Title: Increasing the upper age exemption for prescription charges in line with the state pension age. **IA No:** **RPC Reference No:** N/A **Lead department or agency:** Department of Health & Social Care **Other departments or agencies:** N/A	Impact Assessment (IA)
	Date: 14/06/2021
	Stage: Consultation
	Source of intervention: Domestic
	Type of measure: Secondary legislation
	Contact for enquiries: ageconsultation@dhsc.gov.uk

Summary: intervention and options

RPC opinion: Not applicable

Cost of preferred (or more likely) option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANDCB in 2014 prices)	**One-In, Three-Out**	**Business Impact Target Status**
£4.75bn	N/A	N/A	Not applicable	Non-qualifying provision

What is the problem under consideration? Why is government intervention necessary?

The upper age exemption for prescription charges was introduced in 1968 to be in line with women's State Pension Age (SPA), which was 60 at the time. In the decades since, there have been increases to the SPA, but the upper age exemption for prescription charges has remained the same. The SPA increased from 65 to 66 between 2019 and 2020, and legislation is in place to increase this to 67 between 2026 and 2028, and to 68 between 2044 and 2046.

Blanket exemptions for people aged 60 and over are no longer appropriate. The average retirement age is now 64 for women, and 65 for men, and has been increasing steadily over the last two decades. In 2019/20, around 60% of people in the 60-65 age group were still economically active and potentially able to meet the cost of their prescriptions.

What are the policy objectives and the intended effects?

The objective is to maintain the aim of the upper age prescription charge exemption – to protect those on low income, while ensuring those who are economically active and potentially able to meet the cost of their prescriptions do so. Changing the upper age exemption will raise significant extra revenue for the NHS which found itself under unprecedented pressure in 2020. Aligning the upper age exemption with the SPA would generate valuable additional revenue for the NHS, whilst the most vulnerable would be protected by medical and income-related exemptions.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in evidence base)

Changing prescription exemptions would require amendments to the NHS (Charges for Drugs and Appliances) Regulations 2015. Three options are considered:
1) Make no changes to regulations ("business as usual" option)
2) An immediate increase in the upper age threshold to 66.
3) A phased increase where preservation of entitlement is maintained. This means that anyone over the age of 60 when the regulations are changed will be protected.
The business as usual option is the baseline option against which other options are appraised. Option 3 is the Government's preferred option.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date: Month/2021**

Does implementation go beyond minimum EU requirements?		Yes / No / N/A		
Are any of these organisations in scope?	**Micro** Yes/No	**Small** Yes/No	**Medium** Yes/No	**Large** Yes/No
What is the CO$_2$ equivalent change in greenhouse gas emissions? (Million tonnes CO$_2$ equivalent)		**Traded: N/A**		**Non-traded: N/A**

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible minister:

Date: 14/06/2021

Summary: Analysis & Evidence   Policy Option 1

Description: NO AMENDMENTS TO REGULATIONS (I.E. BUSINESS AS USUAL)

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period 10 Years	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High: Optional**	**Best Estimate:**

COSTS (£m)	Total Transition (Constant Price)Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised costs by 'main affected groups'

Option 1 is the "business as usual" baseline against which other options are assessed, and the costs are zero by definition. No amendments would be made to the regulations regarding the upper age limit for prescriptions charges, the threshold would remain at 60.

Other key non-monetised costs by 'main affected groups'

As above.

BENEFITS (£m)	Total Transition (Constant Price)Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

As above.

Other key non-monetised benefits by 'main affected groups'

As above.

Key assumptions/sensitivities/risks   **Discount rate**

It is assumed here that the upper age limit would remain at 60 over the 10-year horizon period of the analysis. Therefore, no additional revenue would be raised and there would be no additional costs to users of prescriptions.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs:	**Benefits:**	**Net:**	

Summary: Analysis & Evidence

Policy Option 2

Description: Full immediate transition to exemption age of 66

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period 10 Years	Net Benefit (Present Value (PV)) (£m)		
			Low: £6,020	**High: £6,610**	**Best Estimate: £6,220**

COSTS (£m)	Total Transition		Average Annual	Total Cost
Low	N/A		£250m	**£2,170m**
High	N/A		£271m	**£2,350m**
Best Estimate	<£10m		£257m	**£2,230m**

Description and scale of key monetised costs by 'main affected groups'

Individuals aged 60-65 who don't qualify for another exemption could face an average annual cost of £50 to £100 depending on their medicine use and method of payment. In the central scenario, total annual costs would be £257m per year on average over 10 years. This includes the cost to patients of buying prescriptions, the loss of quality-adjusted life years (QALYs) as a result of potential deterrent effects of prescription charges and the administrative costs of this policy change. The likely deterrent cost is relatively small and robust to a range of inputs. The monetised discounted total cost over the ten-year period is £2.23bn.

Other key non-monetised costs by 'main affected groups'

The policy would affect some lower income groups more severely, though patients with the lowest incomes would remain protected by income-related exemptions. People in lower income groups tend to have higher average use of prescriptions and less ability to pay the cost of prescriptions.

BENEFITS (£m)	Total Transition		Average Annual	Total Benefit
Low	N/A		£876m	**£8,190m**
High	N/A		£958m	**£8,950m**
Best Estimate	N/A		£904m	**£8,450m**

Description and scale of key monetised benefits by 'main affected groups'

The NHS would raise on average £226m per year from extra prescription charges over ten years. When reinvested in NHS services, this would be expected to generate health benefits equivalent to around 151,000 QALYs in total over ten years with a monetised discounted value of around £8.45bn (discount rate of 1.5%).

Other key non-monetised benefits by 'main affected groups'

There are no other benefits from the regulation change.

Key assumptions/sensitivities/risks	**Discount rate(%)**	NHS 1.5

A PPC allows as many NHS prescriptions as needed for a set price of £108.10 over 12 months or £30.25 over 3 months. Our central scenario is based on a PPC uptake rate of 73% for high users of prescriptions. We tested scenarios based on an uptake rate of 60%, 80% and 85%, to reflect uncertainty of future PPC uptake. We tested different scenarios for deterrent effects and found that conclusions were robust to a wide range of scenarios described by two parameters: the percentage of prescription users at risk of being deterred was allowed to range from 10% to 20%, compared to 15% in the central scenario; and the number of prescriptions not collected by deterred users was also allowed to change, ranging from 20% to 50%, compared to 40% in the central scenario. These changes had a minimal impact on the net present value (NPV) of the policy change.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs:	Benefits:	Net:	

Summary: Analysis & Evidence   Policy Option 3

Description: Immediate increase with preservation of entitlement

FULL ECONOMIC ASSESSMENT

Price Base Year	PV Base Year	Time Period 10 years	Net Benefit (Present Value (PV)) (£m)		
			Low: £4,590	High: £5,040	Best Estimate: £4,750

COSTS (£m)	Total Transition		Average Annual	Total Cost
Low	Optional		£193m	**£1,620m**
High	Optional		£209m	**£1,750m**
Best Estimate	<£10m		£198m	**£1,670m**

Description and scale of key monetised costs by 'main affected groups'

Individuals aged 60-65 who don't qualify for another exemption could face an average annual cost of £50 to £100 depending on their medicine use and method of payment. In the central scenario, total annual costs would be £198m per year on average over 10 years. This includes the cost to patients of buying prescriptions, the loss of QALYs as a result of potential deterrent effects of prescription charges and the administrative costs of this policy change. The monetised deterrent cost is relatively small and robust to a range of inputs. The monetised discounted total cost over the ten-year period is £1.67bn.

Other key non-monetised costs by 'main affected groups'

The policy would affect some lower income groups more severely, though patients with the lowest incomes would remain protected by income-related exemptions. People in lower income groups tend to have a higher average use of prescriptions and less ability to pay the cost of prescriptions.

BENEFITS (£m)	Total Transition		Average Annual	Total Benefit
Low	Optional		£675m	**£6,210m**
High	Optional		£737m	**£6,790m**
Best Estimate	No transitional benefits		£696m	**£6,410m**

Description and scale of key monetised benefits by 'main affected groups'

The NHS would raise on average £174m per year from extra prescription charges over ten years. When reinvested in NHS services, this would be expected to generate health benefits equivalent to around 116,000 QALYs with a monetised discounted value of around £6.41bn (discount rate of 1.5%).

Other key non-monetised benefits by 'main affected groups'

There are no other benefits from the regulation change.

Key assumptions/sensitivities/risks	**Discount rate (%)**	1.5%

A PPC allows as many NHS prescriptions as needed for a set price of £108.10 over 12 months or £30.25 over 3 months. Our central scenario is based on a PPC uptake rate of 73% for high users of prescriptions. We tested scenarios based on an uptake rate of 60%, 80% and 85%, to reflect uncertainty of future PPC uptake. We tested different scenarios for deterrent effects and found that conclusions were robust to a wide range of scenarios described by two parameters: the percentage of prescription users at risk of being deterred was allowed to range from 10% to 20%, compared to 15% in the central scenario; and the number of prescriptions not collected by deterred users was also allowed to change, ranging from 20% to 50%, compared to 40% in the central scenario. These changes had a minimal impact on the net present value (NPV) of the policy change.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs:	Benefits:	Net:	

Evidence Base (for summary sheets)

Problem under consideration

1. Prescription charges apply in England unless the individual has an exemption. At present, people receive free prescriptions when they reach the age of 60. This upper age exemption is no longer in line with the SPA which was increased in 2020 to 66.

2. The Covid-19 pandemic has led to unprecedented demand and strain on NHS resources. Increasing the upper age exemption for prescription charges could raise significant additional revenue for the NHS (nearly £200m per year in the steady state).

3. Prescription charges are a valuable source of income for the NHS. For 2018/19 they contributed nearly £600 million in revenue. This income helps the NHS to maintain vital and much needed services for patients and is especially important in light of the recent pandemic.

4. The exemptions to the prescription charge cover three broad categories:

    a. Those on low incomes, e.g. via certain DWP benefits and tax credits

    b. Those with certain medical conditions and expectant/new mothers

    c. Those of a certain age, either under 16, 16-18 in full time education, or aged 60 or over.

5. At present the upper age exemption is no longer in line with the SPA which was increased in 2020 to 66. This means that people in the age group 60-65 may still be in employment and economically active and some may be able to meet the cost of their prescriptions.

Policy objective

6. The objective is to maintain the aim of the upper age prescription charge exemption – to protect those on low income, while ensuring those who are economically active and potentially able to meet the cost of their prescriptions do so. Changing the upper age exemption will generate additional revenue for the NHS that has found itself under unprecedented pressure over the last 12-months as a result of the Covid-19 pandemic. It is important that this policy change generates additional revenue for the NHS whilst ensuring that everyone can afford the medication they need and avoiding adverse impacts on medication adherence and health inequalities.

Options considered

7. The costs and benefits of each policy option are outlined in this document. Aligning the upper age exemption threshold with the SPA could be done either immediately or with preservation of entitlement.

8. Changes to prescription charge exemptions would require amendments to the NHS (Charges for Drugs and Appliances) Regulations 2015.

Option 1: Make no changes to regulations ("business as usual" option)

9. Not to make any changes to regulations. The upper age exemption would remain at 60 and people aged 60-65 would continue to receive free prescriptions.

Option 2: - An immediate rise to the SPA

10. Change the upper age exemption straight to 66 with no transitional protection. Anyone between the ages 60-65 who did not qualify for another exemption would need to pay for their prescriptions.

Option 3: An immediate rise to the SPA with preservation of entitlement

11. Change the upper age exemption to 66 with transitional protection. Under this option, anyone who already qualified for the upper age exemption at the time of the regulation change would retain their exemption from prescription charges. Those who had not reached age 60 before the regulation change, and who did not qualify for another exemption, would continue to pay for prescriptions until they reach the SPA. This is the Government's preferred option.

12. Retaining protection for those currently in the age group 60-65, will ensure that people have advance notice of a change and will not have to restart paying for prescriptions that they currently get for free. Not doing so could lead to confusion about the policy, with some people potentially continuing to claim an age exemption and attracting penalty notices and fines as a result, and others potentially being deterred from collecting prescriptions by the unexpected cost. In addition, this option with preservation of entitlement would allow policy officials to monitor any adverse impacts.

Why not remove the upper-age exemption

13. A more radical option of further raising or removing the upper-age exemption has not been considered. This is on the grounds that the age criterion is simple to understand and process and that the majority of people over retirement age have a long-term medical condition and would either qualify for a medical exemption or else be at high risk of being deterred from collecting their prescriptions if they had to pay. There is a strong upward trend in prescription use with age, this trend accelerates above the age of 55[1]. The higher prevalence of long-term conditions in older people is largely responsible for this trend[2].

14. People with long-term conditions are those most at risk of adverse health consequences if they are deterred from taking their prescriptions due to the cost. There is an increase in the number qualifying for medical exemptions with age, but this would not cover a number of people with long-term conditions who do not qualify for a medical exemption. Therefore, removing the upper age exemption could result in a very large increase in the deterrent effect. This would increase as people got older, damaging people's health and resulting in costs for the NHS of treating complications of illnesses where prescriptions are not taken. Later in the document, we monetise this deterrent cost for 60-65-year olds and show that it is relatively small when compared to the health benefits to other NHS patients from revenue generated from both policy options (see paragraph 52 onwards).

Equalities and health inequalities

15. For the purposes of this IA, it is important to identify any potential for worsening access to prescriptions, which may affect some groups of individuals disproportionately. People at the very bottom of the income distribution should be protected from paying prescription charges due to receiving income-related benefits that qualify for a prescription charge exemption or via the NHS Low Income Scheme. These people may also qualify for one of the other main exemptions, such as the medical exemption, and so may be protected from prescription charges. There will be people who are just above qualifying thresholds for income-related benefits and therefore must pay for prescriptions. These people will be more affected, and the prescription charge could potentially lead to them to reduce their medicine usage. The PPC was introduced to cap the costs for very high users of prescriptions and keep any deterrent effect of prescription charges as small as possible. These potential impacts are explored in more detail later in the document.

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[1] Mean prescription use for 55-59-year olds is 39, this increases to 64 for 80-84-year olds.

[2] 65% in people aged 65+, compared to 52% for people aged 60-65 (Percentage of people who have a long-term health condition (12 months or more) by age group. ONS Annual Population Survey 2019)

Evidence used to inform estimates of costs and benefits

Background

16. In England, out of 1.12 billion prescription items dispensed in 2019, approximately 90% were dispensed free of charge. Nearly two-thirds of all items were dispensed free of charge because the patient was aged 60 years or older.

17. The proposed change to the upper age limit would result in a transfer of resources from people who previously received free prescriptions, to the NHS who will spend the money on services for patients, resulting in health benefits for wider society. The cost to individuals who use prescriptions in the age cohort will vary depending on their level of prescription use (and how they pay for it), whether they qualify for another exemption (health or income related), and where they lie on the income distribution. For those towards the bottom of the income distribution, but who do not qualify for low income exemptions, there could potentially be a deterrent effect of medicine usage due to the cost of their prescriptions.

18. Prescription charges generate around £600m in revenue for the English NHS each year. Increasing the upper age exemption could generate additional revenue, with the amount depending on:

    - The number of people aged between 60 and the SPA. This is estimated from ONS population projections for England[3].

    - Whether the policy is phased in to provide protection to people already exempt.

    - The number of people who would retain an exemption because of a long-term medical condition or receipt of income-related benefits. This is estimated to be 34% of prescription users in this age group, extrapolating from trends in exemption rates by age observed across younger age groups from NHS BSA prescriptions data (no data is routinely collected for patients aged 60-65 as these patients currently qualify for the upper age exemption).

    - The number of people who could be deterred from collecting their prescriptions because of the charge.

    - The volume of prescriptions used by people in this age group.

    - The cost of prescriptions. This is based on the current single charge of £9.35 per item, and annual prescription prepayment certificate (PPC) cost of £108.10 covering an unlimited number of prescriptions. Any future increases to prescription charges are not factored in, since these would be separate policy decisions.

    - The way that people pay for their prescriptions i.e. whether they buy a PPC. This makes a large difference to the estimate of additional income, so different rates of PPC use were estimated using four PPC uptake usage scenarios.

19. As well as estimating the revenue that can be raised for the NHS from increasing the age exemption, this analysis describes the costs to users of prescriptions, including:

    - Distributional effects, in particular whether some lower income users will struggle to meet the costs of having to pay for their prescriptions.

    - Potential impacts on medication adherence and associated long-term costs of non-adherence to the NHS using three examples chronic conditions that don't qualify for a medical exemption and where regular prescriptions are needed to manage the condition.

    - The administrative costs of this policy change. This includes the cost of changing the prescription form itself as well as associated costs such as discarding existing prescription form stocks and updating computer systems. It

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[3]https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/z1zippedpopulationprojectionsdatafilesuk

also explores potential additional costs to pharmacies of processing additional payments and to NHS BSA of administering a higher volume of payments and more complex medical and income-related exemptions.

Population scenario used in the analysis

20. Over a 10-year time horizon, population trends will influence the number of people impacted by the policy. The ONS population projections were used with the middle growth scenario as a benchmark. To get an estimate of the projected future size of the English population aged 60-65, the detailed UK projection by single year of age was combined with the England-only projection for five-year age bands. England to UK population ratios for the 60-64 age band were used to scale the UK figures.

21. Preserving entitlement to free prescriptions for people who turned 60 before the implementation date (Option 3) affects how many people will have to pay in the first five years. For Option 2, all 60-65-year olds would immediately have to pay for prescriptions whereas for Option 3 there is a more staggered change. In the first year, the only new people who will have to pay for prescriptions will be those who reach age 60 during that year. This is equivalent to raising the effective age limit to 61 in the first year and increasing to 62 in the second year and so on until 2027/28 when the effective upper-age limit will be 66. After 2027/28, the number of people impacted, and the revenue generated from the two policy options, will be identical.

Prescription charge level

22. For the purpose of this analysis, the current level of the prescription charge of £9.35 for a single charge and £108.10 for a 12-month PPC is held constant over the duration of the ten-year period. In practice, charges are likely to be increased in line with inflation (the single charge has been increased every year since 2011 while the PPC was increased in 2019/20 for the first time in over 5 years). Potential future charge increases are not modelled in this appraisal since these are separate policy decisions that are taken annually. In practice, revenue from prescription charges will be strongly linked to future levels of the charge.

Prescription usage

23. For this section, the prescribing data used comes from a range of sources including data provided specifically for this analysis by NHS Business Services Authority (NHS BSA) and publicly available data extracted using their online platform ePACT2. Most of the fields come from information collected on the prescription form (see Figure 3 in the annex for an image of the back of the FP10 prescription form).

24. The first step to analyse prescription usage in 60-65-year olds was to estimate how many people use at least one prescription per year. To calculate this, data received from NHS BSA's ePACT2 data platform was used; it showed in each going back to 2016, on average, 95% of 60-65-year olds use at least one prescription per year. We used the total number of uniquely identifiable patients who had used at least one prescription in that year, we then divided this by the population of that age group in each year going back to 2016.

25. In England, out of over one billion prescription items dispensed in 2019, close to 90% were dispensed free of charge. Two-thirds of all items were exempt because the patient was aged 60 years or older. Some other exemptions include; being under 16; being pregnant (or in the 12 months after giving birth); having a qualifying medical condition; or receiving an income-related benefit.

26. For this analysis, we estimated how many 60-65-year olds who receive a prescription each year would qualify for another exemption. Based on NHS BSA prescribing data obtained from ePACT2 we estimated that 34% of people in the 60-65 age group would qualify for another exemption with the majority of these being a medical exemption. This means that 66% of 60-65-year olds paid for their prescriptions at least once during the year, including those who used a PPC.

27. The data from the cohort below (55-59-year olds) was used as the starting point to estimate this figure as they are the closest age cohort that currently pay for prescriptions and thus prescription payment data is available. For 55-59-year olds, 31% of prescription users would qualify for another exemption, but this is likely to be an underestimate for 60-65-year olds as there is a clear upward trend in the number of people claiming a medical exemption as age increases. Evidence of this can be seen in Table 5 later in the document. Therefore, 34% was used to account for the higher proportion of prescription users who would qualify for a medical exemption compared to the cohort below.

28. Prescription use varies, and those with higher levels of use are more likely to take out a PPC in order to cap the cost. A PPC lets you get as many NHS prescriptions as you need for a set price of £108.10 over 12 months or £30.25 over 3 months. In the analysis, we consider two groups of prescription users:

   - high users, who use 12 or more prescriptions per year, and who are likely to purchase PPCs since these represent value for money; and

   - low users who use less than 12 prescriptions per year and are likely to pay the single charge per prescription.

29. An individual's decision to purchase a PPC requires a good understanding of their own future medicine use. In some cases, patients may purchase a PPC but not require all the medicines to have made that a cost-effective decision. In other cases, patients may find they would have been better off purchasing a PPC but were unable to predict their prescription usage or may have been unable or unwilling to pay the lump sum (minimum £30.25 for 3-month PPC) or monthly instalments (£10.81 for ten months for 1-year PPC). Therefore, there will be some high users of prescriptions who pay the single charge (at a total cost higher than the annual PPC cost) and some low users who pay for a PPC which was not required.

30. Two approaches were used to estimate the ratio of high to low users for 60-65-year olds, with results shown in Table 1 (below). The first looked at all 60-65-year olds who used prescriptions, it showed that 61% of this cohort used more than 12 items per year and therefore are high users; this group had a mean use of 34 items per year. We are most concerned with users who will need to pay in the future and therefore this figure is likely to be an overestimate because people who retain a medical or income-related exemption are likely to use more prescriptions.

31. The second approach looked at 55-59-year olds but only those who paid for their prescriptions. This showed that 28% were high users; this group had a mean use of around 13 items per year (28 per year among those buying a PPC; 6 per year among those paying the single charge). These figures underestimate use among 60-65 year olds who will need to pay in the future because there is a clear upward trend in the use of prescriptions as age increases (e.g. 55-59 age group used 28 items per year on average vs 34 per year among 60-65 year olds) There are also some data quality issues that lead to underestimation. Therefore, the number of high users is likely to be between these two figures and we use an estimate of 50% high users and 50% low users; with a mean overall use of 25 items per year.

32. The next step was to look at impacts of how individuals pay for their prescriptions by looking at the percentage of users in each group (high and low users) who purchase a PPC. It is expected that the PPC uptake is much higher for high users compared to low users.

33. Data from NHS BSA for the 55-59 cohort showed that 15% of low users bought a PPC, which is not generally cost effective for these people. This includes people who could have bought a 3-month PPC, for whom it may have been cost-effective, and people who thought at the start of the year that they would use 12 or more prescriptions and therefore decided to buy a 12-month PPC.

34. For the high users, PPC usage was 73%. This means that 27% of high users are paying with the single charge which is not cost effective. There

has been a small but steady upward trend in PPC usage. For all prescription users in the 55-59 cohort, including high and low users, the use of PPCs increased from 29% in 2015/16 to 32% in 2019/20.

Cost to prescribed medicine users

35. Table 1 below shows the estimated future cost of prescriptions in a year for high and low users depending on how the prescriptions are paid for.

Table 1 Assumed future prescription use and costs faced by 60-65-year olds who would need to pay for prescriptions.

	Low user (<12 items per year) - 50% of cohort		**High user** (12+ items per year) – 50% of cohort	
PPC or single charge? (% uptake)	PPC (15%)	Single charge (85%)	PPC (73%)	Single charge (27%)
Mean usage per year	5	5	57	14
Average cost per year	£108.10	£46.75	£108.10	£130.90

36. The overall assumed mean number of prescriptions used by people age 60-65 who would have to pay for prescriptions is 25 items per year. It is assumed that high users make up half the cohort and would use 57 items per year when using a PPC, based on a 73% uptake rate, or 14 items per year when paying the single charge. For low users, PPC uptake is assumed to be 15% and mean use would be 5 items per year for those purchasing a PPC or paying the single charge.

Distributional effects of the policy change

37. This section highlights the different effects that this charge could have for different people across the income distribution. Those on low incomes who don't qualify for an exemption based on the receipt of income-related benefits or due to a medical condition may struggle to pay the full cost of prescriptions and therefore may miss or reduce some of their medicine dose leading to adverse health effects.

38. The age group of interest is a particularly diverse group because there is a mix of people still economically active (60%), some people are retired and receiving private pensions (20%) and there are some people who are not working because they are sick/disabled (12%), while some are not working due to caring responsibilities (4%). The table below shows the economic activity of this cohort along with the cohort below and above 60-65-year olds;

Table 2 Employment among older working-age population in the UK, April-June 2020

Economic status		% population	
	55-59	**60-64**	**65-69**
Employed	74.3	56.4	24.2
Unemployed	2.5	2.9	1.8
Retired	6.5	20.4	63.5
Sick or disabled	9.9	11.7	6.7
Looking after home/family	3.2	3.9	1.7
Other	4.3	5.9	3.4

Source: DWP Economic labour market status of individuals aged 50 and over: trends over time, September 2020

39. The ages of interest could be described as a middle ground between work and retirement for many people. From Table 2, approximately 60% of the cohort are still economically active while a further 20% are retired. Among these groups there will be some high-income earners and people with private earning pensions who will have little difficulty paying for prescriptions. However, there will also be people on low incomes or working part-time who may struggle to pay for all their prescriptions. Among those not working due to being disabled or looking after family there will also be people who have a low income and do not qualify for another exemption related to a medical condition.

Table 3 Receipt of pension and income-related benefits among households with highest income member in the UK older working-age population

	% households by age of highest income member[1]		
	55-59	**60-64**	**65-69**
Receipt of State Pension	3	12	97
Receipt of income-related benefits:			
Universal Credit	2	2	-
Income Support	2	2	-
Job Seeker's Allowance	1	2	-
Employment and Support Allowance	10	10	1
Pension Credit	-	1	13
Working Tax Credit	3	1	-
Child Tax Credit	3	1	-

Source: DWP Family Resources Survey 2018/19

The data for 'Receipt of State Pension' is at the household level, so for people aged 60-64 who are receiving the state pension, this will because their partner is above the state pension age and thus receiving the state pension

40. Table 3 shows a mixed pattern of benefits receipt among households in these older working-age groups. This data is from 2018/19 and therefore receipt of Universal Credit is lower than in subsequent years. We would expect for more recent data that many of the other benefits would be converted to Universal Credit.
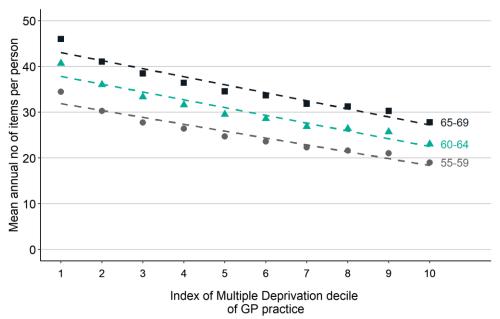
Table 4 Income distribution in the UK older working-age population

	Bottom quintile	**Second quintile**	**Middle quintile**	**Fourth quintile**	**Top quintile**
Median weekly equivalised household income (all UK households):					
before housing costs	£256	£392	£514	£685	£1,035
after housing costs	£176	£319	£447	£607	£940
% of UK older working-age population (aged 55 years +) in each quintile group:					
before housing costs	23%	16%	18%	21%	23%
after housing costs	21%	15%	18%	20%	25%

Source: DWP Households Below Average Income 2018/19, Working-age adults

41. Table 4 shows the income distribution for older working-age population. Older working-age people are slightly over-represented in both the bottom and the top income quintile, the degree depending on how income is measured: older people are more likely to have lower housing costs and live in smaller households resulting in higher relative incomes after deducting housing costs and adjusting for household size through equivalisation.

42. As mentioned, we expect those to be most severely affected by prescription charges to be those in the bottom income quintile who do not qualify for another exemption. The ability to pay for prescriptions will then improve as you move up the income distribution.
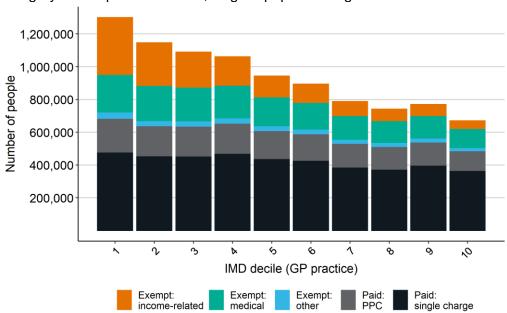
Figure 1 Mean annual number of prescription items used per person by deprivation decile of GP

Sources: NHS BSA ePACT2 2019/20 linked to English Index of Multiple Deprivation by Practice Postcode http://imd-by-postcode.opendatacommunities.org/imd/2019

43. Figure 1 shows that average prescription use is higher among older working-age people living in more deprived areas. Using the Index of Multiple Deprivation (IMD) rank of the GP that a person is registered to as a proxy for a person's socioeconomic status, Figure 1 shows that mean annual prescription use was just over 40 items per year among people aged 60-64 in the decile with the highest deprivation, compared to just under 25 items per year in the least deprived decile.

Figure 2 Number of individuals[1] collecting a prescription in 2019/20 by exemption category and deprivation decile, English population aged 55-59

44. Figure 2 shows the distribution of prescription charge exemptions among people using prescriptions in the 55-59 age group by the IMD decile of their GP. It shows that the number of people using a PPC is similar across the income distribution and that the number of people with a medical exemption is higher at the bottom of the income distribution, consistent with evidence showing that people on lower incomes are more likely to have more health problems.

45. As mentioned, we expect those to be most severely affected by prescription charges to be those in the bottom income quintile who do not qualify for another exemption. Data in this section has shown that people towards the bottom of the income distribution use more prescriptions and therefore will be disproportionately affected by this policy change. The ability to pay for prescriptions will then improve as you move up the income distribution. The potential consequences (both health and cost) for lower-income users are explored in the next section.

Deterrent effects of prescription charge

46. As explained in the previous section, some people towards the lower end of the income distribution may struggle to afford all their prescriptions. This can lead to less than 100% medicine adherence, which can result in future health problems for the individual and a subsequent cost to the NHS. This section uses three examples of long-term conditions where non-adherence can lead to detrimental health impacts and subsequent costs for the healthcare system. This gives an idea of the scale of some of the costs that less than 100% medicine adherence can have. It then reviews evidence from a range of sources to assess the proportion of people with long-term conditions in the 60-65 age cohort who could face difficulties paying and be deterred from collecting all of their prescriptions.

47. While some long-term conditions (e.g. insulin-controlled diabetes) are covered under medical exemptions and therefore qualify for free prescriptions, there are some that are not. In this analysis we look at the negative health impacts that not taking medicine can have in three conditions; inflammatory bowel disease (IBD), Parkinson's

Disease and asthma. We review research that has been done by the York Health Economics Consortium (YHEC)[4] and Asthma UK[5].

Parkinson's disease and IBD

48. The YHEC was commissioned to carry out research by the Prescription Charges Coalition to quantify the extent of non-compliance with prescribed medication in Parkinson's and IBD patients, and the effect on health outcomes and health care use. The economic modelling in this study uses a cost-consequence approach, comparing the incremental costs of extending free prescriptions to sufferers of the disease compared with estimated incremental benefits of 100% adherence to medicine use. The study focuses on a subset of patients whose adherence may be affected by low incomes.

49. Based on the Prescription Charges Coalition 2017 survey[6], they estimate that for Parkinson's, 77% of patients purchase a PPC, and for IBD 53% of patients purchase a PPC. For both diseases, 10% of PPC users are estimated to be less than 100% adherent to medicine use and approximately 40% of patients who pay via the single charge are estimated to be less than 100% adherent. They used international evidence to estimate the likely impact of non-adherence on health and subsequent healthcare use in these conditions. Combined with NHS reference costs, they estimate that providing free prescriptions could result in net discounted cost savings to the NHS of £627 per person for Parkinson's disease[7] and £3,061 for IBD[8].

Asthma

50. The study from Asthma UK has some useful findings for how asthma patients of working age in the UK pay for their prescriptions and how the ability to pay for medicines varies for different income groups of the population. Of the 2.34 million people with asthma in England, 52% are paying for their prescriptions.

51. The Asthma UK study asked over 9,000 asthma patients about their ability to pay for medication, of whom 84% were regularly paying for their prescriptions. The study does not report PPC use or its effect on adherence. Some of the key findings were:

- 57% of all respondents who paid prescription charges felt that they had to reduce their asthma medication because of the cost

- 70% (1,185/1,681) of those on low incomes (earning £20,000 or less per year) admitted to skipping their medication at some point in time because of the cost

- 24% (1,025/4,259) of people reported having had an asthma attack as a result of skipping their medication, with 13% (561/4,259) of people requiring hospital treatment

Scale of potential deterrent effects in the 60-65 age group

52. Data from the ONS Annual Population Survey[9] for 2019 shows that 52% of people aged 60-64 suffer from at least one long-term condition. Data on people with long term conditions is used to monetise the deterrent effect as they are the most likely to face subsequent health problems as a result of not adhering to all prescribed

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[4] http://www.prescriptionchargescoalition.org.uk/uploads/1/2/7/5/12754304/economic_evaluation_report.pdf

[5] https://www.asthma.org.uk/globalassets/get-involved/external-affairs-campaigns/publications/auk-prescription-charges-report-final.pdf

[6] http://www.prescriptionchargescoalition.org.uk/uploads/1/2/7/5/12754304/still_paying_the_price_june_2017.pdf

[7] The time horizon of the model for Parkinson's was 8 years, which is the time it will take the average patient (52 years-old) to reach the free exemption age of 60.

[8] The time horizon of the model for IBD was 26 years, which is the time it will take the average patient (34 years-old) to reach the free exemption age of 60.

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/adhocs/11478peoplewithlongtermhealthconditionsukjanuarytodecember2019

medication. We do not account for any non-regular prescriptions that are missed due to the cost since these are likely to be less frequent with fewer health consequences.

53. Ten long-term conditions provide entitlement to a medical exemption. The proportion of prescription users with a medical exemption increases with age, reaching 25% in the 55-59 age group (Table 5). Extrapolating to the 60-65 age group suggests that 29% could be entitled to a medical exemption leaving around 20% in this age group with a long-term condition who may not be entitled, although some people in this group on low incomes may be entitled to an income-related exemption.

54. Based on a definition of a low income as 60% of median income, just over a fifth of people in the 60-65 age group could fall into this group, roughly matched by the number claiming an income-related exemption for at least one of their prescriptions over the course of a year. However, people's exemptions and entitlements may vary over the year and some people may face charges for some of their prescriptions; also note that percentages cannot be summed across exemption categories for this reason.

55. This evidence is indicative, and it is hard to determine the number likely to be faced by problems paying for their prescriptions. It is also possible that deterrent effects extend beyond people who face problems paying; the existence of a charge may deter some people from taking prescribed medications that they don't perceive as essential, particularly preventative medications such as aspirin, statins and bisphosphonates. In addition, some people may choose to buy alternatives that are available over the counter. Given these uncertainties, we carried out a sensitivity analysis using a range of assumptions about the % of people deterred and the size of health (QALY) impacts linked to non-adherence.

Table 5 Estimated % of people who could face difficulties paying for prescriptions due to high costs linked to multimorbidity and/or a low income

Age group	No. of people using prescriptions[1]	% with at least one long-term condition[2]	% with a medical exemption[3]	% with a low income[4]	% with income-related exemption at least once during year
25-29	2.34m		7%		28%
		~24%		~20%	
30-34	2.48m		9%		32%
35-39	2.49m		12%		33%
		~27%		~20%	
40-44	2.40m		14%		33%
45-49	2.78m		17%		30%
		~36%		~20%	
50-54	3.13m		21%		26%
55-59	3.15m		25%		22%
		~52%		~23%	
60-65	**3.54m**		**~29%**		**~22%**

1 NHS BSA ePACT2 data, 2019/20.

2 Percentage of people who have a long-term health condition (12 months or more) by age group. ONS Annual Population Survey 2019.

3 The proportion of 60-65-year olds who would be entitled a medical exemption is estimated by extrapolating linearly upwards from rates observed for younger groups.

4 Household income below 60% of median. DWP Households Below Average Income 2018/19, Working-age adults.

56. The central scenario is that 15% of prescription users are at risk of being deterred. This is the estimated number of people who have a long-term condition but do not qualify for an exemption. Based on information from Table 5, 52% of the 60-65-year-

old cohort have a long-term condition and 29% qualify for a medical exemption. The difference is 23% but this is likely to be an overestimate of numbers at risk as some people with a long-term condition will also qualify for an income-related exemption. Therefore, 15% was used to account for this overlap; in the sensitivity analysis we allow this to range from 10% to 20%.

57. To calculate how many prescriptions will be missed as a result of the cost, we estimated the proportion of prescriptions that will not be collected by the at-risk group. We use the estimate of 40% from the YHEC study based on a survey done by the Prescription Charges Coalition. This may be an overestimate and subject to bias as discussed in paragraph 62 below. We vary this in the sensitivity analysis by including a high and low scenario of this figure of 50% and 20% respectively.

58. We expressed the health and associated costs of non-adherence to prescribed medications in terms of the number of QALYs that could be lost as a result. There is limited evidence on the cost effectiveness of prescribed medications, so it was assumed to be £15,000, in line with the estimated cost effectiveness of NHS care overall. We allowed this to vary from £8,000 (more cost-effective than other NHS spending) to £22,000 (less cost-effective than other NHS spending). Note that the average cost to the NHS of each prescription, that is the standard Net Ingredient Cost of prescriptions dispensed in the community, was used in this calculation.

59. To summarise, in the at-risk group, we assume that 40% of prescriptions will not be collected. We then monetise the health loss (QALYs) associated with uncollected prescriptions using an estimate of cost effectiveness of prescriptions in the NHS and their Net Ingredient Cost. Therefore, the monetised deterrent effect has two parts; the monetised loss of health from prescriptions not taken and a financial saving to patients/ loss of revenue to the NHS as a result of the single charge not being paid. The steady state of the deterrent effect (after 2025/26) is that there will be a monetised QALY loss of approximately £30 million per year. The results of the deterrent effect are shown in Table A3 in the annex.

60. Table A3 shows the monetised deterrent effect for both Options 2 & 3. For Option 2 the cost in 2022/23 is close to the steady state, the slight increase in the following years is a result of population growth in the 60-65 age cohort and therefore more single charge users. For Option 3 there is a more gradual increase in the cost, this is due to the staggered increase in the number of single charge users as a result of preservation of entitlement. From 2027/28 the cost for both policy options are identical.

61. When monetising the deterrent cost, we focus on single charge users only, this is because people who purchase a PPC are unlikely to be subsequently deterred from taking their medication due to the cost i.e. they have already paid for unlimited prescriptions for the year. There is an important link between the deterrent effect and the PPC uptake rate. In the low PPC uptake scenario there will likely be a stronger deterrent effect as there are more people paying the single charge. This scenario is explored in the sensitivity analysis.

Summary of the deterrent effect

62. It is important to note that the YHEC study draws a considerable amount of its data from a Prescription Charge Coalition survey in 2017. The fact that the survey was advertised by the Prescription Charge Coalition means that it likely attracted people who have struggled to pay prescription charges and is therefore unlikely to be a representative sample of everyone with long-term conditions. Further, PPC uptake is underestimated, likely due to small sample size. It is therefore likely that the results overestimate the scale and costs of non-adherence. The purpose of including these findings is to highlight that for some people with long-term conditions (especially those on lower incomes), prescription costs can have a large effect on their prescription use and on their health.

63. While it is hard to put a precise figure on the scale and impacts of non-adherence among people impacted by the increase in the upper age exemption, it is likely that

the number of people who could be affected, that is, the number of people who have a long-term condition who are not covered by a medical or income-related exemption, is approximately 15% of prescription users. Even if the proportion of prescription users who are at high risk of being deterred is as high as 20%, the estimated health cost to individuals would not be large relative to the overall health benefits of NHS spending from revenue generated from the charges. Therefore, this deterrent effect is unlikely to significantly affect the overall net benefit of the policy change, although it could have a significant negative effect on the health of a small proportion of prescription users.

Implications for health inequalities

64. We have highlighted in the previous two sections that the deterrent effect is likely to impact people on lower incomes who do not qualify for another exemption. These people are likely to have higher medicine use and a lower ability to pay for all their prescriptions. The resulting deterrent effect of prescription charges can have serious negative impacts on the health of these people.

65. In the context of all 60-65-year olds, 15% of prescription users are at risk of being deterred, approximately half of whom would be likely to buy a PPC. Consequently, only 7% of the population are likely to be deterred, with on average an assumed 40% of prescriptions not being collected for these people (likely an over-estimate). Although for this small group of people there could be an adverse effect on health, the effect when set in the context of the population cohort will be small, and the consequent impact on inequalities.

66. Partially offsetting this small negative impact on health inequalities as a result of the deterrent effect, the increase in funding to the NHS could help to reduce health inequalities.

Administrative costs of the policy change

67. This section outlines the main administrative costs of the policy change. This includes costs of changing the prescription form itself and any resultant changes to the process of collecting payments from prescription charges. It is assumed that the administrative costs will be the same for both policy options, both options would require significant changes to the prescription charge collection system and a significant communication plan. Table 6 below outlines the main additional administrative costs that NHS BSA have estimated they will face over the time horizon of the analysis.

Table 6 Summary of the additional administration costs NHS BSA will face as a result of the policy change[1]

Description of the cost	When will it occur	Cost
Prescription exemption checking service- large change to the whole process, more exemption checking, filtering changes, more work around on-line applications and letters. Unlikely to be existing capacity in the team.	First 12 months	£1.3m
Help with healthcare costs- Changes needed in the following areas; PPC internal systems, eligibility checker, Scanning software, MEDEX, PPC on-line.	First 12 months	£3m
Applications for health costs are likely to impact other work areas and have implications for capacity and staffing costs. Contact centre likely to deal with more contacts and complaints	Every year	£1m

Communications campaign- any video, audio, out of home and digital/ social media content that will need to be paid for.	First 12 months	£1.1m
Real Time Exemption Checking- Significant system update would be needed for this service, this cost would only occur in the first year.	First 12 months	£500k
Cost of disposing of obsolete stock of old prescription forms	First 12 months	£500k
Total transitional costs (year 1)		**£6.4m**
Ongoing annual costs		**£1m**

1 Information was provided by NHS BSA specifically for this impact analysis.

68. The prescription exemption checking service is likely to face higher demand for their services as a result of more people being eligible to pay for prescriptions. Additional capacity will be needed in this team for dealing with online applications and sending letters to patients. There could also be more exemption checking which will bare an additional cost to their team that current capacity is unlikely to be able to meet. BSA estimated that most of this cost would occur in the first 12-months but there could be some smaller yearly running costs for this service.

69. 'Help with healthcare costs' includes the cost of changes to the prescription form and then changing the software of scanners so they are able to read the new form. Also included in this is the cost of updating the online platform where patients can buy a PPC and any changes to the PPC internal system that will be needed. These costs will occur in the first 12-months of the policy change only.

70. The next cost is related to staffing costs. There will be approximately 1.25 million additional people claiming either a medical or income related exemption as a result of the policy change. Administering these more complex exemptions will require additional capacity across many areas of NHS BSA, compared to the existing age exemption, including processing more income and medical related exemptions and dealing with a higher number of contacts to the BSA customer services centre. Exemption checking and penalty charge services are unlikely to be affected since these are based on checking a fixed sample of prescription forms. NHS BSA have estimated that these additional staffing costs will total around £1m and will occur every year.

71. For both options there will need to be a significant communication campaign to ensure that prescription users are aware of the changes being implemented. This campaign will have a direct impact on the other costs described in this section. A poor communication campaign could lead to confusion among some users who are unaware they now have to pay. This will result in higher costs for the prescription exemption checking service and more complaints for the customer services team. This could also reduce PPC uptake due to a lack of awareness and therefore can have direct impacts on the distribution and deterrent effects. This cost will occur mainly in the first 12-months and BSA have estimated it will total £1.1m.

72. For both policy options there will be a cost of having to destroy obsolete stock of prescription forms. NHS BSA have estimated this cost to be £500,000 although they argue this could be reduced significantly if they were given sufficient notice of the policy change to allow them to decrease old stock orders. Because of the short timeline of this policy change it is unlikely that this cost will be driven down by much. Therefore, we have used the £500,000 estimate of this cost.

73. Significant changes would be needed for the system that checks the validity of prescription exemptions. This system update would occur in the first 12-months; there would be no extra yearly costs for this system as all prescriptions are put through RTEC whether the patient pays or not, so the overall volume should stay the same. BSA estimate that this will cost £500,000 in the first year.

74. There would be a small additional workload for pharmacies associated with collecting payments and signatures for prescriptions from people previously covered by the upper age exemption and additional processing activities around submission of claims for reimbursement by NHSBSA. Based on our central scenario, we estimate that pharmacies could need to collect and process around seven million additional single charges each year: this is based on our estimate that just over one million people aged 60-65 would pay per item, with each paying around 7 single charges per year.

75. This should be set in the context of over 50 million single charges already collected and processed by pharmacies each year, meaning that the additional workload would represent a less than 15% increase in payment collection. Higher rates of PPC take-up would reduce the volume of single charges and reduce this workload. The expectation is that the policy change would not affect the overall volume of dispensing, although any deterrent effects would reduce the workload. Consequently, it is expected that the small amount of additional activity would not require changes to the Community Pharmacy Contractual Framework (CPCF) and would not result in additional costs to the NHS.

The costs and benefits of each option

Overview of costs and benefits

76. Option 2 increases the upper exemption age immediately to 66. Option 3 increases the exemption age to 66 but with preservation of entitlement and therefore people who have already turned 60 by the time the policy is introduced will continue to be exempt. The same impacts are identified for each option, but the scale of these impacts differs between them. Not all the costs are fully monetised due to the lack of available data.

Benefits
- Additional revenue raised for the NHS from prescription charges

Costs
- A cost to patients of buying prescriptions when they were previously exempt
- Administration costs of the policy change, these include the costs of changing the form and the cost of additional communication budgets for the policy change
- The difference in the scale of the costs for people across the income distribution

- The deterrent effect of prescription charges

77. Additional revenue raised from prescription charges are assumed to be reinvested in NHS services. We estimate the NHS provides one additional QALY for every additional £15,000 of spending[10]. The social value of these QALYs is monetised using a value of £60,000 per QALY, based on standard DHSC valuation methods.[11] The monetised health cost and benefits are discounted at a rate of 1.5%, as is standard for DHSC analysis, all other future costs and benefits are discounted at the usual 3.5%.

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[10] The QALY is a standard unit used to measure health gains that combines impacts on longevity and health-related quality-of-life. The DHSC estimate of the cost at which an additional QALY is gained or lost in the NHS is £15,000. This figure is based on a published estimate of the cost per QALY at the margin in the NHS, https://www.york.ac.uk/che/research/teehta/thresholds/.

[11] https://www.gov.uk/government/publications/quantifying-health-impacts-of-government-policy.

Option 2: Immediate switch to upper exemption age of 66

78. Option 2 would immediately increase the exemption age for prescriptions from 60 to 66, thus all 60-65-year olds would have to pay for prescriptions (unless they are covered by another exemption). The additional average revenue raised from prescription charges would be **£226 million per year**, this is equal to the annual financial cost of purchasing prescriptions that is transferred from patients to the NHS.

79. The net monetised and discounted benefits over 10 years are valued at approximately **£6.22 billion.** The costs and benefits are described and summarised in Table 7.

Option 2 benefits

80. The estimated additional prescription charge revenue from increasing the upper exemption age for prescriptions is **£2.26 billion** over the ten-year appraisal period (undiscounted total). It is assumed that these savings are reinvested into other NHS services, where they generate health gains (151,000 QALYs). When monetised at a rate of £60,000 per QALY, and discounted at a rate of 1.5% per year, these additional health gains are valued at **£8.45 billion**.

Option 2 costs

81. For patients, the estimated additional cost of now having to purchase prescriptions are **£2.26 billion** over 10 years, and these are discounted at a rate of 3.5% per year to give a total of **£1.94 billion.**

82. For the NHS, there would be additional administration costs of **£15 million** over 10 years, these are discounted at a rate of 3.5% per year to give a total of **£14 million.** These include the cost of changing the prescription form, the additional cost of communication of the policy and the cost of throwing away obsolete stock.

83. The deterrent effect monetises the health costs to the patient and the associated costs to the NHS of treating conditions as a result of non-complete medicine adherence due to the increase in the upper age exemption. The deterrent effect for Option 2 is **£297m** over 10 years, and these are discounted at a rate of 1.5% per year to give a total of **£277m**.

Option 3: Increasing the upper age exemption to 66 with preservation of entitlement

84. Option 3 would also increase the exemption age to 66 but with preservation of entitlement and therefore anyone between the ages of 60-65 will continue to receive free prescriptions. This means that the revenue raised will be smaller compared to option 2. This will only be up until 2027/28, after which the costs and benefits for both policy options will be identical. The additional average revenue raised from prescription charges would be **£174 million per year**, this is equal to the annual financial cost of purchasing prescriptions that is transferred from patients to the NHS.

85. The net monetised and discounted benefits over 10 years are valued at approximately **£4.75 billion.** The costs and benefits are described and summarised in Table 7.

Option 3 benefits

86. The estimated additional prescription charge revenue from increasing the upper exemption age for prescriptions is **£1.74 billion** over the ten-year appraisal period (undiscounted total). It is assumed that these savings are reinvested into other NHS services, where they generate health gains (116,000 QALYs). When monetised at a rate of £60,000 per QALY, and discounted at a rate of 1.5% per year, these additional health gains are valued at **£6.41 billion**.

Option 3 costs

87. For patients, the estimated additional cost of now having to purchase prescriptions are **£1.74 billion** over 10 years, and these are discounted at a rate of 3.5% per year to give a total of **£1.44 billion.**

88. For the NHS, there would be additional administration costs of **£15 million** over 10 years, these are discounted at a rate of 3.5% per year to give a total of **£14 million.** These include the cost of changing the prescription form, the additional cost of communication of the policy and the cost of throwing away obsolete stock.

89. The deterrent effect monetises the cost to the patient (through a loss of health) and the cost to the NHS of treating conditions as a result non-complete medicine adherence due to the increase in the upper age exemption. The deterrent effect for option 3 is **£228m** over 10 years, and these are discounted at a rate of 1.5% per year to give a total of **£210m**.

Table 7 Estimated costs and benefits of each policy option relative to option 1 (no change to regulations, "business as usual" option) over 10-year appraisal period

£ millions, QALYs

Costs and benefits of policy	Option 2 – immediate change to exemption age	Option 3 – preservation of entitlement
Net benefits of policy (net present value)	**£6,220**	**£4,750**
Benefits (net present value of discounted monetised health benefits of extra NHS revenue)	£8,450	£6,410
Additional revenue raised over 10 years (discounted)	£1,940	£1,440
Health benefit to patients (QALYs)	151,000 QALYs	116,000 QALYs
Monetised value of health benefits (discounted)	£8,450	£6,410
Costs (net present value of discounted financial and monetised health costs from the policy change)	£2,230	£1,670
Discounted costs to patients of prescription charges	£1,940	£1,440
Administration costs (discounted)	£14	£14
Health loss due to deterrent effect (QALYs)	5,000 QALYs	4,000 QALYs
Monetised health cost of deterrent effect (discounted)	£277	£210

Figures are not discounted unless stated. Additional income for the NHS is assumed to produce health benefits at a rate of £15,000 per Quality Adjusted Life Year (QALY). In turn, QALYs are assumed to have a societal value of £60,000 per QALY. Monetised health benefits are discounted at a public health discount rate of 1.5% per year. All other monetised costs and benefits are discounted at 3.5%.

Assumptions, sensitivities and risks

90. Different population growth forecasts were tested as part of the sensitivity analysis and had limited effect on the revenue and associated impacts of the policy change (+/- £2m per year compared to the central scenario).

91. A sensitivity analysis was carried out to assess the impact of different rates of PPC uptake. The PPC is the key means through which Government caps prescription costs for high users of medicines who are not protected by an exemption. PPC uptake depends on awareness of the PPC and some people on low incomes could be deterred because of the cost or uncertainty about how much medication they will need over the coming year. There has been a clear trend in recent years of increasing use of PPCs by prescription users, this is likely a result of more people being made aware of PPCs from pharmacists/ GPs and a communication scheme from NHS BSA to increase their usage.

92. We expect this communication scheme to continue (and likely increase) and therefore we have modelled four different PPC uptake scenarios describing the response; 60%, 73%, 80% and 85%. The 60% option was introduced to represent the possibility of lower PPC uptake if there is confusion about eligibility immediately after the policy change. In this scenario, many people who were previously exempt from prescriptions who now have to pay may be unaware of PPCs leading to a drop in their use. However, we believe that it is very unlikely that PPC uptake will drop to 60% over the 10-year horizon period.

93. Table 8 outlines the effect on total discounted net benefits of the policy under the different PPC uptake scenarios. A low PPC uptake of 60% will increase the revenue raised from prescriptions and increase the cost to patients. This is because under a lower PPC uptake scenario, there are more high users paying for prescriptions with the less efficient single charge. This will result in a higher cost for some high users and subsequently more prescription charge revenue for the NHS. On the other hand, a high PPC uptake scenario would decrease total revenue and decrease the cost for patients. More people are paying with a more cost-effective method and therefore this will provide savings for more high users.

94. The estimated net benefits of the policy were sensitive to a range of PPC uptake scenarios. Comparing the lowest PPC uptake scenario to the highest, this would result in a difference of **£590 million** over 10 years for option 2 and **£450 million** over 10 years for option 3.

95. NHS BSA provided an estimate for cost of the communication policy for PPCs that will support this policy. We believe that ensuring that PPC uptake is as high as possible is necessary to minimise the distribution and deterrent effects of the policy. High users on low incomes that are not covered by another exemption are the users that are most likely to be deterred from taking prescriptions as a result of the cost. High users that were previously exempt need to be made aware of PPCs to minimise the risk of the deterrent effect.

Table 8 Impact of alternative assumptions on estimated policy impacts

		£ millions
Alternative assumption	Option 2 NPV	Option 3 NPV
PPC uptake among high users of medicines		
60% uptake	£6,610	£5,040
73% uptake (Central Scenario)	£6,220	£4,750
80% uptake	£6,090	£4,650
85% uptake	£6,020	£4,590

96. Next, sensitivity analysis was carried out to assess the impacts of different rates of people being deterred by the charge from collecting all their prescriptions. Due to the lack of available data and the limited evidence on the likely scale and impacts of non-adherence, a range of scenarios were explored. The overall deterrent cost consists of two parts; the monetised value of the QALYs lost as a result of prescriptions not being taken and the financial savings to patients/loss of revenue for the NHS due to prescriptions not collected. For option 2, the central scenario is a monetised QALY loss of £277m (discounted) over 10 years and a financial saving/loss of NHS revenue of £87m (undiscounted). For option 3, the central scenario is a monetised QALY loss of £210m (discounted) over 10 years and a financial saving to patients/loss of revenue of £67m (undiscounted). Tables 9 and 10 show the results of the sensitivity analysis for the deterrent effect.

Table 9 Sensitivity analysis of the deterrent effect for Option 2

£ millions

Variable (input range)	Monetised discounted QALY loss over 10 years (low scenario)	Monetised discounted QALY loss over 10 years (high scenario)
% of single charge users deterred (10% to 20%)	£185	£370
Prescription QALY effectiveness (£8,000 to £22,000)	£189	£520
PPC uptake (85% and 60%)	£264	£329
% of prescriptions not collected (20% to 50%)	£137	£347

Table 10 Sensitivity analysis of the deterrent effect for Option 3

£ millions

Variable that changes	Monetised discounted QALY loss over 10 years (low scenario)	Monetised discounted QALY loss over 10 years (high scenario)
% of single charge users deterred	£140	£280
Prescription QALY effectiveness	£143	£394
PPC uptake	£200	£250
% of prescriptions not collected	£105	£263

97. In this analysis we allow one of the key variables from the deterrent calculation to change while holding the others constant. The first variable that is changed is the percentage of single charge users that are deemed at high risk of being deterred. In the central scenarios this is 15%, but this is changed to 10% and 20% in this analysis. The deterrent cost is fairly robust for both options 2 and 3 when this variable is allowed to change. For option 2 the total discounted cost moves approximately £185 million up and down for the high and low scenarios respectively. For option 3 we see a £140 million move of the cost in either direction.

98. There is a similar movement in the cost for the other inputs that are allowed to change. The largest increase in the cost is when there is a higher cost effectiveness of prescriptions. This assumes that £22,000 worth of prescriptions would generate an additional QALY compared to £15,000 in the central scenario and therefore there is a bigger QALY loss as a result of prescriptions not being collected due to the cost. The largest decrease in the cost is when the percentage of prescriptions not collected by those at high risk is 20% compared to 40% in the steady state.

99. Although there is considerable movement in the deterrent cost when some of the inputs are changed (the cost roughly halves when the percentage of prescriptions not collected by those at high risk drops to 20%), it is important to consider this cost in relation to the benefits and the overall NPV of the policy change. These relatively large movements have a very small impact on the overall NPV and do not strongly influence the overall narrative of the policy change.

100.   While individual movements of the inputs of the deterrent cost have little impact on the overall NPV of the policy, it is important to consider an extreme scenario where the individual high scenarios of the deterrent inputs occur in tandem. This means that the percentage of prescription users at risk of being deterred is 20%, the effectiveness of prescriptions in reducing QALYs is £22,000, there is a low PPC uptake (60%) and the percentage of medication not taken by those deterred is 50%. The results of this scenario are presented in Table 11 below.

Table 11 Extreme scenario for deterrent effect inputs

£ millions

Policy option	Average deterrent QALY loss per year (extreme scenario)	Total discounted deterrent QALY loss over 10 years
Option 2	£110	£1,030
Option 3	£85	£781

101. The deterrent effect is roughly 4 times larger compared to the central scenario. Even in this scenario, the annual monetised deterrent effect is less than 15% of the average annual benefits for both policy options (£853m and £684m for Options 2 and 3 respectively). Therefore, the overall impact on the NPV is still relatively small.

102. Although the NPV will not significantly change in the extreme scenario it is important to note that in this scenario the distribution effects of the policy will be larger and there will be a greater effect on health inequalities. There would be significantly more people at risk of being deterred and these people will likely be those on low incomes who do not qualify for another exemption.

Annex – Additional tables

Table A1 Benefits of increasing the upper age exemption threshold for prescriptions compared to option 1 ("business as usual" option)

£ millions, QALYs

	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
Option 2 – Immediate switch to 66										
NHS: Additional revenue raised from prescriptions	209	215	220	225	229	232	233	233	232	232
- health benefits generated (no. of QALYs)	14,000	14,000	15,000	15,000	15,000	15,000	16,000	16,000	15,000	15,000
- monetised value of health benefits	835	858	881	901	918	928	933	933	929	926
Option 3 – Switch to 66 with preservation of entitlement										
NHS: Additional revenue raised from prescriptions	38	76	116	155	194	232	233	233	232	232
- health benefits generated (no. of QALYs)	3,000	5,000	8,000	10,000	13,000	15,000	16,000	16,000	15,000	15,000
- monetised value of health benefits	152	306	462	619	774	928	933	933	929	926

Table A2 Costs of increasing the upper age exemption threshold for prescriptions compared to option 1 ("business as usual" option)

£ millions, QALYs

	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
Option 2 – Immediate switch to 66										
Patients: cost of paying for prescriptions	209	215	220	225	229	232	233	233	232	232
NHS: Admin costs to NHS	6	1	1	1	1	1	1	1	1	1
Cost of the deterrent effect	27	28	29	30	30	30	31	31	30	30
Option 3 – Switch to 66 with preservation of entitlement										
Patients: cost of paying for prescriptions	38	76	116	155	194	232	233	233	232	232
NHS: Admin costs to NHS	6	1	1	1	1	1	1	1	1	1
Cost of the deterrent effect	5	10	15	20	25	30	31	31	30	30

Table A3 Summary of the deterrent effect from the policy change   £, millions

Description of impact	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
Option 2										
Monetised value of QALYs lost	27	28	29	30	30	30	31	31	30	30
NHS revenue lost / financial savings to patients	-8	-8	-8	-9	-9	-9	-9	-9	-9	-9
Option 3										
Monetised value of QALYs lost	5	10	15	20	25	30	31	31	30	30
NHS revenue lost / financial savings to patients	-1	-3	-4	-6	-7	-9	-9	-9	-9	-9

Figure 3- The back of the FP10 prescription form

When should I pay?

You must pay if none of the statements apply to you on the day you were asked to pay. These are the only accepted reasons for not paying.

I'm not sure if I should pay

Pay and ask for a prescription refund form (FP57). You can't get one later. If you find you didn't need to pay, you can claim a refund up to 3 months later.

What if I don't pay when I should?

We check claims made for free prescriptions. If we can't confirm that you are entitled to exemption from prescription charges, you may be issued a Penalty Charge Notice and you may have to pay up to £100 as well as your prescription charge(s), and you could be prosecuted.

Can I get help to pay?

Help with costs may be available. You could also save money by buying a prescription prepayment certificate.

Check at www.nhsbsa.nhs.uk/check

Is my exemption certificate still valid?

Visit www.nhsbsa.nhs.uk/exemption to see what help is available or ask at your GP surgery or pharmacy.

I am unable to collect my prescription

If you are unable to collect your prescription someone can do so on your behalf. Your representative should complete the 'If you paid' box and sign the form, or you or your representative should complete the 'If you didn't pay' box, and your representative should sign the form. Your representative will need to put a cross in the 'on behalf of patient' box next to their signature.

Why did the pharmacy ask to see evidence?

We need to check your exemption is valid.

The NHS Business Services Authority is responsible for this service. We will use your information to check your exemption is valid, pay the dispenser and help plan and improve NHS services. Find out more at www.nhsbsa.nhs.uk/yourinformation

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If you paid — Enter amount paid and sign below £ [ ][ ][ ] . [ ][ ]

If you didn't pay — Mark a line in one box and sign below

A [ ] is 60 years of age or over or is under 16 years of age (unless your date of birth is printed on the form)

B [ ] is 16, 17 or 18 and in full time education

D [ ] Maternity exemption certificate

E [ ] Medical exemption certificate

F [ ] Prescription prepayment certificate

G [ ] Prescription exemption certificate issued by Ministry of Defence

L [ ] HC2 (full help) certificate

H [ ] Income Support or Income-related Employment and Support Allowance

K [ ] Income-based Jobseeker's Allowance

M [ ] Tax Credit exemption certificate

S [ ] Pension Credit Guarantee Credit (including partners)

U [ ] Universal Credit and meets the criteria. *Find out more at* www.nhsbsa.nhs.uk/UC

Read the declaration and sign the form

The information I have given is correct and complete and I confirm proper entitlement to exemption.

⓵ **I understand that if I falsely claim, I may be issued a Penalty Charge Notice, and I may have to pay up to £100 - as well as my prescription charge(s).**

I understand the NHS Business Services Authority may use and share my information within the NHS and with relevant Government bodies to check for fraud and mistakes. Find out more at: www.nhsbsa.nhs.uk/yourinformation

Signature	Date	On behalf of patient
		[X]

SIGNATURE OF COLLECTOR OF SCHEDULE 2 & 3 CDs [ ]   PHARMACY USE ONLY EVIDENCE NOT SEEN [X]