Prescription Charges Review

Implementing Exemption from Prescription Charges for People with Long Term Conditions

A report for the Secretary of State for Health by Professor Ian Gilmore

November 2009

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Letter to the Secretary of State

Dear Secretary of State

I was asked by Department of Health Ministers in October 2008 to lead a review to consider how the Prime Minister's pledge to exempt people with long term conditions from prescription charges could be implemented. The terms of reference for this review are set out in Annex A and I am grateful to the Government for asking me to take on this important work.

The review has been challenging but rewarding. The issues raised have been complex and contentious, often driving at the heart of the core principles of the NHS. Prescription charges, directly or indirectly, affect everyone who comes into contact with the NHS. This made the task of engagement easier – most people have a view on this subject and they are happy to share it.

In conducting the review I have, as required by the terms of reference, gathered evidence and views from a wide range of stakeholders (Annex B sets out the methods for engagement). This comprehensive process has enabled me to arrive at the recommendations that I summarise below, and which are described in more depth in section 3 of this report.

Summary of recommendations

1. There should be a broad definition of a long term health condition

The key question for the review has been how to define long term conditions. Estimates, based on self reporting, indicate that there are over 15 million people in the country living with at least one long term condition. There are two main approaches in deciding how to meet the Prime Minister's pledge. The current list of conditions that are exempt from prescription charges could be extended to include a much wider range of conditions that are long term in nature. The alternative would be to develop a broad definition of long term condition that patients would have to satisfy in order to qualify for free prescriptions. I consider the former approach to be impractical and inflexible. Therefore, I recommend that in future the exemption should be based on a broad definition of a long term health condition that is based on duration (at least 6 months) and the need for some form of continuing management (which might include regular medication; periodic monitoring and review; psychological therapies).

2. Patients' eligibility should be determined, against this definition, by their doctor

The main issue with a broad definition of long term condition is that it introduces the need for judgement. Someone has to judge whether the patient's condition meets the definition. In my view, this is a matter for clinical judgement and in most cases, though not always, it is likely that the patient's General Practitioner (GP) will be best placed to fulfil this role. This is because of the nature of the primary care relationship with patients, and also because of their prescribing role. However, GPs could be supported in this role by a member of the practice staff who has some clinical responsibility for patients with long term conditions, for example, nurse practitioners.

3. The Government will need to develop detailed plans for implementation, working in particular with primary care and patient group stakeholders

Whilst it is clear that GPs will usually be best placed to judge whether patients meet the requirements for exemption from prescription charges, this carries the potential for additional workload. Because I am recommending moving away from a disease-based list to a broader definition, there will be some patients who potentially qualify for exemption with less clear-cut diagnoses than is the case for the present medical exemptions. However, one criterion in the proposed definition is the need for continuing management, so I anticipate that many patients are unlikely to need to make appointments specifically for exemption certification purposes. GPs also raised concerns about the potential for their relationship with a patient to be prejudiced if they deem them to be ineligible for exemption. However, they welcome the fact that more patients would no longer have to pay prescription charges, and could see the advantages of a broad-based and principled definition of a long term condition for those patients who had chronic ill-health but could not be categorised precisely in medical terms. Government will need to engage closely with stakeholders in developing systems that allow for smooth implementation of the new policy. This will need to be backed up by clear and effective guidance for professionals and for the public.

4. People who receive incapacity benefit without income support, or contribution based employment and support allowance, or disability living allowance should gain an automatic exemption from prescription charges

There were strong arguments presented to the review about extending free prescriptions to people entitled to incapacity benefit without income support, or contribution based employment and support allowance, or disability living allowance. Recipients of incapacity benefit with income support or income related employment and support allowance already receive an automatic entitlement to free prescriptions. The main argument in favour of extending exemption in this way is that recipients of these benefits are highly likely to have a long term condition. It also includes those who, in many cases, are on lower incomes and has the added benefit of reducing the number of cases that require a clinical decision on eligibility. This recommendation will need to take into account any future changes that are made to disability benefits following the current consultation on the future of social care.

5. As now, exemption should be for the person rather than restricted to the treatment of the condition for which he/she is exempt

Currently, patients who are exempt from prescriptions on medical grounds, receive all of their prescriptions free and not just the drugs that relate to the condition for which they are exempt. This is often regarded as unfair. However, it is frequently difficult to determine whether the patient's current need for treatment is related or not to the index condition, or might exacerbate it. In the interests of practicality, exemption from charges on medical grounds should continue to relate to the person rather than the condition.

6. Disagreement on whether a patient's condition is a long term condition should be resolved using existing processes

There are currently no appeals mechanisms open to patients in general practice and nor is there a right to appeal against a decision not to grant exemption under the current system. If a patient is unhappy with the advice or treatment they have been given, there is the option of asking for a second opinion although patients do not have a legal right to this. Patients can ask their GP to refer them to another GP and they may also consider seeing another GP at the surgery if they are registered with a multi-GP practice. As a last resort they can deregister with their GP and join another practice. Patients who have a hospital doctor involved in their care can also consult that doctor. Patients also have recourse to the NHS complaints mechanism, which has been reformed recently to improve its speed and accessibility.[1] For these reasons, and also because of the potential to increase bureaucracy and create an adversarial environment between patient and doctor, I do not think that a separate appeals process should be created. Instead, the system should rely on supporting good clinical judgement with effective guidance. Clinicians will need to provide a clear explanation to patients about the decisions they make regarding exemption. I should add, however, that many of the patient representative stakeholders consulted argued strongly for an appeals mechanism. I recommend that the Government should seek views from patients in evaluating the implementation of the new exemption so that there can be an ongoing review of whether an appeals mechanism is required.

7. Exemption should last for three years

Current medical exemptions last for five years and the simplest option would be to allow the same period for all long term conditions. However, the current exemptions (with the exception of the recent addition of cancer) are based on conditions that are almost certainly life long, whereas with the new exemptions, there will be cases where the criteria are no longer satisfied after five years because the condition has resolved (either temporarily or permanently). This would point to having a shorter period of exemption. This has to be balanced against the fact that the new system will require some form of medical certification – the current system of renewals is largely based on self certification. An option would be to grant an initial exemption for two years, with a five year duration on renewal. However, this creates complexity so on balance I recommend that the period of exemption (whether initial or a renewal) should be reduced to 3 years for all. I also recommend that it should be possible for the renewal to be confirmed at any point during the final year of the current exemption period. This would allow a renewal to be made during an existing consultation or review (rather than requiring a separate consultation) if it was clear that the patient would continue to meet the conditions set in the definition.

1 Listening, responding, improving: a guide to better customer care. Department of Health. February 2009

8. Phasing should be achieved by stepwise reductions in the price of the prescription pre-payment certificate

The primary purpose of any phasing is to mitigate the financial impact on the NHS budget of the annual loss of a significant proportion of prescription charge revenue, which is currently totals almost £500 million. Phasing by factors such as age group, duration or type of condition would be arbitrary and unfair. I recommend that the prescription pre-payment certificate (PPC) should be used as the device for phasing as this is already targeted to those with long term conditions who need regular medication. This could be achieved by a stepwise reduction in the price of the annual PPC. The current uptake on PPCs is low, largely because of low awareness, high up front costs for those who cannot use the direct debit facility and a system for purchasing that is not patient centred. Although a decrease in price should stimulate increased uptake of PPCs, the Government should actively consider how to improve awareness and uptake. This could include the wider availability of PPCs at pharmacies and the ability to qualify for a PPC after paying the equivalent cost of an annual PPC through accumulated individual prescription charges, for example, through a loyalty card mechanism or by registration with a pharmacist.

This mechanism of phasing through the PPC is simple, targeted to those with the greatest need for prescriptions, and allows ample time to implement the new arrangements.

9. Patients who are exempt under the current medical exemption categories should retain their exemption throughout the phasing period. Patients who are newly diagnosed with these conditions during phasing should also continue to be exempted from prescription charges.

There are currently 1.5m people with a medical exemption certificate including those exempt under the new cancer category. Given that these patients are already exempt (and there is no dispute about whether the current list of medical exemptions, although out of date, is justified) I recommend that they should retain their exemption status throughout the phasing period. The argument is less clear cut for patients who are diagnosed with these conditions once the phasing period starts but I recommend that they should also continue to qualify for free prescriptions as it would be anomalous to determine exemption status on the basis of whether the diagnosis of the patient's condition falls either side of a particular date. In other words, the current exemption system should continue to operate alongside the PPC phasing arrangements.

10. The Government should consider bringing in the changes as soon as possible

Whilst I recognise the constraints on public spending that we are now faced with and the need for phasing, I would urge Government to give priority to the introduction of these changes so that they can start to benefit patients as intended. Phasing down the cost of the PPC should be implemented as soon as possible – it is not contingent on the work with stakeholders to develop detailed implementation plans.

In conducting the review, I have been very impressed by, and am grateful for, the level of engagement shown by all of those who contributed their views to the review. Because of this, I am confident that the recommendations reflect the range of views that I have heard.

In conclusion, I would also urge the Government to continue to review the policy around prescription charges. I hope that my recommendations demonstrate that a system can be built that allows patients with long term conditions to be exempted from prescription charges. However, the danger is that this system could be burdensome, with hidden costs, for example in terms of GP time, which mean that the overall costs of administration are disproportionate to the level of income raised. There is also the danger – somewhat paradoxically – that exempting long term conditions would create more perverse incentive towards treatment seeking than would total abolition of charges. Patients will be reluctant to give up exemption once they have had it, and there could be an incentive towards seeking treatment in order to warrant continued exemption. For this reason, I think the policy needs to be reviewed, with an open mind towards either abolishing prescription charges altogether, or wider reform that considers the question of the prescription charging arrangements more fundamentally.

Yours sincerely

Professor Ian Gilmore

1. Background to this review and the case for reform

In a system that has largely upheld the principle of healthcare being free at the point of access, prescription charges have always been controversial. They were first introduced into the NHS in June 1952 for each prescription form, and then in December 1956 for each prescription item. In March 1965, charges were abolished, only to be reinstated in June 1968, which was also when the extensive exemption arrangements that remain largely in place today were introduced. Annex C provides a list of the current exemptions.

Prescription pre-payment certificates were also introduced in 1968, in order to help those patients with long term conditions that were not included on the medical exemptions list. In 1975, there was a further extension to the exemption arrangements with the introduction of charge-free contraceptive drugs and appliances. The only further change to the medical exemption categories occurred earlier this year, when the new exemption for patients receiving treatment for cancer, or for the effects of cancer treatment, was introduced.

Unsurprisingly, for a system that has not seen reform for 40 years, the current charging arrangements are widely regarded as flawed, and were criticised by the Health Select Committee in their 2006 report on NHS Charges.[2] The criticisms tend to focus on three issues in particular, each of which is fundamental to the ethos of the NHS. These are:

- **Cost to the individual.** Scotland and Northern Ireland are phasing out prescription charges, and Wales has abolished them altogether. Therefore, the current charge in England (£7.20) is seen as comparatively expensive.
- **Equity.** The list of medical conditions that currently defines exemption is criticised for being out of date, inconsistent and arbitrary. This list-based approach for defining exemptions would require periodic review and updating but the list has not been revised since its introduction in 1968 (with the exception of the recent addition of cancer) even though patterns of illness and treatment have changed substantially over the past 40 years.
- **Fairness.** For example, the blanket exemptions for people aged 60 and over means that many people on relatively high incomes receive an exemption whereas younger people on low incomes are not exempt.

2 http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/815/81502.htm

In response to the Health Select Committee's recommendations, the Government made a commitment to reviewing the system and then to carrying out a consultation on the options for change on a cost neutral basis. Subsequently, the Prime Minister announced last year that from 2009, the Government would abolish prescription charges altogether for cancer patients (a pledge that has now been introduced) and that over the next few years, it would also abolish charges for patients with long term conditions.

Prescription charges – statistics

- Many people in England are already exempt from prescription charges – around 60% – through exemptions relating to age, medical condition or income (see Annex C).
- Nearly 90%[3] of the 843 million prescription items dispensed each year are free. However, prescription charges raise almost £500M per year for NHS services.
- Prescription pre-payment certificates (PPCs) are available to patients. A 3 month PPC costs £28.25 and a 12 month PPC costs £104 and can be purchased by 10 monthly direct debit instalment payments. The 12 month PPC saves money to patients who have more than 14 items prescribed over the year.
- The number of items dispensed in the community continues to rise from 796 million items in 2007 to 843 million in 2008. The drug cost to the NHS (not including dispensing costs) of all prescriptions dispensed in the community was £8.3 billion in 2008.

3 Prescriptions Dispensed in the Community Statistics for 1998 to 2008: England. Health and Social Care Information Centre (2009). Note this figure is based on the 93.2% of prescriptions for which there is no charge at the point of dispensing. This does, however, include patients with pre-payment certificates ie. non-exempt patients.

2. Findings

The question of what should be done to reform the current prescription charging system gives rise to heated debate. Yet there is a good deal of consensus on the key issues, which I have listed below.

- There is universal support for reform of the current system of prescription charges and for extending the exemption criteria.
- Any reform of the system should be based on principles of equity and fairness; clarity; consistency; simplicity.
- Many thought the wrong question was being asked and that it is not possible to easily define long term condition. They favoured a more fundamental review of the system, examining a wider range of options. For example, they thought there could be a greater focus on low income groups.
- This view is based on evidence that patients with lower incomes who do not qualify for exemption are deterred from accessing medicines. This could be because they do not visit a GP in the first place or because they do not get their prescription dispensed or, where they have multiple items, they get only some of the items dispensed. Although much of the evidence I heard on this issue was anecdotal (from patients, GPs, pharmacists) there is also research evidence.[4,5] And, evidence from the United States suggests that even small costs can have big effects on treatment uptake.[6,7] In the UK, the impact is most apparent on those with an income of less than £20,000. The Commonwealth Fund recently carried out a survey in eight countries looking at the extent to which people with chronic illness are deterred from using healthcare because of cost.[8] In this study of more than 7,000 people (1,200 in the UK) those in the Netherlands were least deterred, followed by those in the UK. However, 13% of the UK sample still reported that cost was a barrier to healthcare with 7% reporting that they did not have their prescriptions dispensed or skipped doses, and 4% saying they avoided visiting the doctor because cost was a barrier to getting medication.

4 Schafheutle E, Hassell K, Noyce P, Weiss M. Access to medicines: cost as an influence on the views and behaviour of patients. Health & Social Care in the Community 2002; 10(3):195–87.

5 Schafheutle E, Hassell K, Seston E, Noyce P. Non-dispensing of NHS prescriptions in community pharmacies. The International Journal of Pharmacy Practice 2002; 10:15–1.

6 Soumerai S, McLaughlin T, Ross-Degnan D, Casteris C, Bollini P. Effects of a limit on Medicaid drug reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia. The New England Journal of Medicine 1994; 331(10):655–0.

7 Tamblyn R, Laprise R, Hanley J *et al.* Adverse events associated with prescription drug cost-sharing among poor and elderly persons. JAMA: the Journal of the American Medical Association 2001; 285(4):429–1.

8 Schoen C, Osborn R, How S, Doty M, Peugh J. In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008. Health Affairs 2008; w16–w1.

- Many thought that removing the financial barrier to accessing prescription medication would improve concordance, and hence would improve health. In part, this is because extending exemption could be used to underpin policies on prevention (such as vascular checks). Some argued that this would also save the NHS money downstream.
- On this basis, many of those I consulted argued that prescription charges should be abolished altogether.

How can long term conditions be defined?

The fundamental question is how to define long term conditions for the purpose of determining who should be exempt from prescription charges. Effectively, this question boils down to two approaches. Should there be a broad definition, which captures the key principles of what would constitute a long term condition? Or should there be a revised, and considerably lengthened, list of conditions that qualify for exemption?

In general, the public and most professional and voluntary sector stakeholders favour a broad definition. Around 70% of the 1,700 respondents to the web survey (mostly members of the public) favoured a broad definition.

> "Whenever you create a list you create a problem" *(Royal Pharmaceutical Society of Great Britain)*

On the other hand, members of the public involved in the deliberative research supported a list based approach – although their starting point had also been a broad definition. GPs consulted through the deliberative research also supported a list as did the prescriptions coalition of charities.

> "What I would like is a clear list, black and white…" *(GP involved in deliberative research)*

As the above quote indicates, the main argument in favour of a list is that it is clear cut as to what is and what is not within the scope of exemption, and hence it fulfils the principles of clarity and simplicity. That said, because of the limitations of this approach, it is recognised by its advocates as being a "least worst" option.

As we have seen with the current list of medical exemptions, there are problems with a list-based approach. For example, it would be very difficult to capture all the conditions that we would want to include. There are between 5–8,000 rare diseases, affecting between 6–8% of the population world wide and according to the European Medicines Agency five new diseases are described every week in the medical literature.[9] This patient population could be easily overlooked.

9 European Medicines Agency: Orphan drugs and rare diseases at a glance. July 2007

"Rare long term conditions affecting only 10s or 100s of people in the UK should receive equal weighting to common conditions" *(Web survey respondent)*

A list is likely to be very lengthy and unwieldy, and the system is likely to be subject to regular appeal. This means it would require frequent review and updating. The approach is also relatively inflexible, for example, it would preclude the inclusion of patients with symptom-based conditions that lack a definitive diagnosis and would deter application of clinical judgement and commonsense.

The main argument in favour of a broad definition is that it allows for flexibility and is potentially an easier system to operate because it would not require frequent review. On the other hand there is the potential to frame a definition that is too inclusive or too exclusive. The other major concern is that a broad definition would introduce the need for clinical judgement which could introduce inconsistency in decision making.

Duration was widely considered to be the most reasonable factor on which to base a definition, because it clearly implies a condition could be long term in nature (as indicated by the definitions of long term condition listed below).

"We see duration as the key principle – the most important for our group. We know that many people with mental health problems will experience their condition beyond the six month line – which is the line that we are supporting" *(MIND)*

Other factors such as severity, periodicity of symptoms, and the potential for health gain were not supported because they are too subjective and potentially unfair. The general view was that for a condition to be long term it should be likely to persist for a period of at least 6 months.

Some definitions of long term condition

Existing definitions of "long term condition" seem to hinge around the fact that they are chronic in nature and that they are not generally curable, though their symptoms may be mitigated to some extent through management and/or treatment.

- A condition that cannot at present be cured, but can be controlled through medication and other therapies and may limit people's ability to cope with day to day activities *(Department of Health; Long Term Conditions Programme)*.
- A chronic disease is one lasting 3 months or more. *(US National Center for Health Statistics)*
- Chronic diseases are generally characterised by uncertain aetiology, multiple risk factors, a long latency period, a prolonged course of illness, non-contagious origin, functional impairment or disability, and in most cases, incurability. *(US Center for Disease Control and Prevention)*
- Health problems that require ongoing management over a period of years or decades. *(World Health Organisation)*

Are there any proxies that can be used to define long term conditions?

The review considered whether proxies could be used to define long term conditions. The most obvious proxy might be volume of prescriptions that the patient requires within the year. For example, if the patient reaches a defined threshold of prescriptions in a set period, that could be taken as a reliable proxy for the presence of a long term condition. A number of problems were identified to this approach including:

- It is illogical to define an illness (or group of unrelated illnesses) as a long term condition purely on the basis of medicine usage.
- There is a risk that it would create incentives for the over-medicalisation of a condition.
- It would not assist those who do have a long term condition but who do not require much medication. Sometimes, the patient might need less medication because they manage the condition effectively themselves (eg. diabetes managed through diet alone) and this type of approach could be seen as penalising these patients for effective self care.
- Patients who are given longer prescription durations may end up being excluded because they would have fewer prescriptions over the year.
- There would be logistical issues to implementation in accurately tracking when a patient reaches the threshold of prescriptions dispensed and in refunding them for what they have already spent on prescriptions.

The Citizen's Advice Bureau put forward a view that people entitled to incapacity benefit without income support, or contribution based employment and support allowance, or those on disability living allowance, should be included within the scope of the definition of long term conditions on the basis that these benefits are a reasonable proxy for the presence of a long term condition.[10]

"A rough analysis of our recent evidence on CAB clients who have had problems affording their prescription charges, shows no common pattern in terms of their medical condition. Depression appears to be the most frequently mentioned condition, whilst asthma, arthritis and high blood pressure also feature regularly. But the range of conditions is wide and includes severe mental health problems, alcoholism, treatment for drug addition, anaemia, heart conditions, psoriasis, Parkinson's and memory loss, with many clients receiving multiple prescriptions for multiple conditions. What is a strikingly common feature is that in virtually every case they are in receipt of incapacity benefit, employment and support allowance or disability living allowance. For all three benefits the medical condition or disability is likely to be long term. IB/ESA people will usually have exhausted six months statutory sick pay before becoming entitled, and a condition of being awarded DLA is that the person has met the disability conditions continuously throughout the three months preceding their claim and is likely to continue to meet these conditions for at least a further six months" *(Citizen's Advice Bureau)*

10 It should be noted that there could be changes to the structure of disability benefits in the future. The Social Care Green paper (Shaping the Future of Care Together. Department of Health. July 2009) is consulting on integrating some elements of disability benefits to create a new offer for individuals with care needs.

On a linked point, there have also been suggestions that low income groups such as housing benefit recipients and students should receive free prescriptions. I have not considered these issues further as they are clearly separate from the issue of exempting people on the grounds of long term conditions.

Can the care planning process be used to define patients with long term conditions?

High quality care for all, the final report of the NHS Next Stage review, re-affirms the commitment that over the next two years, every one of the 15 million people in England with one or more long term condition should be offered a personalised care plan. The review has considered whether there is any scope to link exemption from prescription charges to the process of care planning, given the aspiration to extend care planning to everyone with a long term condition. Many of those I spoke to expressed concern about this proposal on the basis that it would introduce perverse incentives, and would potentially undermine the objective of having high quality care planning, which could instead become a tick box exercise designed mainly to confer exemption from prescription charges. Also, there may be patients who do not wish to have a care plan and it was felt that they should not as a result of this personal decision be disadvantaged. However, there was support for the process of care planning to include a discussion about prescription charges as it can assist practitioners in making the judgement about whether someone should qualify – or continue to qualify – for exemption.

What should be the duration of the exemption period?

> "There should be a review period to ensure that taxpayers' money is not being wasted" *(Web survey respondent)*

Currently, a medical exemption certificate lasts for 5 years and the simplest option would be to allow the same period for all long term conditions. However, the current exemptions (with the exception of the recent addition of cancer) are based on life long conditions, whereas with the new exemptions, there will be cases where the criteria are no longer satisfied after 5 years because the condition has resolved. This points towards a shorter exemption period at least in the first instance so that patients can be reviewed against the qualifying criteria. For example, initial exemption could be for two years, after which it could be extended to a five year period. This would help to ensure that those patients with conditions that resolve relatively quickly would not get a lengthy period of exemption from charges, although it would also create complexity as there would be two different types of exemption certificate. The alternative would be to have a shorter exemption period (say 3 years) for all.

The new system will also require some form of ongoing certification – the current system of renewals is largely based on self certification, which is acceptable where the diagnosed conditions are known to be lifelong but would not work with a broader range of long term conditions being included. Ongoing certification requirements increase the workload for those approving the certification (unless this is done as part of a routine review e.g., care planning reviews). In this regard, another point worth considering is whether exemption certificates can be renewed for a further term at any point within the last year of their existing term. This would allow a GP to certify a renewal during the course of a routine review preventing the need for an appointment to be made specifically for a renewal.

Should exemption be based on the person or the condition?

An issue that has generated much debate has been whether exemption should be for the patient or the condition. At present, it is patients who are exempt. This means that if a patient is exempt on the grounds of hypothyroidism, he/she will receive exemption for all drugs, and not just for the hormone replacement for their index condition. The deliberative research with the public identified this as a major reason for why people consider the current system to be unfair.

The alternative would be to exempt the condition so that only prescriptions relating to the index condition are exempt. While there are attractions to this approach, which many saw as being fairer, there are some significant problems. In many cases it will simply not be possible to determine whether a particular condition and its treatment is in some way linked to the index condition. For example, diabetes has a wide ranging impact on health and it would be difficult for practitioners to make a judgement in each case whether the treatment was linked or not linked to the diabetes. For some other conditions it would be more straightforward to make these judgements but it is clearly not practical to have different sets of arrangements for different conditions. It would also place a further burden on prescribers if we were to ask them to make judgements about whether a prescription was linked or not to the condition for which the patient is exempt, certainly more burdensome than the single decision as to whether that patient's overall condition falls within a principled definition of a long-tem condition.

> "This (exempting the patient for all their prescriptions) represents the triumph of the practical over the logical" *(Written submission from an individual)*

A variant of this approach advocated by some is to exempt drugs rather than patients or conditions. This is an interesting idea and its main benefit would be that it could be linked to incentives for more effective prescribing if the exempted drugs were those that are the most clinically and cost effective. However, there are significant problems with this approach in practice. A list of drugs would require regular oversight and review. Newer, innovative drugs would not immediately be exempt and could therefore, become more readily accessible only to those who could afford to pay. There would still need to be exemption arrangements (for example, age based exemptions) in place to cover patients who needed drugs that did not meet the criteria for inclusion. And the system would be difficult for patients and practitioners to understand and navigate.

Who should assess whether a patient qualifies for exemption?

The present medical exemption system does not require a direct input from the patient's GP after the initial application for an exemption certificate, which is usually signed by a GP or a member of the practice staff with access to the patient's clinical record. The application is then submitted to NHS Business Services Authority, which issues an exemption certificate to the patient. Patients obtain renewals after 5 years.

Any system that relies on a broad-based definition for long term conditions requires a clinical judgement to be made against whether the patient meets criteria for having a long term condition. Many consider GPs to be well placed to make the judgement about whether a patient qualifies or not for exemption because of their central role in managing long term conditions.

> "It should be recommended by the GP responsible for the person's care"
> *(Web survey respondent)*

However, in some circumstances, patients with long term conditions will be in more regular contact with a secondary care doctor, and in these cases it may be more appropriate for that clinician to sign off the exemption.

The GP community raised significant concerns about their potential role in the exemptions system. They have two fundamental concerns. First, that they will face a significantly increased workload with many more patients eligible for exemption. Second, they are concerned about the potential impact on their relationship with patients.

I have spent time with GP leaders in the second part of my review to discuss in more detail how a new exemption system might work in practice. Overall, GPs were supportive of a policy that extends free prescriptions as they consider that this will be much fairer for patients. However, concerns remain about how this is achieved in practice, and it is clear that the Department of Health will have to continue to engage closely with them and other stakeholders in the detailed design of the implementation proposals. There are clearly many opportunities to mitigate the impact on general practice, for example, through the use of their computerised information systems.

Should there be an appeals process?

Under the current system of medical exemption, there appears to be little dispute about whether a patient is eligible or not for free prescriptions. This is probably because the conditions listed are clearly diagnosed and (with the exception of the recent addition of cancer) lifelong. Any system that relies on a judgement about whether a patient meets criteria for eligibility, sometimes with limited objective data, opens itself up to challenge and the potential need for an appeals or arbitration process. Most patient group stakeholders felt that an appeals mechanism should be available, and that for some patients there should also be the offer of advocacy in navigating the appeals process. On the other hand, other stakeholders felt that an appeals mechanism would not be desirable because of the added bureaucracy and also because of the adversarial nature of appeals, which could create ongoing damage to the doctor-patient relationship.

How can changes be phased in?

The terms of reference included examining the way in which any changes could be phased. Phasing limits the impact on public finances that would result from lost prescription charge income. That said, most stakeholders would like to see the new policy implemented quickly, ideally with no phasing period.

> "It should happen as quickly as possible with plenty of information made available to patients, patient groups, GPs and pharmacists" *(Web survey respondent)*

In considering this question as part of the review, I have been clear about two points. First, my remit is to recommend possible mechanisms for phasing – the precise details and timescale for phasing are decisions for the Government because they relate directly to questions of affordability. Second, I think it is critical that any mechanism for phasing must be fair and simple.

Phasing in by factors such as age group, duration of condition, type of condition etc. would clearly be arbitrary and unfair. The consensus view was that the fairest option would be to phase in by using the prescription pre-payment certificate (PPC) as this is likely to be used by those with long term conditions. The simplest way of using the PPC as the device for phasing would be to progressively reduce its cost. This benefits those with the most need for medication (and hence the greatest financial burden). The alternative would be to phase in by reducing the prescription charge for patients with long term conditions. This would be more complex as it would require some way of identifying those with long term conditions, in other words, the machinery of the new exemption system would need to be available from the outset. This method could also be more confusing for patients as there would be different levels of prescription charge, and it would possibly require increased processing costs at pharmacies and the NHS Business Services Authority.

What should happen to current medical exemptions during the phasing period?

There are currently 1.5m people with a medical exemption certification. When the new arrangements are introduced, some of these certificates will span the entire phasing period but many will not, which means that at some point during phasing they could lose the benefit of free prescriptions if subject to the new arrangements.

There is also a question about what happens during the phasing period for patients newly diagnosed with conditions that are on the current medical exemption list. They could be given exemption from all charges on the grounds that their condition has historically been considered to warrant free prescriptions. On the other hand, the view could be taken that these conditions should not continue to be given preferential status against other long term conditions, so newly diagnosed patients would be subject to whatever phasing arrangements are in place.

Stakeholders were clearly in favour of protecting the benefits for patients who are medically exempt under the current rules, including those newly diagnosed, so that they continue to receive free prescriptions throughout the phasing in period.

How can PPC uptake be improved?

> "More emphasis needs to be placed on the availability of pre-payment certificates – very few people need to be in a position where they can't afford an essential medication, but some are poorly informed about their options" *(Web survey respondent)*

The prescription pre-payment certificate (both 3 month and 12 month) is seen as useful in helping patients to reduce their annual expenditure on prescriptions. The main criticism of the PPC is that take up is low. This is because there are no clear responsibilities to promote it so those that may benefit may not be aware. The annual PPC (at £104) represents a costly outlay, and it requires either up front payment or a bank account so that payment can be through ten, monthly direct debit payments. The process for purchasing a PPC is also not patient centred, for example, patients have to claim a refund for the prescriptions they have paid for while waiting for their PPC to be issued. PPCs can now be bought from many pharmacies (around 1,600 across England) but it is not possible to pay by direct debit if purchased through this route.

There is a strong consensus that more should be done to promote the uptake of the PPC including:

- Publicity campaigns – which may need to be targeted for groups that are harder to reach.
- More prominent information about PPCs on NHS Choices and NHS Direct website.
- An increased role for health professionals (e.g., pharmacists) in making patients aware about the PPC, for example, during routine medication reviews.
- Better processes to facilitate the purchase of the PPC – especially where patients do not have bank accounts from which they can set up direct debits. The ideal solution would be to develop some form of "loyalty" card based-system.

Can an extension of exemption from prescription charges help to reduce medicines wastage and improve patient concordance?

I have been keen to explore how the extension of exemption arrangements for patients with long term conditions could be used as a driver for improving prescribing practice and patient concordance. Extending exemption could help to underpin some of the mechanisms that are at the disposal of primary care to improve prescribing practice and concordance but that are not as widely used as they could be at present, for example, repeat dispensing.

Patient concordance with medication could also be improved if doctors are able to prescribe smaller quantities to patients (without the concern that this increases the cost burden to patients) thus enabling them to optimise therapy. This may go someway to finding a treatment regime with reduced side effects, often a deterrent to concordance, and a cause of medicines wastage.

What has been the impact of removing prescription charges in Wales?

Prescription charges in Wales were abolished in 2007 (with phasing starting in 2004). Hence, it is still relatively early days to judge the impact of this policy on the health system in Wales. There are some early pointers, however, suggesting there has so far been limited impact on overall prescribing:

- In a three centre study in Wales, prescribing practice was compared with a comparable English region (North East). This study was commissioned by the Welsh Assembly and the detailed findings will be published shortly. The study showed that there has been a rise in overall dispensing rates in both Wales and North East England in the period since the Welsh policy on prescription charging was introduced in 2001 but the difference in the rates of increase between Wales and North East England was very small. However, for the 14 medicines that had the most items dispensed at a charge in Wales prior to abolition, the rate of increase in Wales (37%) was significantly greater than in North East England (19%). *(Personal Communication; Professor David Cohen; University of Glamorgan)*.
- Data on growth in dispensing fees for 2007–8 (from 2006–7) show growth in England at 5.5% vs 5.1% in Wales.[11] Growth in items dispensed was similar 5.4% (England) vs 5.3% (Wales). This suggests that, in the first year of free prescriptions at least, there had not been a marked impact on prescription volumes in Wales compared with England.
- A study examining the use of over the counter versus prescription medications for hay fever that suggests that there is some switching from over the counter to prescription medication; this seems higher in less deprived areas.[12]

Alternative proposals for reform

Not surprisingly, a number of different proposals for reforming the prescription charging system have been put forward. This is either because many consider the task of trying to define long term conditions for the purpose of exemption from prescription charging too difficult or because they thought this was the wrong policy. Although this strays beyond the terms of reference of this review, it is worth summarising the three most popular proposals below, none of which has been examined in any detail.

11 Prescriptions Dispensed in the Community in Wales 2000–2007 issued by the Statistical Directorate, Welsh Assembly 13 March 2008

12 Dhippayom T, Walker R. Impact of the reduction of the prescription charge in Wales on the prescribing of non-sedating antihistamines in primary care. Health Policy (Amsterdam, Netherlands) 2008; 87(3):315–09.

- **Abolition of prescription charges:** Many considered this to be the fairest, simplest and most equitable option and of course the position of the devolved countries has added to pressure for England to follow suit. Many have argued that this option would pay for itself because downstream health service costs would be reduced if patients were not deterred from getting the medication they needed. There is also an argument that removing people with long term conditions from charging would reduce prescription charge income to a level where the administration costs of the system would be disproportionate,[13] so that there is little benefit to retaining prescription charges for the few who would remain liable to pay charges.
- **Capped annual payments:** A number of people have highlighted the system of capping costs that is used in Sweden and Norway. Patients would pay up to a certain threshold after which they would be exempt from further charges. Current exemptions would still be included but the current medical exemptions would be removed on the basis that the costs to these patients would be capped to a maximum level – which would depend on where the cap is set (for example, if this was set at 6 prescriptions then under the current charge arrangements nobody would pay more than £43.20). The main problems with this system are that it is not clear at what level a limit should be set or how the scheme would be administered because the system would have to be operated at an individual patient level. However, the phasing recommendations draw on this principle.
- **Significantly reduced prescription charge for all:** A number of people noted that the level of charge income could be preserved at the current level if everyone paid around 60p for their prescription. However, the greatest burden would fall on those with the heaviest medicines usage, most likely to be the elderly, therefore there may be a case for retaining some exemptions under this system (for example, on age grounds) although the level of the charge would need to be higher than 60p if this were the case. There may also be a case for retaining a low cost PPC. Many thought this would be a fair way of reforming the system because the level of charge would be much less likely to deter use, while at the same time creating a notion of "value" from the patient's view, if they had to pay for their medication. Anecdotally, some reported that medicines wastage is more common among patients who are exempt.

Equalities

I have not considered in detail how proposals to extend exemption from prescription charges might impact on different groups of patients. Older and younger patients are exempt in any case, and clearly, extension of exemption is a positive policy designed to benefit patients. The Department will need to carry out an equalities impact assessment to ensure that all of those patients who will benefit are able to access free prescriptions when the new policy is implemented.

13 The core administrative costs that are required to support the current system of exemptions are relatively low. Costs arise from issuing prescription pre-payment certificates by NHS Business Services Authority and exemption certificates to those that are exempt on the basis of a medical condition or pregnancy. This is the only direct cost of the system that can be identified and the cost in 2007–08 was £4.5m.

3. Recommendations

1. There should be a broad definition of long term health condition

A person should qualify for exemption from prescription charges when, in the medical practitioner's view:

(1) they are likely to have a long term health condition that will persist for a period of at least six months; and

(2) there is a need for continuing management of the condition, although this does not have to be limited to management with medication.

This definition is simple, and although broad, will allow some distinction to be made between health conditions that are long term in nature and those that are not. In drafting the legal framework that will underpin this definition, the following principles should be reflected:

- Long term health conditions in this context include those where the condition may resolve over time.
- Asymptomatic conditions (such as hypertension) should be included.
- Continuing management can mean a range of measures such as treatment with drugs, including drugs for prevention; psychological therapies; periodic monitoring and review.
- Patients exempt under the current rules should continue to be exempt, including the various criteria under which cancer patients are currently exempted from prescription charges.
- Terminal conditions should not be excluded, even if the prognosis is that the patient will not live beyond 6 months.

2. Patients' eligibility should be determined, against this definition, by their doctor

An approach that relies on a broad definition of long term condition requires a decision to be made about whether the patient satisfies the definition, and hence qualifies for exemption. In my view, the initial decision about whether a patient meets the definition should be taken by a doctor involved in the patient's care. As is the case with the current medical exemptions, which are mostly approved by GPs, the GP will be usually best placed to take on this role. This is because of the nature of the primary care relationship with patients, and also because of their prescribing role, though I recognise that for some long term conditions, much of the care is based around the secondary care setting. GPs could be supported in this role by a member of the practice staff who has some clinical responsibility for patients with long term conditions, for example, nurse practitioners. For renewals, there may be a case for allowing other healthcare practitioners involved in the patient's care to approve the renewal and the Government should explore this further as part of the implementation planning.

3. The Government will need to develop detailed plans for implementation, working in particular with primary care and patient group stakeholders

I recognise that my recommendations will potentially have a greater impact on GPs than any other healthcare professional. That is why I discussed the proposals in detail with the representatives from national GP bodies during the second phase of the review. They have legitimate concerns about their role in policing the new system. They are concerned about the potential impact on their relationship with patients if, for example, they have to tell a patient that their condition does not warrant exemption. They are also concerned about the workload implications.

That said, it is clear to me that GPs are keen to do what is best for their patients. They recognise that the current system is not fair, and that an extension of exemption to those with long term conditions will make the system much fairer.

The Government will need to engage closely with stakeholders in developing systems that allow for smooth implementation of the new policy. They will need to engage particularly closely with GPs on the detail of how the new policy is to be put into practice. Technological solutions should be considered in order to ease the administrative burden of the new system. For example, it should be possible to build prompts into GP IT systems that allow a trigger to be raised for those patients who may fit the criteria for having a long term condition. The infrastructure in GP IT systems required for this would be similar to that developed for managing the Quality and Outcome Framework. It may be possible to mark the prescription form in a secure way to indicate to the dispenser that the patient is exempt from charges. This would remove the need for exemption certificates. The Government should scope the potential options for IT led solutions with Connecting for Health, GP system suppliers and the NHS Business Services Authority.

The new arrangements will also need to be supported by clear and effective guidance for professionals and for the public, which should be developed with stakeholders. The guidance for patients should provide:

- a clear explanation of how the new exemption and renewals process works, including the exemption periods and the possibility that the exemption will not be renewed.
- what they can do if they think they qualify for exemption.
- what to do if the medical practitioner considers that they do not meet the criteria, and they disagree with this assessment.

The guidance for practitioners should be developed with clinical input and will need to provide:

- clarity about how the definition is to be interpreted.
- advice about the meaning of continuing management.
- case examples.
- advice on how to assess entitlement for conditions that are likely to fluctuate.
- advice on what to do where there is not immediately a clear cut diagnosis though in the doctor's view there are indications to suggest that the patient may fulfil the criteria.

4. People who receive incapacity benefit without income support, or contribution based employment and support allowance, or disability living allowance should gain an automatic exemption from prescription charges

There is a strong argument for extending exemption in this way. It serves as an effective proxy for identifying people with long term conditions – these individuals are likely to meet the proposed definition of long term condition in any case. It also, generally speaking, targets those on lower incomes and it reduces the burden in terms of the number of cases that require a clinical decision on eligibility. In my view, the Government should consider whether to introduce exemption for these groups at the same time as any phased reduction in the cost of the PPC as it is relatively straightforward to implement and is not contingent on the wider system changes that will be needed to bring in exemption for all long term conditions.

5. As now, exemption should be for the person rather than restricted to the treatment of the condition for which he/she is exempt

There was considerable debate about this issue during the review. It would be attractive in principle to exempt prescription charges for treatments that relate to the specific long term condition only. However, in many cases it would be difficult in practice for practitioners to make judgements about whether another condition and its treatment are linked or not to the index condition.

6. Disagreement on whether a patient's condition is a long term condition should be resolved using existing processes

There are currently no appeals mechanisms open to patients in general practice and nor is there a right to appeal against a decision not to grant exemption under the current system. If a patient is unhappy with the advice or treatment they have been given, there are various options open to them, including:

- They can seek a second opinion, although there is no legal right to a second opinion. Patients can ask their GP to refer them to another GP or they may consider seeing another GP at the surgery if they are registered with a multi-GP practice.
- They can deregister with their GP and join another practice.
- Patients who have a hospital doctor involved in their care can also consult that doctor.
- They can make a complaint under the NHS complaints procedure.

The process for deciding who is exempt from prescription charges will hinge on clinical judgement about whether the patient has a long term condition according to a definition that is broad and allows for flexibility. Hence, an appeal would have to be based on the reasonableness of one clinical judgement against another. I have concerns that an appeals mechanism would add an additional and complex layer of bureaucracy and would potentially be damaging to the relationship between patients and their doctor.

For these reasons, I do not think that an appeals process should be created. Instead the Government should ensure that:

- There is effective guidance to support good decision making. This should include guidance about the responsibility of clinicians to provide a clear explanation to patients about the decisions they make regarding exemption.
- Patient information is provided about what they can do if they disagree with the doctor, including what routes are open to them in seeking a further opinion.
- There should also be an ongoing review to look at how often disputes occur and how they are resolved so that the Government can, if necessary, revisit the issue.

7. Exemption should last for 3 years

In my view, the five year exemption period that currently applies to medical exemptions can no longer be justified, as some conditions will resolve well within this period of time. In the interests of simplicity, the exemption period should be the same for all patients – a system that has different exemption periods for conditions that are lifelong and those that may resolve would be confusing for all. A shorter exemption period does, however, increase administrative burdens depending on the way in which the new exemption is put into operation. I recommend a three year exemption period, as this provides a fair balance between what is fair for the patient and the need to limit system bureaucracy.

Exemption certificates should, however, be renewable for a further term at any point within the last year of their existing term. This would allow a doctor to certify a renewal during the course of a planned appointment or review – preventing the need for an appointment to be made specifically for a renewal.

Patients will need to be given clear information about the duration of their exemption certificate so that they understand that they could lose the exemption after three years if their condition has resolved. This issue – of patients "losing" their exemption status rarely arises with the current medical exemptions, which are recognised to be lifelong conditions (with the exception of the new exemption for cancer).

8. Phasing should be achieved by stepwise reductions in the price of the 12-month prescription pre-payment certificate

The prescription pre-payment certificate provides a fair and efficient way of phasing in exemptions for long term conditions. It is already targeted to those with long term conditions who need regular medication and using the PPC for phasing would require no changes to the existing system infrastructure. Phasing could be achieved by progressively reducing the cost of the annual PPC (I have set out an illustrative example in Section 4). There would be no restrictions on who could buy a PPC though it is very likely that only those with long term conditions would purchase it. During the latter part of the phasing period, patients with long term conditions could apply for their exemption and certificates would be issued. This allows for the burden of certification to be spread out over a longer period.

When the new exemption is fully implemented, eligible patients would have certificates entitling them to free prescriptions. The cost of the annual PPC could be maintained at the new lower level or increased. In practice, the need for these should disappear. The three month PPC could be maintained at the same level throughout the phasing period and beyond. Once the new exemption for long term conditions is introduced, the three month PPC would be used mostly by patients with a high medication need for an acute health problem.

This phasing method would not immediately benefit patients who have a long term condition with a relatively low medication need. These patients would start to benefit only once phasing is completed and full implementation in place. This would be one of the anomalies of phasing but it should be clear to these patients that the intention was to include them once prescription charges for patients with long term conditions are completely phased out.

Alongside this, the Department should make a renewed effort to increase uptake of PPCs. Although a decrease in price should stimulate increased uptake of PPCs, as has been seen in Scotland,[14] the Government should actively consider ways in which both awareness and uptake of PPCs can be improved, for example, through increased publicity, examining the role of health professionals in raising awareness, and introducing better, more patient friendly mechanisms for purchasing a PPC. This might include wider availability of PPCs at pharmacies and the ability to automatically qualify for a PPC after paying the equivalent cost through accumulated individual prescription charges, for example, through a loyalty mechanism (possibly using smartcard technology) or registration with an individual pharmacist.

9. Patients who are exempt under the current medical exemption categories should retain their exemption throughout the phasing period. Patients who are newly diagnosed with these conditions during phasing should also continue to be exempted from prescription charges.

In effect, I am recommending that the current system of medical exemptions continues to run alongside the phasing period. Hence, new applications and renewals for those conditions exempted under the current system should continue to be treated in the same way as they are now. In due course, once exemptions for all long term conditions are introduced, all medical exemptions should be treated in the same way.

10. The Government should consider bringing in the changes as soon as possible

The Prime Minister's announcement of the intention to abolish prescription charges for patients with long term conditions was well received by patient groups. They would like patients to start reaping the benefits from this policy as soon as possible. I recognise that this review arrives at a time when there are significant constraints on public finances, which will impact on public expenditure plans for some years. However, I urge Government to give priority to the introduction of the new exemptions. Phasing down the cost of the PPC could be implemented quickly and efficiently and would start to make a difference for patients with long term conditions.

14 Information Services Division Scotland, PPC sales volumes http://www.isdscotland.org/isd/2237.html

4. Costs

This section provides:

- Estimates of the potential financial impact on prescription charge revenue of extending exemption to people with long term conditions, including free prescriptions to patients on certain benefits.
- An illustrative example of how exemption could be phased in by a stepwise reduction in the cost of the prescription pre-payment certificate.
- Quantification of potential benefits of extending exemption to people with long term conditions through reduced NHS expenditure in primary and secondary care as a result of improved patient concordance.

I recommend that the Department of Health undertakes more detailed analysis, using other data sources, to refine this analysis particularly in relation to estimating the overall cost of exempting people with long term conditions. However, the analysis below provides a reasonable estimate of the likely financial impact of extending exemption from prescription charges.

Financial impact on prescription charge revenue of widening exemption to people with long term conditions

Extending exemption from prescription charges reduces the number of charge payers, which in turn has a direct impact on prescription charge revenue. The financial impact is calculated on this basis. Lost prescription charge revenue was calculated for two groups of people who would become exempt from prescription charges:

(i) **Benefits claimants.** Claimants of incapacity benefit without income support, contribution based employment and support allowance or disability living allowance. This relates to my recommendation that recipients of these benefits should be exempt from prescription charges on the basis that they are likely to have a long term condition.

(ii) **Quality and Outcomes Framework (QoF) conditions.** Patients with common long term conditions.[15] The total revenue loss for all long term conditions is extrapolated from this, however, there is a significant caveat to this approach because the QoF conditions in the analysis only covered about half of all long term conditions and the analysis assumes that prescription consumption for the remaining 50% of long term conditions is similar.

Table 1: Revenue loss from extending exemption to prescription charges

Patient group	Loss of revenue (£M) per annum
Claimants group	Up to 60
QoF conditions	Up to 200
All conditions likely to designated long term (excluding those that are already exempt)[16]	Up to 430[17]

Phasing in by reducing the cost of the PPC

I have recommended that exempting people with long term conditions from the prescription charge can be phased in by stepped reductions in the price of the 12-month PPC. The level of reduction, and the period required for phasing, is a decision for Ministers, as it will be subject to decisions about funding. For illustrative purposes, I have set out in Table 2 the cost (in terms of lost prescription charge revenue) for a three year phasing option, but I stress that this is for illustrative purposes only rather than an implicit recommendation.

15 Loss of revenue for prescription charge exemption was estimated for patients aged 16–59 with those conditions likely to be designated long term that have the highest prevalence in the 2007–8 Quality and Outcomes Framework excluding depression and those conditions that are already exempt. The conditions included in the analysis are: asthma, hypertension, coronary heart disease, psychoses, chronic obstructive pulmonary disease, stroke and transient ischaemic attack, chronic kidney disease, atrial fibrillation and heart failure. Prevalence data were obtained from the IMS disease analyser.

16 This is calculated by extrapolating from the data for Quality and Outcomes Framework (QoF) conditions ie. we know from the General Household Survey 2006 that there are 15.4 million people in England with an LTC in total and the number of patients aged 16–59 with an LTC is 7.7 million. Data show that circa 76% of these patients will currently pay prescription charges hence the estimated number of patients who would be covered by the exemption is 5.9 million. The QoF conditions cover 47% of this population so it is possible to extrapolate total costs based on the significant assumption that prescriptions consumption for all long term conditions is broadly similar. Note that the benefits groups is likely to be subsumed within the all long term conditions group, although it is acknowledged that a small number may not actually have a long term condition as defined by the review eg. those receiving the mobility component of DLA only.

17 The total revenue loss is between £360–430M, depending on what assumptions are made about what the current level of usage of prescriptions (single item or pre-payment certificates) is by those with long term conditions who pay charges at present.

In addition, I recommend that people on incapacity benefit without income support, contribution based employment and support allowance or disability living allowance should become exempt from the outset of phasing. This could cost up to £60M per year. Hence, phasing according to the example I have set out in Table 2 could result in revenue loss of £100M in year 1 (2010/11) increasing to £170M in year 3 (2012/13). The analysis assumes that even at a cost of £60, the majority of 12 month PPCs will be purchased by people with long term conditions. It also assumes that the cost of the 3 month PPC and the single prescription charge remains at 2009/10 levels. It also takes no account of any savings through improved medicines concordance and nor does it take account of any increase in PPC uptake that may be driven by improving the mechanisms for purchasing PPCs.

Table 2: Three year phasing option: loss of revenue[18]

Year	Cost of PPC	Revenue lost from PPC reduction (£M)[19]	Revenue lost if benefits claimant group is included (£M) (based on 2008/09 costs)
2010–11	£80	40	100
2011–12	£70	70	130
2012–13	£60	110	170

Potential benefits of widening exemption from prescription charges to people with long term conditions

We know that people with long term conditions use disproportionately more primary and secondary care services. In England, 15.4 million people have a long term condition. People with long term conditions are the most intensive users of the most expensive services. They account for 52% of GP appointments, 65% of outpatient appointments and 72% of all inpatient bed days.[20] Clearly, better management of long term conditions should help to reduce the use of NHS services.

It is clear from research (detailed on page 9) that charges can deter people from having their prescriptions dispensed or from seeking treatment. Hence, removing charges could improve access to medicines and patient concordance, which in turn could reduce the need for NHS services in primary and secondary care. Indeed, alongside reducing the financial burden on patients with long term conditions, this is one of the key aims of this policy. There are also wider benefits to society if better management of a health condition enables people to be in work – people with a long term condition that impacts on their day-to-day activity are twice as likely to be out of work compared with those without a long term condition.[20]

18 Figures are rounded to the nearest £10M.

19 Revenue lost is calculated by (a) calculating the revenue that would be obtained if all prescription charges (including PPC) remained at 2009–10 levels (b) calculating the revenue that would be raised with the reduced PPC and then subtracting b from a. Increased administration costs from processing extra PPCs (based on assumptions around the level of increased uptake) are also taken into account.

20 Raising the Profile of Long Term Conditions Care: A Compendium of Information. Department of Health 2008

It is, however, difficult to quantify the potential savings associated with removal of prescription charges, in part because it involves assumptions about the level of concordance improvement that could be gained, and the consequent impact this might have in terms of reduced health service usage.

I asked the analytical team to look at the potential secondary care savings from reduced hospital admissions for asthma, cardiovascular diseases, other heart conditions and chronic obstructive pulmonary disease or bronchitis in order to get some illustration of the potential scale of cost savings in this area. Estimates (based on 2007/8 data) show that lack of medicine concordance could cost between £70 million and £180 million for these conditions, in terms of preventable hospital admissions. If removing prescription charges leads to a level of improved concordance that has the effect of reducing hospital admissions for these conditions by as much as 10%, the potential savings to the NHS would be between £7 million and £18 million per annum.

5. Concluding remarks

This review has demonstrated that while the principle of extending exemption from prescription charges to people with long term conditions is widely supported, the practicality of achieving it is complex. The fundamental problem relates to definition and identification of those who should benefit from such an exemption. It would be all too easy to devise a system that creates a new set of anomalies and is complex to the point of being unworkable. There is clearly more work to be done on some aspects of implementation, but I believe that this review has set out a way forward that is practical and achievable and allows the underlying policy intention, of better access to medicines for people with long term health conditions, to be realised.

I would also urge the Government to continue to review the policy around prescription charges. There is the potential for the system to become overly burdensome, with hidden costs, for example in terms of the clinical time required in assessment and certification. Currently, around 40% of patients have to pay prescription charges. Extending exemption to long term conditions will significantly reduce this proportion. Broadly speaking, it will leave charges in place for short term, self limiting conditions. This means that the overall costs of administration could be disproportionate to the level of income raised.

There is also the danger that exempting long term conditions could create perverse incentives towards seeking treatment possibly more so than would total abolition of charges. Patients would be reluctant to give up exemption once they have received it, and there could be an incentive towards seeking ongoing treatment in order to qualify for continued exemption from charges. For this reason I think the policy will need to be reviewed. Clearly, one option that emerges from this is abolition of prescription charges. There is, unsurprisingly, much support for this from patients and clinicians. I too favour this view, and I hope exemption for patients with a long term condition is a stepping stone towards total abolition. In evaluating this option, the Government should draw on the experience in the Devolved Administrations.

The alternative to complete abolition of prescription charges would be to consider a wider reform of the system that examines the question of prescription charging more fundamentally. But for the present, I believe I have put forward recommendations that will be of benefit to the group of citizens most burdened by prescription charges, those with long term conditions who are not exempt under existing arrangements.

Acknowledgements

I would like to thank those colleagues who assisted me in hearing oral evidence from some of the main stakeholder groups (listed at Annex D). Annex E lists those who provided oral and written evidence.

I am also indebted to all those who have provided evidence to the review.

I have been greatly assisted by members of the Medicines, Pharmacy and Industry group at the Department of Health, in particular Dilip Chauhan, Eleanor Shenton, Luisa Stewart, Sarah Jonas, and by Susan Shepherd at the Royal College of Physicians.

The Medicines Pharmacy and Industry Group's analytical team undertook the analysis in section 4 of the report.

Annex A: Terms of Reference for the Review

The Prescription Charges Review will consider how to implement the Government's commitment to exempt patients with long term conditions (LTCs) from prescription charges over the next few years following the exemption for cancer patients.

The Review will engage with patients and their representatives, clinicians, the public, healthcare organisations and other interested groups to ensure the widest range of views contribute to its findings.

It will consider:

- how to define the range of long term conditions affecting patients that should be exempted from prescription charges;
- how exemption from charging can best be phased in, with due regard to:
  - what is in the best interests of patients.
  - the potential impact on the wider health care system.
  - implications for existing policies on management of long term conditions.
  - implications for public expenditure.

Annex B: Methods

The following activities were carried out as part of the review:

- An initial scoping workshop to define the key questions for the review.
- A written consultation (37 responses) and a web-based survey aimed primarily at the public (1750 responses).
- Oral evidence was taken from a number of key stake holders (see Annex E).
- Deliberative research (carried out by Corr Willbourne Research & Development) including workshops and in-depth interviews with patients, the public and with GPs.
- A stakeholder workshop hosted by National Voices (the umbrella organisation for long term conditions).
- Meetings with key individuals including David Colin-Thome (National Clinical Director for Long term Conditions); Mike Richards (National Clinical Director for Cancer); Philip Routledge (Professor of Clinical Pharmacology, University of Cardiff); David Cohen, (Professor of Health Economics, University of Glamorgan).
- Meetings with representatives of National Voices; Prescriptions Coalition of charities[21] and NHS Alliance, Breast Cancer Care, Macmillan, the British Medical Association, the Royal College of General Practitioners, National Association of Primary Care, NHS Alliance, National Pharmacy Association, Pharmaceutical Services Negotiating Committee, Royal Pharmaceutical Society of Great Britain.
- A review of the UK and international literature.
- Economic analysis to examine the cost of implementing exemptions for long term conditions, and costs of phasing options.
- Officials supporting the review have visited a GP surgery and have spoken to NHS Connecting for Health and a GP IT systems supplier.

21 Membership of the Prescription Coalition includes: Androgen Insensitivity Syndrome Support Group, Arthritis Care, Association for Spina Bifida and Hydrocephalus, Asthma UK, Behcets Syndrome Society, British Heart Foundation, Diabetes UK, Disability Alliance, Klinefelter's Syndrome Association, Mind, MS Society, National Ankylosing Spondylitis Society, National Association for Colitis and Crohn's Disease, National Rheumatoid Arthritis Society, Parkinson's Disease Society, Pernicious Anaemia Society, Rethink, Stroke Association, Skin Care Campaign, Terrence Higgins Trust

Annex C: List of Current Exemptions From Prescription Charges

No charge for any prescriptions for the following patients:

- Children under 16.
- Young people aged 16, 17 18 receiving full-time education.
- Men and Women aged 60 and over.
- Pregnant women and women who have had a child in the previous twelve months who hold a valid exemption certificate.
- People who hold a valid war pension exemption certificate (but only in respect of medication for the accepted disablement).
- People suffering from the following conditions who hold a valid exemption certificate:
  - Permanent Fistula (including caecostomy, colostomy, laryngostomy, or ileostomy) which requires continuous surgical dressing or requires an appliance.
  - 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.
  - Myxoedema.
  - Epilepsy requiring continuous anti-convulsive therapy.
  - continuing physical disability which prevents the patient from leaving his residence without the help of another person;

  OR

  - they are undergoing treatment for cancer, the effects of cancer or the effects of current or previous cancer treatment. (From 1 April 2009).

No charge for any prescriptions for patients who are not in any of the above groups but who have a low income:

(a) The patient is named on an HC2 charges certificate for full help under the National Health Service Low Income Scheme. (This includes asylum seekers and their families if they are supported by the Immigration and Nationality Directorate). The level of help is broadly based on income support applicable amounts plus housing costs and council tax the individual/couple is liable to pay. The level of income at which help ceases will depend on the individual's/couple's circumstances. No help is available when capital is more than £23,000 for people living permanently in a care home or £16,000 for anyone else; Or

(b) Recipients of the following who do not need to make a separate Low Income Scheme claim (this includes the partner and any dependant young people aged under 20):

- Income Support.
- Income-based Jobseekers' Allowance.
- Income-related employment and support allowance.
- Pension Credit guarantee credit (for partners under 60, recipient will be entitled on age grounds).
- Tax credit awarded and family's annual gross taxable income (from 6 April 2009) is £15,276 or less with:
  - child tax credit, or
  - working tax credit with a disability, or severe disability element.

In addition, any patient not in any of the above groups may purchase a prescription pre-payment certificate (PPC). There is no restriction on the number of prescribed items that may be obtained using a PPC.

Annex D: Membership of review panel for oral evidence sessions

Ian Gilmore (Chair)
President, Royal College of Physicians

Susan Bews
President, Faculty of Pharmaceutical Medicine

Catherine Duggan
Associate Director, Clinical Pharmacy Development and Evaluation for East and South East England Specialist Service, NHS, and Senior Clinical Lecturer, The School of Pharmacy, London

Sam Everington
General Practitioner, and Deputy Chair, British Medical Association

Steve Field
Chairman of Council, Royal College of General Practitioners

Margaret Goose
Independent, and previous-chair of RCP Patient and Carer Network

Nick Hoile
Policy and Public Affairs Officer, National Voices

Frank Holloway
Consultant Psychiatrist and Chair, Rehabilitation and Social Psychiatry Faculty, Royal College of Psychiatrists

Suzie Hughes
Member of the RCP Patient and Carer Network

Martyn Partridge
Consultant Physician and Member of RCP Council

James Ritter
Consultant Clinical Pharmacologist and chair of the RCP joint Specialist Committee on Clinical Pharmacology and Therapeutics

Derek Waller
Consultant Physician and Clinical Pharmacologist

Alan White
Chair, RCP Patient and Carer Network

Susan Shepherd (Secretary to oral evidence sessions)
Senior Policy Officer, RCP

Note: Positions current at the time the oral evidence sessions were held (January to March 2009)

Annex E: List of respondents (for oral and written evidence)

Oral evidence sessions were held with:

Advisory Committee on Borderline Substances, British Medical Association, Citizen's Advice Bureaux, Dispensing Doctors' Association, Kings Fund, MIND, National Pharmacy Association, National Association of Primary Care, National Voices, Patients' Association, Pharmaceutical Services Negotiating Committee; NHS Business Services Authority; Prescriptions Coalition of charities (including Asthma UK; Diabetes UK; Behcet's Syndrome Society; Parkinson's Disease Society); Royal College of General Practitioners; Royal College of Nursing; Royal Pharmaceutical Society of Great Britain; a Strategic Health Authority prescribing advisor; University of Manchester.

The following organisations provided written evidence. Note that in some cases it was individuals from the organisation that provided the response, and not necessarily a response that represented the organisation:

Academy of Medical Royal Colleges; Addisons Disease Self Help Group; All-Party Parliamentary Group on Sickle Cell and Thalassaemia; The Association of Cancer Physicians; Asthma UK; British Heart Foundation; British Medical Association; British Society for Rheumatology; British Thoracic Society; Coeliac UK; Cystic Fibrosis Trust; Diabetes UK; East Birmingham and Solihull GP Vocational training scheme – West Midlands Deanery; Epilepsy Action; Gorlin Syndrome Group; HEART UK; Highcliffe Medical Centre Patient Participation Group; Jubilee Medical Centre; MRC Environmental Epidemiology Unit; Southampton General Hospital; MIND; Motor Neurone Disease; Parkinson's Disease Society; Prescriptions Coalition; Royal College of General Practitioners; Royal College of Ophthalmologists; Royal College of Physicians; Diabetes and Endocrinology; Joint Specialty Committee; Royal College of Physicians; Ethical Issues in Medicine Committee; Royal College of Physicians GP Network; Royal College of Physicians, Palliative Medicine Joint Specialty Committee; Royal Hospital for Neuro-disability; Sickle Cell Society; Socialist Health Association; Society for Endocrinology; South Bank University; Spinal Injuries Association; UK Thalassaemia Society.