threshold of 25.

4.3.7 As already stated, the Executive’s policy position remains that patients who can afford to do so should make a contribution to the costs of prescribing and dispensing – on the basis that exemption arrangements are in place for those most likely to have difficulty paying charges. A straightforward age exemption is, therefore, anomalous in terms of this policy.

4.3.8 Children under the age of 16 do not have an independent income and therefore will be exempted on those grounds. Also, childrens’ access to medication should not be dependent on their parents’ decisions on use of their income. Such circumstances do not, however, apply to people above the upper age limit. This section lists no options with regard to the issue of age exemptions but the Executive would welcome any views that consultees may wish to express on this matter.

The Executive recognises that it may be difficult to provide narrow responses to the consultation and will therefore be happy to consider replies which are not strictly limited to chronic conditions and young people in education and training.

SECTION 5: SUMMARY OF CHANGE POSSIBILITIES AND VIEWS SOUGHT

1 REVIEW OF EXEMPTIONS RELATED TO MEDICAL CONDITIONS

CP 1: Review the criteria by which chronic conditions are defined and consider the therapeutic categories of drugs that are essential to their treatment, where that consideration is carried out by an expert group.

CP 2: Link exemption to the drug and not the condition.

CP 3: Convert the medical exemption category to a 'high prescription user' category.

Views are sought on:

- 1. Whether exemption from all charges should continue to be given on medical grounds alone, and if so, whether the list of conditions should be reviewed.**
- 2. Whether, where exemption is given on medical grounds, that exemption should relate only to drugs for the treatment of the medical condition in question, rather than (as at present) covering all drugs whether or not they relate to the condition that gives rise to the exemption.**
- 3. Whether it makes more sense to provide exemption based on a list of drugs, or based on a list of conditions.**

2 ECONOMIC NEED – AFFORDABILITY

Exemptions on Income Grounds

CP 4: Extend exemption from paying prescription charges to all persons holding a LIS HC3 certificate – which would extend charge exemption in Scotland to over 21,500 people and their dependants.

Pre-payment certificate scheme

CP 5 - issue a PPC retrospectively to patients whose prescription charges over a set period amount to the value of a PPC, (i.e. based on current charges, once 5 prescriptions have been charged in a 4-month period) or to offset the cost of the PPC by the amount paid over a preceding set period.

CP 6 - restructure the minimum period for which the PPC applies.

Views are sought on:

- 1. Whether prescription charge exemption should be extended to HC3 holders.**
- 2. What changes to the PPC system would address current barriers to its use, particularly by those on low income, and maximise patients' benefit.**

Capping and concessionary fees for higher users

CP 7: Introduce a monthly charge cap with the limit set in line with the current cost of pre-payment certificate but with a more affordable entry point.

CP 8: Introduction of a concessionary rate for those patients who require regular repeat prescriptions or acute prescriptions frequently – either with or without some form of capping.

Flat Fee

CP 9: Introduce a lower flat rate charge that would be payable by all, except those with low income or age exemption.

Views are sought on:

1. Whether there should be a reduced flat fee for all (with current income based exemptions) and, if so, the level at which affordability to the patient and cost to the NHS can be balanced.

2. Whether there should be a monetary cap to the charges that a patient is required to pay over a set period of time, after which prescriptions should be free within this period of time.

3. Whether there should be a concessionary rate for patients who require frequent prescriptions, and whether the concession should be triggered by the costs incurred over a set period of time.

4. Whether there are other changes in the arrangements for pre-payments or caps that are not listed above and which would maintain charge income in general for NHS Boards.

3 ABILITY TO PAY

CP 10: Extend exemption to (a) persons up to the age of 24 or (b) all persons, in full time education or training.

CP 11: Introduce concessionary charges for persons aged 19 or over in full time education or training.

CP 12: Improve system for exemption on income grounds for persons aged 19 and over in full time education or training.

Views are sought on:

1. Whether there is a case for extending the current ‘full time student’ threshold to cover tertiary education.

2. Whether exemption should be extended to all persons in full time education or training, regardless of their ability to pay.

3. Whether there should be concessionary charge arrangements for full time students or trainees above set age thresholds.

4. Whether there are other changes in the charging system that could remove the need for special arrangements for full time students or trainees.

SUMMARY FROM THE SCOTTISH EXECUTIVE HEALTH DEPARTMENT'S REVIEW OF THE USE OF PATIENT CO-PAYMENTS IN OTHER COUNTRIES

1. In the modern world of health care, pharmaceutical drugs are a central part of the treatment for patients. How to contain the cost of this component of health care systems, while providing a fair and effective method of providing drugs to those patients who need them, has been a preoccupation of governments around the world for many years.

2. The main forms of cost containment employed by governments in relation to pharmaceutical drugs are:

- Price and profit controls applied to pharmaceutical companies, distributors and sellers;
- Reimbursement systems including patient co-payments, the use of prescriptions and over the counter medication (OTC), the introduction of reference price lists, generic substitution, and drawing up lists of reimbursable drugs;
- Other fiscal measures, such as having a budget for how much a country will spend on prescription medication, and
- Quality measures, such as prescription guidelines and the work of NHS Board prescribing advisors^{1,2}.

3. This summary focuses on the second of these cost containment measures, and summarises how it has been used in Western Europe, North America and Australasia, looking particularly at the use of patient co-payments. It should be noted that, co-payments for medication are complex and vary considerably from country to country, as do health care systems, number of reimbursable drugs and co-payment systems³⁻³⁹.

4. As this variation in policy across countries renders it difficult to draw sound conclusions about whether or not patients pay more or less in Scotland/UK compared to other countries, the conclusions which can be drawn from two case studies based on hypothetical drug prices and usage rates are also included here.

5. The evidence provided in this summary has been derived from a search of a range of pharmaceutical pricing and reimbursement texts, government websites, and the international literature on prescription charging policy, as it relates to patient co-payments.

Health care systems in Western Europe⁵, North America and Australasia

6. There is a huge variety of different health care systems in Western Europe, North America and Australasia. Firstly, in terms of health care systems generally, three main types exist:

- Predominantly Private Health Care Systems such as the USA,
- Predominantly Public Health Care Systems such as the UK, and
- Truly Mixed Systems such as Ireland³⁻³⁹

7. However, in looking at health care systems in more detail, it becomes clear that no system can be seen as being exclusively funded by either public or private monies. Even in the USA, Medicare and Medicaid offer publicly funded health care for certain groups⁵.

⁵ Western Europe is defined for the purposes of this review as the Nordic Countries, the United Kingdom, Republic of Ireland, the Benelux countries, Germany, France, the Alpine Countries, the Italian peninsula and the Iberian peninsula.

8. Secondly in terms of medication, a consistent feature of all health care systems in this review is government systems for subsidising the cost of medication for at least some groups of the population³⁻³⁹.

9. Many countries offer this subsidy only on medication which forms part of a list; drugs on this list are normally prescription based medication, rather than OTC drugs. Some countries have 'negative lists' of medication which are not reimbursable, while others have 'positive lists' of medication which are reimbursable. Positive lists tend to limit what can be reimbursed to a far greater extent, than negative lists, as only those products listed can be reimbursed. The UK operates a loose form of negative list system, whereas many other countries such as Austria have positive lists to reduce their pharmaceutical costs and encourage the use of generics³⁻³⁹.

Patient Co-payments

Table 1: Patient Co-Payments for Medication (Normal Co-Payments)³⁻³⁹

Country	Maximum Contribution	Contribution (£)*
Counties with Almost No Co-Payments		
Netherlands	Theoretically, patients may pay the difference in cost between the reference and actual price, but in reality this rarely happens	
Countries with Fixed Co-Payments		
Austria	£3.06 (per pack**)	
Australia	£12.54 (per drug)	
Italy	£2.12-£3.89 (in regions where these rates still apply)	
New Zealand	£5.61 (per item)	
UK	£6.50 (per item in England, Scotland and Northern Ireland) £4.00 (per item in Wales)	
Countries with Fixed and Percentage Co-Payments		
Finland	£7.07 plus 50% of the remaining cost of the medication	
Germany	£3.54-£7.07 or 10% of the reference cost of the medication	
Countries with Cap Based Co-Payments***		
Ireland	£60.10 cap on costs per month	
Sweden	£62.73 cap per year	
Countries with Complex Co-Payments		
Canada	Varied	
USA	Varied	
Countries with Percentage Based Co-Payments		
Belgium	0%, 22.5%, 50-80%, 100% (based on assessed usefulness of medication)	
Denmark	15%, 25%, 50%, 100% (based on drug consumption)	
France	35-65% for serious disease drugs & 65-100% for non-serious disease drugs (based on usefulness of medication)	
Luxemburg	20% for most drugs (0%, 60%, 100% for serious illness, less important medication, supplements respectively)	
Portugal	20% for most generic medication and 30% for most non-generic medication (0%, 50-60% and 70-80% drugs for chronic condition, infections, and drugs still under consideration respectively)	
Spain	40% for most drugs	

* It should be noted that although a conversion to sterling is included, cost of living and other aspects of health care systems vary between countries so caution should be taken in interpretation.

** Charges are either per drug prescribed, per pack of a given medicine or per item on a prescription form.

*** Other countries have caps on payment but their system is not solely based on this.

10. In terms of co-payments for government subsidised prescription medication, all the countries in the review, apart from The Netherlands, have some form of co-payment – i.e. patients must make a contribution towards their medication (see table 1). However, the health care system in the Netherlands is currently being reformed, and as part of this reform, it has been proposed that patients will start to pay something towards their drugs³. It should also be noted that although Wales is in the process of abolishing its prescription charge, co-payments are being phased out through year on year reductions³⁹. Finally, in Italy, regions are now able to introduce their own system of reimbursement, leading to some regions abolishing patient co-payments³.

11. As can be seen in Table 1, **the most frequent form of co-payment for the countries in this review is asking patients to pay a percentage of the cost of their medication**. As can be seen above, different geographical locations seem to favour different approaches, with Australasia favouring a fixed charge, Europe a percentage charge, and North America complex co-payment systems.

Reduced Co-payments and Co-payment Exemptions

12. All the countries in this review offer some form of exemption or co-payment reduction for certain groups who might find it hard to pay for the cost of their medication. The exception is The Netherlands, where medication is practically free for everyone (see table 2) although the introduction of patient co-payment is being considered at present.

13. Thirteen of the 18 countries in this review have some form of exemption, or reduced co-payment, for certain medical conditions e.g. diabetes, or for certain uses of drugs e.g. in life-saving situations. However, apart from the UK, where patients exempt on medical grounds receive exemptions for *all* of their prescription charges, all these countries **give reductions and exemptions only for the prescribed medication to treat the condition in question**, with occasional specific exceptions e.g. Ireland which gives free prescriptions to patients infected with certain disease via blood transfusions.

14. Eleven countries have reduced payments or exemptions on the grounds of age, with older people or pensioners receiving additional help. Other common exemptions and co-payment reductions **are for income and disability groups.**

15. As can be seen in Table 2, most countries have a mixture of exemptions and reduced co-payments however three countries only offer exemptions and a further three solely reduced co-payments.

Table 2: Patient Co-Payments for Medication³⁻³⁹ (Reduced and/or Exempt by category*)

Country	Use of drug/ Medical Condition	Disabled	High Users	Income	Child	Older People	Other
Countries With Reduced Co-Payments, But No Exemptions							
Australia				✓		✓	✓
Denmark				✓	✓	✓	
Finland	✓						
Countries With Exemptions, But No Reduced Co-Payments							
UK	●	●		●	●	●	●
Ireland	●	●		●	●	●	●
Luxemburg	●						
Countries With Both Reduced Co-Payments and Exemptions							
Austria	●	●		●	●	●	✓
Belgium	✓ ●	✓				✓	✓
Canada	✓			✓		✓	●
France	✓ ●	●		●			●
Germany					●		✓
Italy (some regions)	✓ ●			✓			
New Zealand			✓	✓	✓ ●	✓	
Portugal	●					✓	
Spain	✓	✓				✓	✓
USA	✓	✓		✓ ● **	✓	✓	●
Sweden	●		✓		●		
Totals	13	8	2	10	8	11	10

* It should be noted that this table indicates where reductions and exemptions lie. However what these cover within each category vary from country to country. The Netherlands is not included in this table as in reality patients do not pay co-payments.

** Low income pregnant women, children, care home patients.

Key: ✓ = Reduced Payment ● = Exemption (greyed out items indicate that only a partial reduction or exemption is available e.g. New Zealand where children do not pay for prescriptions under 6 year of age)

Caps on Co-payments

16. Although only two countries have reduced co-payments for high users of services or prescription medication (see table 2), it should be noted that at least 10 of the countries in the review have some form of cap on co-payments. The most common is a cap on how much any patient pays for their prescription medication over a given time period. In some countries a cap is placed on costs only for certain groups or services.

Case Studies

17. As noted above, the variation in charging policy across countries renders it difficult to draw sound conclusions about whether or not patients pay more or less in Scotland/UK compared to other countries. Given this difficulty, case studies based on a hypothetical range of drug prices and usage rates were considered to look at the impact of differing charge regimes and the use of capping. These case studies showed that:

- At very low drug costs, patients in Scotland/UK pay more, but face lower costs relative to other countries for medium to high priced medication.
- Overall, patients in fixed co-payment regimes, such as the UK, pay more relative to patients in other types of co-payment regime (related to the cost of the medication) when the cost of the medication is low, but pay less when the cost of the medication is high.
- The case studies excluded the Netherlands, where, although in theory patients pay the difference in cost between the reference and actual price, in practice patients make almost no payment.

Conclusion

18. As can be seen above, co-payments for medication are complex and vary considerably from country to country as do health care systems, number of reimbursable drugs and co-payment systems. There are however some common themes:

- All the countries in this review offer some form of subsidised prescription medication for at least some of their population. The commonest type of co-payment is to ask patients to pay a percentage of their medication related cost.
- Reduced co-payments and exemptions are available in all the reviewed countries apart from the Netherlands, which has basically free prescription medication for everyone.
- Most countries have a mixture of reduced payments and exemptions.
- The most common exemption and reduced payment category is medical grounds/ the use of the drug for a particular purpose. The UK offers exemption from the cost of **all** prescriptions on medical grounds. The next most frequent reason for exemption and/or reduced payments is age (older people) followed by income and disability.
- Most countries also have a cap on how much patients pay for their medication, most frequently by capping how much patients pay in a given time period.

19. All of the above suggests that the UK has a relatively unusual co-payment system for prescription medication. Out of the 18 countries in this review, only the UK and four other countries have a co-payment system based on a fixed price. The UK does not offer reduced co-payments, only exemptions. Only two other countries have this type of system and they do not operate fixed price systems. The UK is also the only country which offers exemptions from **all** prescription medication costs for those patients given exemption on medical grounds. It can be concluded that the UK has one of the most generous subsidised medication systems of those reviewed.

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SUMMARY NOTE OF PRESCRIPTION CHARGE AND EXEMPTIONS POLICIES

1. Prescription charges were first introduced in 1952 for patients in the community and, except for a three-year period between 1965 and 1968, have been levied ever since. The flat rate prescription charge (currently £6.50) does not relate directly to the cost of the prescribed item or the cost to the NHS of supplying it, but is a contribution towards the cost of the service as a whole.

2. NHS prescription charge exemption arrangements are designed to protect those who are most likely to have difficulty paying charges. NHS National Services Scotland (NSS) estimates that around 50% of the population qualifies for free prescriptions under the current exemption rules. However, because this group includes the elderly and children, both high 'users' of medicines, over 90% (68 million) of items dispensed in Scotland are supplied to the patient free of charge. Qualification for exemption or remission of charges fall into three main categories.

3. **Medical grounds:** The chronic medical conditions that confer exemption from charges were agreed with the medical profession in 1968 and are listed in the NHS (Charges for Drugs & Appliances) (Scotland) Regulations and are:

- Forms of hypoadrenalism (including Addison's disease) for which specific substitution therapy is essential;
- Diabetes insipidus or other forms of hypopituitarism;
- Diabetes mellitus (except where treatment is by diet alone);
- hypoparathyroidism;
- myasthenia gravis;
- myxodoema, or other conditions which require supplemental thyroid hormone;
- epilepsy requiring continuous anti-convulsive therapy;
- a permanent fistula, requiring an appliance or continuous surgical dressing;
- continuing physical disability which prevents the patient from leaving his/her residence without the help of another person.

4. The criteria for placing conditions on the list were that they must be easily recognisable, lifelong and life threatening. All require regular, prescribed medication. Representations are made regularly on behalf of patients who suffer from a wide range of chronic medical conditions that do not confer exempt status. Because of the number and diversity of cases made, Scottish Ministers have until now consistently considered that extending exemption to any one additional medical condition could not be justified.

5. **Age:** People aged 60 and over, pregnant women and nursing mothers, children under 16 and young people under 19 in full-time education are exempt from paying charges.

6. **Financial status:** Those receiving Income Support, Income-Based Job Seeker's Allowance, Working Family and Child Tax Credits and people who qualify for full help under the NHS Low Income Scheme are exempt. In addition, those who hold a valid exemption certificate because they receive a War or MOD Disablement Pension receive free prescriptions in respect of medication arising from their disablement. Non-exempt people who hold a valid prescription pre-payment certificate also receive free prescriptions and prescriptions for contraceptives (except condoms) do not attract a charge.

7. To put the cost of exemption into context, **the cost of providing pharmaceutical services from community pharmacies and by dispensing doctors and appliance suppliers in Scotland in 2004-05 was £982 million (£859 million for drugs etc and £123 million for remuneration). For the same period, prescription charges, including the sale of pre-paid certificates, totalled £44.4 million, which is 4.5% of the cost of pharmaceutical services and around 1% of NHS Boards' total revenue budget.**

8. The prescription charge has risen from £5.90 in 1999-00 by 10 pence increments each year to the current £6.50. Charges collected in 1999-00 totalled £42.9 million and rose to £46.3 million in 2002-03 but, as evident from above, has fallen back since then. This is probably due to changes in the tax credit arrangements that have resulted in more people being exempt on the grounds of financial status under the Low Income Scheme.

9. Pre-payment certificates remain a cost effective way of paying prescription charges if a patient needs more than 5 items in a four month period (charge - £33.90), or more than 14 items in a 12 month period (charge - £93.20).

NOTE ON POSSIBLE COST IMPLICATIONS OF ABOLISHING PRESCRIPTION CHARGES

1. The Executive's policy intention is to retain prescription charges but to augment these by a range of appropriate exemption arrangements. This consultation is about identifying system changes that will make the arrangements fairer, more transparent and more affordable to those who find it difficult to pay the charges. It follows that abolition of prescription charges is not an option under this consultation. However, consultees may find it helpful to understand the possible consequences of abolition.

2. In the preparation of this consultation document, extensive use was made of the Scottish Parliament Information Centre (SPICe)⁶ briefing paper for the Scottish Parliament's Health Committee's consideration of the Abolition of NHS Prescription Charges (Scotland) Bill. What follows draws on evidence provided in this briefing paper.

3. The SPICe briefing paper suggests that introducing or raising prescription charges generally leads to a reduction in the take-up of prescriptions and vice versa. However, whether patients take medication as prescribed (sometimes referred to as "patient compliance") is a complex area of behaviour. Prescription charges are only one of many factors influencing patients' decisions.

4. If patients fail to take their essential medication for whatever reason, there may be detrimental effects on the health of these individuals. This might lead to additional demand for health services, including hospital admission, which is likely to cost more than the medication not taken. Overall, it is difficult to generalise the findings of the available research to Scotland and as such, it is not possible to assess the degree to which prescription charging would adversely affect health status due to reduced take-up of prescriptions, or, for that matter, the degree to which non-compliance with taking medication for *any* reason would have this effect.

5. The consequence of abolishing charges is not simply a cost increase equivalent to the current income from paid-for drugs. The evidence suggests that complete abolition of charges leads to a significant increase in scripts dispensed, with a consequential rise in drugs bill costs and increased consultations with GPs to obtain prescriptions.

6. There is therefore evidence that on the one hand, if prescription charges are introduced or increased, uptake is likely to fall (with possible adverse consequences); and on the other, if charges are abolished, there is likely to be a significant increase in prescribing and dispensing charges.

7. The one clearly identifiable cost of abolition is the revenue loss of £44.4⁷ million that health boards would incur through lost charges. With regard to the possible cost consequence of an increased demand for prescriptions, the SPICe briefing reported research⁸ that pointed to a possible increase in demand in the range of 22% to 64% of currently chargeable prescriptions⁹ – this equates to a range of £17.5 million to £51 million in 2003-04 cost terms in Scotland.

⁶ Abolition of NHS Prescription Charges (Scotland) Bill, Robson K (2005) SPICe briefing.

⁷ 2004-05 income from NHS prescription charges and sale of pre-payment certificates.

⁸ Lavers (1989), O'Brien (1989), Hughes & McGuire (1995), Smith & Watson (1990) and Hitiris (2000).

⁹ 6 million in both 2003-04 and 2004-05.

8. The SPICe briefing paper did not identify any research that quantified the impact of increased demand on GP services from the abolition of prescription charges. However, to quantify a possible scenario, if there were to be a 20% increase in the current demand for prescriptions then, based on the assumptions that each person obtained an average of 2 prescriptions when they saw their GP, and an average cost to the NHS of £25.00¹⁰ per consultation, the additional cost of consultations would be in the region of £15 million per annum.

9. The SPICe briefing paper suggested that administrative savings would accrue as a consequence of abolition of prescription charges. This would be in the region of £1.5 million – mostly in respect of charge exemption or abatement certificate work undertaken by the Prescription Pricing Authority on behalf of the Department.

10. In summary, even with a conservative estimate, the net cost of charge abolition could be at least £75 million (£44.4m lost revenue + £17.5m for a 22% increase against currently chargeable prescriptions + £15m for increased GP consultations, less £1.5m administrative savings), which equates to 7.5% of the cost of providing pharmaceutical services in Scotland and just under 1% of its total health budget. This excludes any reduced cost to the NHS through the prevention of ill-health; the SPICe briefing paper identified a lack of research in this area and concluded that it was impossible to generalise from available research and impossible to quantify the potential benefit from this effect.

¹⁰ Estimated on 26.5 million consultations per annum and a funding envelope of £656 million for GMS.

LIST OF ORGANISATIONS TO WHO THIS CONSULTATION HAS BEEN SENT

CoSLA
Clerk of the Health Committee
All Scottish MEPs
All Scottish MPs
Equal Opportunities Commission
Commission for Racial Equality
Disability Rights Commission
SE Library
SPICe Library
6 Legal Deposit/Copyright libraries

Members of the Scottish Parliament

Chief Executives NHS Boards
Chief Executives Special Health Boards
Chairs NHS Boards
Directors of Finance NHS Boards
Directors of Finance Special Health Boards
Medical Directors NHS
Chief Pharmacists NHS Boards
Directors of Public Health
Directors of Clinical Information NHS Boards/Special Health Boards
Designated Directors of Public Involvement
NHS Scotland Counter Fraud Services

Community Health Partnerships

Chief Executives, Local Authorities
Directors of Social Work, Local Authorities
Chief Social Work Officers, Local Authorities
Scottish Partnership Forum
Lead Officers, Local Authority Community Learning

Scottish Universities
Scottish Colleges
Other Higher Education Institutes
Scottish Student Unions

Libraries
Citizens Advice Bureaux

Department of Health, England
Health and Social Care Department, Wales
Department of Health, Social Services and Public Safety, Northern Ireland

Care Commission

Medical Bodies

Association of Dental Hygienists
Association of Dental Nurses

Association of Dental Technicians
Association of Dental Therapists
BMA Scotland
General Dental Council
General Medical Council
Health Service Commissioner for Scotland
National Appeals Panel
NHS 24
NHS Education for Scotland
NHS Tribunal
Royal College of Nursing
Royal College of Physicians and Surgeons Glasgow
Scottish Dental Practice Board
Scottish General Practitioners Committee
Scottish Medicines Consortium
Scottish Pharmaceutical General Council

Patient Groups and Voluntary Sector Organisations

Age Concern Scotland
Alzheimer Scotland
Association of Community Councils
Association of Independent Multiple Chemists in Scotland
Association of Scottish Chief Pharmacists
Association of Scottish Colleges
Asthma UK
Boots the Chemist
C Plus Mainliners
Citizens Advice Scotland
Community Practitioners and Health Visitors Association
Community Voices Network
Consumer Association
Davidson Chemist
Diabetes UK Scotland
Donald Munro Ltd
Epilepsy Scotland
Ethnic Minority Resource Centre
Fair for All – Disability
Help the Aged
Inclusion in LGBT Health
Lindsay and Gilmour
Lloyds Pharmacy
McConnell Pharmacy
Moss Pharmacy
Patients Association
Rowlands Pharmacy
Scottish Association of Mental Health
Scottish Centre for Social Research
Scottish Consumer Council
Scottish Council for Voluntary Organisations
Scottish Funding Council for Higher and Further Education
Scottish Health Council
Scottish Independent Advocacy Alliance
Scottish Public Pensions Agency
Scottish Public Services Ombudsman

Scottish Trade Union Congress
Scottish Youth Parliament
SIGN
UNISON
Voluntary Health Scotland
Volunteer Development Scotland

Plus a number of named individuals including those who gave evidence to the Health Committee and members of the public who wrote to Ministers regarding prescription charges.

THE SCOTTISH EXECUTIVE CONSULTATION PROCESS

Consultation is an essential and important aspect of Scottish Executive working methods. Given the wide-ranging areas of work of the Scottish Executive, there are many varied types of consultation. However, in general Scottish Executive consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work. Consultation exercises may involve seeking views in a number of different ways, such as written papers, public meetings, focus groups, questionnaire exercises or on-line discussion forums.

While details of particular circumstances described in a response to a consultation exercise may eventually inform the policy process, consultation exercises can not address individual concerns and comments, which should be directed to the relevant Scottish Executive department or public body.

Typically, Scottish Executive consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the area of consultation, and they are also posted under the current consultations section of this website, enabling a wider audience to access the paper and submit their responses. The Scottish Executive now has an email alert system for consultations (**SEConsult**). The system allows individuals and organisations to register and receive a weekly email containing details of new and forthcoming consultations (including web links).

Copies of all the responses received to consultation exercises (except those where the individual or organisation requested confidentiality) are placed in the Scottish Executive library at Saughton House, Edinburgh and the Scottish Executive's website.

The views and suggestions detailed in consultation responses are analysed and used as part of the decision-making process. Depending on the nature of the consultation exercise, the responses received may:

- indicate the need for further policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

Within the Consultation section of the Scottish Executive website there is a full list of all closed consultations and a listing of forthcoming consultations. The "closed" section will, in the future, provide details about the outcome of consultations and have links to any reports produced from the consultation exercise.

If you have any queries about the consultation process within the Scottish Executive please contact the Civic Participation and Consultation Research branch:

Scottish Executive
4th Floor West Rear
St Andrews House
Regent Road, Edinburgh
EH1 3DG

consultationqueries@scotland.gsi.gov.uk

RESPONDEE INFORMATION FORM

Please complete the details below and attach it with your response. This will help ensure we handle your response appropriately:

Name:

Postal Address:

Consultation title:

1. Are you responding as: (please tick one box)

- (a) an individual (go to 2a/b)
(b) **on behalf of** a group or organisation (go to 2c)

2a. INDIVIDUALS:

Do you agree to your response being made available to the public (in SE library and/or on SE website)?

- Yes (go to 2b below)
No, not at all

2b. **Where *confidentiality is not requested***, we will make your response available to the public on the following basis (**please tick one** of the following boxes)

- Yes, make my response, name and address all available
Yes, make my response available, but not my name or address
Yes, make my response and name available, but not my address

2c ON BEHALF OF GROUPS OR ORGANISATIONS:

Your name and address as respondees **will be** made available to the public (in the SE library and/or on SE website). Are you content for your response to be made available also?

- Yes
No

3. We will share your response internally with other SE policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for the Scottish Executive to contact you again in the future for consultation or research purposes?

- Yes
No

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