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Prescription Charges in Northern Ireland:

A cost and benefit review.

December 2007

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EXECUTIVE SUMMARY

Introduction

On 15 May 2007, there was a debate in the Northern Ireland Assembly entitled Health Prescription Charges. The Assembly motion called upon the Minister of Health, Social Services and Public Safety to establish a cost and benefit review for the purpose of abolishing health service prescription charges as has been carried out in Wales; and to review the list of conditions that currently entitle patients to free prescriptions in order to reduce anomalies². The Assembly debate and correspondence to the Minister regarding the current prescription charges have suggested that prescription charges act as a barrier to individuals accessing the medication that they need.

The purpose of the prescription charge review was to identify options to change the current system of prescription charges and review the current exemption categories in Northern Ireland (NI). A cost and benefit analysis of some of the possible change options, including abolition, within the current system has been undertaken, taking into account developments in the rest of the UK and other countries around the world.

Background

The prescription charge from April 2007 is a flat rate fee of £6.85 per item. This charge has historically been viewed by UK Health Departments as a reasonable amount to be paid, by patients who can afford to do so, for prescribed drugs and appliances. The prescription charge does not directly reflect the cost of the prescribed item or the cost to the NHS of supplying it as many items prescribed are considerably more expensive than the flat rate charge.

Prescription prepayment certificates (PPC) can be purchased and are cost effective when a patient needs more than 5 items in a four month period or more than 14 items in a twelve month period. The prepayment scheme is effectively a means of financial capping on patients' expenditure for prescription items. For patients who

are not entitled to free prescriptions under the exemption categories, but who require frequent prescriptions, the PPC offers a more affordable method of payment for medication at a discounted rate.

Since their introduction in 1968 the exemption categories that confer free prescriptions have remained fundamentally unchanged. The categories of exemption can be grouped as follows:

- Age related
- Income or benefit related.
- Specified medical condition (i.e. holders of a valid medical exemption certificate)
- Maternity certificate
- Contraceptives

Current position in Wales and Scotland

In May 2007 the Scottish National Party manifesto commitment to abolish prescription charges was one of a number of key policy pledges announced by the new devolved administration. On 6 December 2007 the Scottish Health Secretary announced a reduction in prescription charges ahead of their planned abolition in 2011. The cost of a single prescription is to be cut by more than 25% in 2008, from £6.85 to £5, and will be further reduced by £1 in each of the two subsequent years before abolition, whilst the cost of a 1 year pre-payment certificate will be cut over the same timescale, from £98.70 to £48, then down to £38 and finally £28, before they are abolished. The move is similar to developments in Wales where prescription charges were gradually reduced from 2000 and abolished altogether in April 2007.

Benefit criteria

There is some evidence from the UK and elsewhere in the world of the impact of prescription charges on utilisation of medication, however compliance with

medication is complex and cost is only one factor. Evidence does not support a direct link between prescription charges and ill health. The impact of cost on medicines management by individual patients is more likely to affect non-essential medicines although there is some evidence that essential medicines may also be affected. The impact is not equitably distributed across the population and is more likely to affect certain socio-economic groups.

The benefit criteria in **Table 1** have been drawn from the published literature and also take into account the practicalities of administration and the ease of understanding of any changes to the current system. The criteria have been used to assess the range of options identified in the review.

Table 1 Benefit Criteria

Supports Programme for Government policy of reducing inequalities, improving access to healthcare (Investing for Health)
Promotes equal access for all
Reduces the financial barrier for patients to obtain medication which they need
Affordable for patients at the time of need
Improvement in Health
Removes anomalies in current system e.g. medical exemptions, pension age, multiple charges
Easy for public to understand
Contributes to the efficient and effective provision and use of primary care services including medicines
Places value on medication
Minimal impact on healthcare delivery e.g hospital admissions
Practicable to deliver

Options

The options were considered in three broad categories;

- Abolition
- Reform of the current system of prescription charges and exemptions

- Introduction of a new system of prescription charges and exemptions

Option 1	Abolish prescription charges. This could be phased over a defined period similar to the Wales and Scotland approaches
Option 2	Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21)
Option 3	Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21) and introduce top-up payments for premium priced alternatives

The main argument in favour of abolishing prescription charges is that it would remove the financial barrier to access to medicines and indirectly improve health. It would also remove the anomalies arising from the current system of charges and exemptions. The cost of abolition is estimated to result from loss of revenue from charging and higher demand for prescriptions resulting in increased cost of prescribed medicines and additional community pharmacy and GP workload. The cost estimates range from £13.1million to £24 million depending on the level of increased prescribing as a consequence of abolition. Options 2 and 3 describe ways to minimise the impact of removing the financial barrier through restricting the range of drugs and appliances available on health service prescription in NI based on the principles of safety, quality and cost-effectiveness. This could be achieved through an NI drug tariff, however considerable resources would be required to develop and administer a full formulary for NI in a way which is transparent, evidence-based and legally watertight.

Option 4	Maintain the current arrangements
Option 5	Extend exemption from prescription charges to include up to age 25
Option 6	Remove exemption from prescription charges for the 60-64 age group
Option 7	Make Prescription Prepayment Certificates (PPC) available retrospectively on provision of EPES proof of receipt of a qualifying number of prescriptions

Option 8	Enable Prescription Prepayment Certificates to be purchased by monthly instalment
Option 9	Extend the medical exemptions to include patients suffering from a greater range of chronic illnesses

Options 4 to 9 consider the possible changes which could be made to the current arrangements. Many patients, representative groups and professional bodies have called for change to address the anomalies in the current system and to reduce the financial barrier. Options 5 and 6 look at changes to the current age groups for exemption. In order to provide exemption for those up to age 25, the cost is estimated to be from £0.75 million to £1.5 million. This change would benefit young people in education, training and employment and would particularly benefit young couples with children. Increasing the upper age limit from 60 to 65 would bring exemption from prescription charges into line with state pension age. Individuals in this age-group are higher users of medication than average and a large proportion of prescription items would still attract an exemption for another reason. This option is estimated to result in increased revenue from charges of £4.7 million. Options 7 and 8 propose possible changes to the current PPC as a means to providing additional benefit through a monetary cap on the cost of prescriptions for those who require multiple medications. Option 9 looks at the possibility of extending the current list of medical exemptions. This is an appealing proposition to address the current anomalies identified in relation to the inclusion of some illnesses in the list and the exclusion of others. However, there is currently no definition of chronic illness in legislation and it would be complex to develop and maintain a new list that would be fair and inclusive and which would gain the support of the medical profession and patient groups. Extending the list of exemptions on medical grounds is likely to substantially increase the number of prescription items which would be dispensed free of charge. There was support in Scotland for conferring exemption to patients who hold a DS1500 certificate. This certificate is issued by a GP or consultant to a patient who may be suffering from a potentially terminal illness. A similar change in Northern Ireland would be relatively easy to introduce in order to provide benefit for patients and their families at a very distressing time.

These options could be implemented alone or be combined into a package of changes.

Option 10	Introduce a new prescription charge system with a reduced fee (80p) per item and exemptions based on ability to pay and passport benefits only
Option 11	Introduce a new prescription charge system with a reduced fee (80p) per item and exemptions based on ability to pay, passport benefits and age only

Options 10 and 11 propose a new system of charging and exemptions. These options propose a low level of charge in response to concerns that the current charge is too high and acts as a financial barrier to access to medicines. Option 10 describes a system which is based on exemptions which are already defined as passports from Social Security benefits, War Pensions and Maternity certificates. In this option, the majority of prescriptions would attract a charge and with a charge as low as 80p per item, the change is estimated to be cost neutral. If the exemptions were extended to include those aged under 16 and over 65, the additional exemptions are estimated to reduce revenue from prescription charges by £8.7million. The actual level of the charge could be varied in both these options. Despite the low level of the charge, a monetary cap would still be required to minimise the financial burden on those who require multiple medicines.

Implementation

Theoretically, any of the proposed options could be introduced in a phased manner, however this would be administratively difficult for several of the options. The benefit of introducing changes slowly would be to allow time to manage the financial impact, to engage with the public and to develop the necessary infrastructure to support the changes. It will be essential to give due consideration to the need to minimise bureaucracy and maximise efficiency for all parties involved in the future administration of any new systems designed to deliver the chosen option for collection of prescription charges. Also, further information from the abolition of prescription charges in Wales should be available by summer 2008 to enable a more

robust assessment of the likely impact of abolition in Northern Ireland. The data that was available for the cost and benefit analysis was limited. A new system known as the Electronic Prescription and Eligibility System (EPES) is being piloted at present. This system will capture more information about the items prescribed and exemption categories for each prescription. It will provide more comprehensive data which will be valuable in enabling more accurate analysis of the financial consequences of the options.

Conclusions

The review concluded the following;

- It is not possible to determine if the current system of prescription charges directly impacts on health gain.
- There has been a call for change to address anomalies in the current system and to reduce the financial barrier to access to medicines. Feedback from the public engagement conducted for this review suggests that the option of status quo i.e. no change to the current system, will be unpopular with patients and professionals.
- An extended list of medical exemptions has been proposed. It will be difficult to achieve a new list that is comprehensive, consistently up to date, equitable and legally defensible. It would be simpler and more effective to provide benefits for patients who have multiple medication needs through administration of a monetary cap on an annual or monthly basis or via abolition.
- Extension of exemption to include holders of a DS1500 certificate could be easily achieved and is likely to be universally popular.
- Raising the upper age limit for exemption from 60-65 would be in line with recent changes to the state pension age. Individuals in this age group are

high users of medicines and over 50% of the items prescribed for this age group will qualify as exempt under another exemption category.

- Abolition of prescription charges would provide benefit to all of the population and as such would also benefit those who can continue to afford to pay prescription charges.
- The volume of prescriptions is likely to increase in response to abolition of prescription charges. Measures to control the increase in volume and cost will be required. A restricted list of drugs and appliances which may be prescribed would be effective if developed on the principles of safety, quality and cost-effectiveness. Further analysis of the feasibility and cost of a restricted list for NI would be required.
- It is questionable as to whether the existing exemption categories accurately target those patient groups who may experience prescription charges as a barrier to access to medicines.
- Implementation of any of the options, except abolition, will require a new system of administration in community pharmacy, the Central Services Agency (CSA) and possibly General Practice. Any new system will require a full analysis of the inherent costs for all relevant parts of the service.
- Information from EPES and the research on the impact of abolition in Wales should be used to calculate the financial consequences of the options more accurately. Sufficient prescribing data from Wales should be available by summer 2008.

1.0 Introduction

This review paper was prepared by a multi-disciplinary, multi-agency Project Board chaired by the Director of Primary and Community Care from the Department of Health, Social Services and Public Safety (DHSSPS). The Board membership comprised representation from the Northern Ireland General Practitioners Committee of the BMA, the Pharmaceutical Contractors Committee NI, the Health and Social Services Councils, the Central Services Agency, Health and Social Services Boards and the Department. The membership of the Project Board and the terms of reference are set out in **Appendices 1 and 2** respectively.

1.1 Purpose

The purpose of the prescription charge review paper is to identify options to change the current system of prescription charges and review the current exemption categories in Northern Ireland. A cost and benefit analysis of some of the possible change options within the current system has been undertaken, taking into account developments in the rest of the UK and other countries around the world.

1.2 Methodology

A series of activities were undertaken to inform this report.

1.2.1 Literature review

The information sources consulted include research studies, consultations and government publications regarding healthcare systems from the four United Kingdom countries, Ireland and internationally. A complete listing of consulted literature is provided in the reference list at **Appendix 3**.

1.2.2 Specialist Advice

A small project subgroup, with specialist advice from a health economist, was formed to analyse the costs and benefits of the options which were considered as change possibilities. An options framework was developed to guide the analysis of the costs and benefits of the option variables. The membership of the subgroup is listed at **Appendix 1**.

1.2.3 Public Engagement

A public engagement event took place to test public opinion on abolition of prescription charges and the change options short of abolition. The Health and Social Services Councils organised and facilitated this event. Invitations were extended to a range of representative groups and approximately 50 people attended the event. The workshop discussions are summarised at **Appendix 4**.

1.2.4 UK and other countries

There was considerable liaison with the other three UK countries regarding their prescription charging systems and their experience of prescription charge review methodology. As Northern Ireland shares a land border with the Republic of Ireland discussions were held with the Department of Health and Children to examine what impact, if any, changes made to the Northern Ireland prescription charges system may have on both sides of the border.

A review of healthcare systems and the use of co-payments in other countries was conducted as part of the review of prescription charges in Scotland and this was used to provide an

evidence base and source of reference for this report. It examined and compared how much patients contribute to the cost of their medication and what exemptions and reduced payment policies are in place in Western Europe, North America and Australasia.¹

2.0 Background

On 15 May 2007, there was a debate in the Northern Ireland Assembly about Health Service Prescription Charges. The Assembly motion called upon the Minister of Health, Social Services and Public Safety to establish a cost and benefit review for the purpose of abolishing health service prescription charges as has been carried out in Wales; and to review the list of conditions that currently entitle patients to free prescriptions in order to reduce anomalies².

The Assembly debate and correspondence to the Minister regarding the current arrangements for prescription charges have suggested that prescription charges act as a barrier to individuals accessing the medication that they need.

The National Health Service (NHS) was established in July 1948. The underpinning principles of the then new healthcare service was that provision of care should be based on need and not ability to pay and that it should be free at the point of use.

Originally, prescription charges were introduced in the UK in 1952 for patients in the community. Charges were removed for a three year period between 1965 and 1968 and were reintroduced in 1968 as a mechanism to raise revenue towards the cost of the NHS and limit costs by reducing unnecessary demand. Exemption categories were established to protect patients likely to have difficulty in paying. In 1974 exemptions were extended to include children up to age 16 and women aged 60 and over. In 1975, free contraceptive services were included and in 1982, the exemptions were

extended to include mothers of stillborn children. A further change was made in 1996 when men aged over 60 became entitled to free prescriptions³. From April 2007 prescription charges have been abolished in Wales and there are plans for abolition in Scotland in 2011.

2.1 The current arrangements in Northern Ireland

2.1.1 Charges

The prescription charge from April 2007 is a flat rate fee of £6.85 per item. This charge has historically been viewed by UK Health Departments as a reasonable amount to be paid, by patients who can afford to do so, for prescribed drugs and appliances. The prescription charge does not directly reflect the cost of the prescribed item or the cost to the Health Service of supplying it as many items prescribed are considerably more expensive than the flat rate charge.

Unless the patient claims exemption, a **single prescription charge** is payable where:

- The same drug or preparation is supplied in more than one container.
- Different strengths of the same drug formulation are ordered as separate prescriptions on the same prescription form.
- More than one appliance of the same type (other than hosiery) is supplied.
- A set of parts making up a complete appliance is supplied.
- Drugs are supplied in a powder form with a solvent separate for subsequent admixing.
- A drug is supplied with a dropper, throat brush or vaginal applicator.
- Several flavours of the same preparation are supplied.

Unless the patient claims exemption, **multiple prescription charges** are payable where:

- Different drugs, types of dressings or appliances are supplied.
- Different formulations or presentations of the same drug or preparation are prescribed and supplied.
- Additional parts are supplied together with a complete set of apparatus or additional dressing(s) together with a dressing pack.
- More than one piece of elastic hosiery (anklet, legging, knee cap, below knee, above knee or thigh stocking) is supplied.

2.1.2 Prescription Prepayment Certificates (PPCs)

PPCs can be purchased and are cost effective when a patient needs more than 5 items in a four month period or more than 14 items in a twelve month period. The prepayment scheme is effectively a means of financial capping on patients' expenditure for prescription items. For patients who are not entitled to free prescriptions under the exemption categories, but who require frequent prescriptions, the PPC offers a more affordable method of payment for medication at a discounted rate.

Once the PPC has been purchased the number of items the patient can obtain is unlimited. This benefits high prescription users.

The charges from April 2007 are:

- Four month certificate - £35.85
- Twelve month certificate- £98.70

2.1.3 Exemption Categories

Since their introduction in 1968 the exemption categories that confer entitlement to free prescriptions have remained fundamentally unchanged. The categories of exemption can be grouped as follows:

- Age related
- Income or benefit related.
- Specified medical condition (i.e. holders of a valid medical exemption certificate)
- Maternity certificate
- Contraceptives

A comprehensive list of exemptions is given at **Appendix 5**.

2.1.4 Electronic Prescribing and Eligibility System (EPES)

The Department has been working over a number of years with key stakeholders on a computer-based project, known as the Electronic Prescribing and Eligibility System,(EPES), aimed at preventing prescription fraud by identifying the individuals concerned and leading to securing the prescription charges due, along with any fines that may be imposed. Around £7.6 million per year is lost due to patients claiming free prescriptions when they are not entitled to do so. The target is to reduce losses due to patient prescription fraud by at least 50%, realising an additional £4 million approximately per year for healthcare in Northern Ireland. Implementation of the project is at the pilot stage. Additional gains from EPES have been identified including the development of an electronic payments process.

2.2 Current arrangements in the rest of the United Kingdom

2.2.1 Scotland

The Scottish Executive under Labour undertook a review of prescription charges in 2006. Following a period of public consultation the findings of the Scottish Executive's Review of NHS Prescription Charges showed that there was strong support for all people with long-term medical conditions and those on low incomes to be exempt from prescription charges.

The Scottish Executive's review had highlighted popular support for helping those with a chronic condition, those on low incomes who had been faced with choosing which prescriptions they can afford to buy and for young people in full time education or in training⁴. As part of the phasing process it was decided to exempt patients who are terminally ill and hold a DS1500 certificate with immediate effect. When the Scottish National Party came into power in May 2007 their manifesto commitment to abolish prescription charges was one of a number of key policy pledges announced by the new devolved administration.

On 6 December 2007 the Scottish Health Secretary announced a reduction in prescription charges ahead of their planned abolition in 2011. The cost of a single prescription is to be cut by more than 25% in 2008, from £6.85 to £5, and will be further reduced by £1 in each of the two subsequent years before abolition, whilst the cost of a 1 year prepayment certificate will be cut over the same timescale, from £98.70 to £48, then down to £38 and finally £28, before they are abolished. The move is similar to developments in Wales. Ministers have set aside £97m over the next three years to phase out prescription charges. Once the charges have been abolished the policy is

expected to cost £57m a year. Under current exemption rules, about half the population qualifies for free prescriptions and about 92% of items dispensed in Scotland are given to patients free of charge⁵.

2.2.2 Wales

Abolition of the prescription charge was a manifesto commitment by the Labour party in Wales. A phased approach was taken to ensure affordability and allow health officials to identify and manage the effects of abolition on patient behaviour. In 2001, prescription charge exemption was extended to all young people up to the age of 25, and charges were frozen at £6 per item. As of October 2004 the charge fell to £5, £4 in April 2005 and to £3 in April 2006. The charge was abolished from 1 April 2007.

Changes to the exemption list had support from the Liberal-Democrats but it was decided to "keep it clean and simple" and abolish the charge altogether.

The Welsh Assembly allocated annual budgetary increases to its Health and Social Care Department so that NHS Wales did not have to absorb the loss of prescription income. To date there is no hard evidence available regarding the financial impact of the abolition of prescription charges.

2.2.3 England

The House of Commons Select Committee on Health's report into NHS Charges was published in July 2006⁶. The Government response to the report at the end of October 2006 was to confirm that Ministers had asked officials in the Department of Health to undertake a review of prescription charges⁷. The Government stated in its response that it would

report the outcome of this review to Parliament before the 2007 Summer Recess.

It was planned that this review would include options to:

- Revise the list of medical exemptions to prescription charges;
- Introduce a flat-rate prescription charge with no exemptions;
- Base exemptions to prescription charges solely on income.

These options would be considered on the basis that any changes to prescription charge exemptions would be cost-neutral to the NHS.

Following this internal review, the Government decided to hold a consultation in the autumn so that the public could contribute their views on any proposals prior to a final decision on future prescription charges. The consultation paper is not yet available.

2.3 Current arrangements in the Republic of Ireland

The Department of Health and Children in Dublin provided information on how the system of prescription charges is administered in the Republic of Ireland. Everyone in Ireland is entitled to either free or subsidised approved prescribed drugs, certain medical and surgical aids and appliances⁸.

2.3.1 Categories of exemption from charges

Those on low incomes and people who contracted Hepatitis C directly or indirectly from the use of Human Immunoglobulin-Anti-D or from the receipt, within Ireland, of any blood product or a blood transfusion and who have a Health Amendment Act Card are entitled to get approved prescribed drugs and medicines free of charge.

Under the Long Term Illness Scheme people suffering from certain long-term illnesses are entitled to get the drugs and medicines for the treatment of *that illness only* free of charge. The Long Term Illness Scheme does not depend on income or other circumstances.

The medical conditions that qualify under the Long Term Illness Scheme include:

- Mental handicap
- Mental illness (for people under 16 only)
- Diabetes insipidus
- Diabetes mellitus
- Haemophilia
- Cerebral palsy
- Phenylketonuria
- Epilepsy
- Cystic fibrosis
- Multiple sclerosis
- Spina bifida
- Muscular dystrophies
- Hydrocephalus
- Parkinsonism
- Acute leukaemia
- Conditions arising from use of Thalidomide

Once eligible, a person suffering from any of these conditions is issued with a long-term illness book. This book lists the drugs and medicines for the treatment of their condition, which will be provided to them free of charge through their community pharmacist.

The list of medical exemptions was drawn up in the 1970s and has not been revised since then. The Department of Health and Children are currently reviewing the prescription charging

system including the list of medical exemptions which is generally accepted to be outdated.

Patients over 70 years who are normally resident in Ireland are entitled to free drugs and medicines regardless of means.

2.3.2 Discount scheme

The Drugs Payment Scheme, DPS, acts as a discount or capping system. Under this Scheme an individual or family in Ireland has to pay a maximum of €85 for approved prescribed drugs, medicines and certain appliances for use by that person or his or her family in that month. In order to qualify for this scheme, you must be ordinarily resident in Ireland. In order to avail of the DPS, individuals or families must use the services of one community pharmacy in a particular month.

Family expenditure covers the nominated adult, his or her spouse/partner and children aged under 18 years or 23 if in full-time education. A dependant with a physical or mental disability/illness living in the household who does not qualify for exemption within the other categories and who is unable to fully maintain himself/herself, may be included in the family expenditure regardless of age.

2.3 Western Europe, North America and Australasia

Most countries in Western Europe, North America and Australasia have some form of patient contribution to the cost of their medication, most commonly as a percentage of the cost of the medication¹. Patient contributions vary considerably in different countries and healthcare systems. In the Netherlands, patients pay the difference in cost between the reference and actual price. In reality, up to 2006, very few prescription medications attracted any co-payment although the system

was changed in 2006. A number of countries such as Austria, Australia, Italy, New Zealand and UK have fixed co-payments for their government subsidised prescription medication. More complex systems of co-payments exist in Canada and the USA and these vary across the healthcare funding systems. There are examples of countries, Finland and Germany, with fixed and percentage co-payments based on the cost of medication or a reference cost for the medication. Belgium, Denmark, France , Luxembourg, Portugal and Spain have systems in which there is a varying percentage co-payment based on criteria such as seriousness of condition, drug consumption, usefulness of medication and generics. Ireland and Sweden operate a cap based co-payments system on a monthly and annual basis respectively. Other countries also include some form of capping within a wider system.

Most countries offer some form of exemption or reduction in co-payment for certain groups who might find it hard to pay for the cost of their medicines including, medication to treat certain medical conditions, age, income and disability.

3.0 Strategic Context

The review of prescription charges in Northern Ireland is taking place against the backdrop of radical reform of public services nationally and regionally. There is an expectation from the public that the barriers to accessing essential healthcare services including attendant drugs should be removed or reduced. There is increasing public demand for reform of an outmoded system of charging as evidenced by media interest and the lobbying of the Department of Health Minister by Members of the Legislative Assembly and the public.

3.1 National strategic context - public sector reforms

Public sector reform nationally, as set out in the No 10 principles of reform, include the following objectives to inform strategic policy making across the four UK countries:

- national standards to ensure that people have the right to high quality services wherever they live;
- devolution to give local leaders the means to deliver these standards to local people;
- greater customer choice.

These principles are the basis for government and the building blocks of policy making in the devolved administrations.

3.2 Strategic priorities of Government in Northern Ireland.

The over-arching aim of the devolved Assembly's draft Programme for Government is to build a peaceful, fair and prosperous society in Northern Ireland, with respect for the rule of law and where everyone can enjoy a better quality of life now and in years to come.

The Executive's stated objectives are to deliver on priorities that are underpinned by two cross-cutting key themes:

- To pursue an innovative and productive economy and a fair society that promotes social inclusion, sustainable communities and personal health and well-being.
- To do this in ways that protect and enhance the physical and natural environment and use resources as efficiently and sustainably as possible.

The Northern Ireland Assembly has pledged to develop new and innovative measures that will address existing patterns of socio-

economic disadvantage and target resources and efforts towards those in greatest objective need. Within this programme the Executive has made it a priority to strive to eliminate all forms of inequality⁹.

The Programme for Government is constrained by the national Comprehensive Spending Review (CSR) and the implications for resources for the Northern Ireland public sector for the period 2008/09 to 2010 /11. In the case of the DHSSPS the Northern Ireland CSR settlement will influence the priorities to be pursued by the Department. Within the context of a constrained budget it is vital that policies which support the promotion of good health and well-being, the prevention of illness and injury, early intervention and good long term care, are achievable.

3.3 Strategic priorities of the Department of Health, Social Services and Public Safety.

The Department's regional strategy is set out in A Healthier Future – A Twenty Year Vision for Health and Well-being in Northern Ireland¹⁰.

The strategy is built around five crosscutting themes:

- Investing for health and well-being
- Involving people
- Responsive integrated services
- Teams which deliver
- Improving quality

These themes all point in the same direction of “upstream interventions” in the form of multi-sectoral promotion of healthy, independent living and in the development of care pathways away from the hospital sector – managing disease, illness and disability in the community through supported self help programmes and through the expertise of more highly skilled practitioners operating in the community.

A focus on preventing crises and exacerbations of illness and disease will reduce the number of patients that would otherwise require intensive intervention in the acute hospital sector or in a residential, long term care environment.

3.4 Investing for Health

Health and well-being is largely determined by the social, economic, physical and cultural environment. Health policy has so far tended to concentrate on the treatment of ill health rather than on its prevention. The Investing for Health strategy seeks to shift that emphasis by taking action to tackle the factors which adversely affect health and perpetuate health inequalities.

The Investing for Health strategy is an interdepartmental government action to tackle the factors that adversely affect health in the first place. It also aims to reduce health inequalities within the population.

3.5 Targeting Social Need and Health Gain

As with every Northern Ireland Department, the established policies and commitments to targeting social need and promoting equality of opportunity are expected to permeate all policies and strategies.

Poor people die younger, enjoy poorer health and make less use of health services than richer people. The services they get tend to be of poorer quality. This “inverse care law” was expounded by Dr Julian Tudor Hart, and subsequent research has demonstrated how inequality of income affects the health of all members of a society, not just the poor¹¹.

The Chief Medical Officer stated in his annual report 2006 that *“unfortunately not everyone in Northern Ireland will experience the*

same levels of good health or life expectancy. People who experience disadvantage, social exclusion, lower educational attainment, poor housing or are unemployed, for example, are likely to suffer poorer health and an earlier death when compared with the rest of the population. There is also a clear link between poverty and ill health. People living in the 'more disadvantaged' areas are more likely to have poorer health and are less likely to live as long as people living in the 'well-off' areas". Addressing the health inequalities experienced by those living in the more deprived areas will result in significant health gain¹².

3.6 Pharmaceutical Clinical Effectiveness Programme

Historically, utilisation of prescribing resources in Northern Ireland has resulted in higher costs per capita in comparison with other UK countries.

Northern Ireland provides a setting where greater uniformity and consistency of therapeutic care could be achieved with gains in quality, safety and economy. The Pharmaceutical Clinical Effectiveness Programme was designed to achieve service improvements in the area of pharmaceuticals in the context of the reform, modernisation and efficiency programme during 2005 - 2008 and within the subsequent CSR period 2008-2011. It is built around the concept that **QUALITY + SAFETY → HEALTH IMPROVEMENT AND EFFICIENCY** with a principal focus on improved medicines management. This encompasses the way medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care. A range of initiatives has been implemented to improve the quality and safety of services for patients. The Programme has also demonstrated its potential to inform the maintenance of a dedicated NI Drug Tariff.

It is within this context that the prescription charges review is set. Removing the barriers to getting drugs and medicines supports these policies at a fundamental level. Improved access to medicines will be a mechanism to tangibly address the health inequalities and social exclusion that exists within our society.

4.0 Literature Review

Research has been conducted on the relationship between prescription charges and access to medicine^{13,14,15,16}. The literature suggests that whenever patients make some financial contribution towards the cost of their medicines, the demand for prescription drugs is reduced¹⁷. There is some evidence that as the charge increases there is decreased utilisation of medicines^{18,19}.

Compliance with medication is a complex area and cost is only one factor which may influence a patient's decision to have their prescription dispensed or to take their medication as prescribed²⁰. Patients in studies in the US, UK, New Zealand and Canada have all decided not to have prescriptions dispensed as a result of cost^{19,21,22,23,24}. This affects essential as well as non-essential medicines, however, there is evidence that patients are more likely to get prescriptions for essential medicines dispensed^{15,19,25,26}. The effect has also been observed to a lesser extent for over-the-counter drugs¹⁷.

Although there is no evidence of a direct link between prescription charges and ill health, there is evidence that poor compliance with prescribed medication can have health consequences which may lead to increased resource utilisation in health services e.g. hospital admissions^{23,27}. Two studies highlight this; one showing increased mental health service use²⁸; and another linking adverse events such as emergency room visits and deaths²⁹ with increased patient drug charges leading to poor compliance.

Individuals with chronic illness, poor health status, poor educational status, low incomes and high social need have been found to be particularly affected

by the cost of medication^{13,15,20,24,30}. Children, students and the elderly have also been identified from studies^{21,29}. These groups of individuals are more likely to decide not to have their medication dispensed as a result of cost.

A number of chronic illnesses and drug groups have also been studied and the effect of cost on medication utilisation has been identified for; chronic heart failure, asthma, COPD, statin therapy, schizophrenia, and mood disorders^{28,31,32,33,34,35,36,37}. Not all studies have identified that cost acts as a barrier to access to medicines. Patients for whom cost was not identified as a barrier were generally relatively healthy, of higher income or the charge studied was lower than the UK charge³⁸. A study from New Zealand showed that increased charges did not affect patients' decisions to collect asthma drugs prescribed by their doctor, however, the study was limited to a six week period and was not designed to establish if the increased charges led to patients not visiting their doctor, doctors prescribing less or patients not presenting their prescriptions for dispensing³⁹.

Patients have been shown to modify behaviour in relation to their medication in response to prescription charges or equivalent. Patients may choose not to have their prescription dispensed or they may choose to substitute their prescribed medication for an over-the-counter alternative that is cheaper⁴⁰. They may also choose to alter the dose⁴¹. The UK Citizen's Advice Bureau survey in November 2006 found that 50% of clients who had paid prescription charges had difficulty affording the charge and 28% had failed to get all or part of a prescription dispensed during the previous year because of the cost⁴². Patients who under-use their medication as a result of cost are unlikely to discuss this issue with their doctor and few patients report that their doctors had asked them about payment difficulties⁴³.

Doctors have also been shown to change their behaviour in response to the ability of their patients to pay the charges. Doctors will use a variety of strategies to reduce the cost, such as: increasing the quantity prescribed and prioritising prescriptions⁴⁴. This has been shown with UK and Italian GPs; however, in the study the UK GPs reported that they use more strategies than

their Italian counterparts. Dutch and French GPs have also reported that they take the cost of drugs to patients and to society into consideration whenever they prescribe^{45,46}. An English study of repeat prescribing reported that prescription charges influence the length of the repeat prescribing cycle in primary care⁴⁷.

In summary, the evidence suggests that there is a relationship between cost and utilisation of medicines. This particularly affects patient groups such as the young, those with poor health status, and various socioeconomic groups. This may have an indirect impact on longer term health outcomes and use of health services, however, research in this area is limited.

5.0 Analysis of Current Scheme

5.1 Data Available for Analysis

The data available for analysis of the costs and benefits of the current scheme and therefore any of the options considered in this report is limited. It is based on information collected as a result of making payments for pharmaceutical services through the CSA. The information that is collated at individual drug or category of drug level is not associated with any patient level data, diagnosis or exemption category. Information on the exemptions claimed is limited to the analysis of a sample of data derived from a Counter Fraud Unit (CFU) random sample of just over 2,000 prescription forms each year for which an exemption has been claimed. It is representative of all prescriptions in NI that are not paid for at the point of dispensing. The sample is small, covering approximately 4,000 items for the year 2006/07, i.e. less than 1%, however the results have shown consistency across the exemption categories over recent years and are accepted by CSA and DHSSPS Statisticians to be reasonably robust for this exercise. There is no other representative NI data available to indicate the number of prescriptions/items dispensed within each exemption category.

A pilot of the implementation of EPES began in November 2007. Data from the pilot relates to prescriptions dispensed from 6 pharmacies in the East Down area during November 2007. The data was taken from the electronic submissions from the pharmacists prior to the CSA keying the data for verification purposes. The data cannot be used as representative data for Northern Ireland for the following reasons;

- The data is taken from one month and does not therefore allow for seasonality;
- The data is from 6 pharmacies in the same general area;
- The data has not been validated by a double keying exercise for verification purposes;

When the data was compared to the results from the CFU random sample, it was noted that the percentage of items dispensed for some of the exemption categories was similar and for others it was slightly different. This may be due to the fact that the data is simply a snapshot of one month's prescriptions from only 6 pharmacies and the CFU sample is representative of all pharmacies in Northern Ireland over the entire year. It is therefore too early to use the EPES data as the sole basis for the prescription charge review. CSA should be capturing all data from prescriptions via the new EPES data capture and electronic submissions by the summer of 2008 and at this point the data will be fully representative of all prescriptions dispensed in Northern Ireland.

In order to refine the analysis for some exemption categories, data from the EPES pilot was used. This provided useful additional information although it has significant limitations.

There is also very limited data available on the incidence or prevalence of the conditions described as chronic diseases. Information from the General Medical Services, Quality and Outcomes Framework, (QoF),

provides some data on the local prevalence of conditions that are recorded in chronic disease registers as a requirement of the QoF. However, as individuals may have more than one illness and it is not possible to identify duplicates, this data cannot be used to estimate the proportion of the population suffering from chronic diseases. In addition, none of the QoF indicators relating to medicines management provide useful information about the numbers of people taking multiple medications.

The Department of Social Development (DSD) data regarding Social Security Agency benefits that was available for analysis was limited, especially in relation to the NHS Low Income Scheme because records for this scheme are clerically maintained records. There was no information available about the number of successful claims that resulted in the issuing of a HC2 or HC3 certificate. In addition there was no breakdown of the proportion of HC2 and HC3 that were issued or the age groups to which these were awarded. For the under 25 age group, it was not possible to find out how many individuals were in receipt of some benefits eg Jobseekers Allowance, and Tax Credit. Therefore the EPES pilot data has been used to identify the number of prescription items which have been dispensed against each of the exemptions categories that have been claimed by patients aged 16-25.

Information on the numbers in receipt of a DS1500 certificate was available from DSD. The number of individuals aged over 60 in receipt of Pension Credit was also identified, however this could not be broken down to identify the number in the 60-64 age group. In order to estimate the numbers in receipt of pension credit in this age group, the data from 50-60 year olds in receipt of income support or jobseekers allowance included in the EPES pilot was used as a proxy.

Government census information was sourced from NISRA and provided the numbers of people aged 16, 17, and 18 in full time education.

Data on prescribing volumes and costs in the four UK countries was obtained from the Office of Health Economics Compendium 18th Edition 2007 and CSA in Northern Ireland³. Health Solutions Wales also provided data on prescription items dispensed in Wales.

5.2 Prescription charges

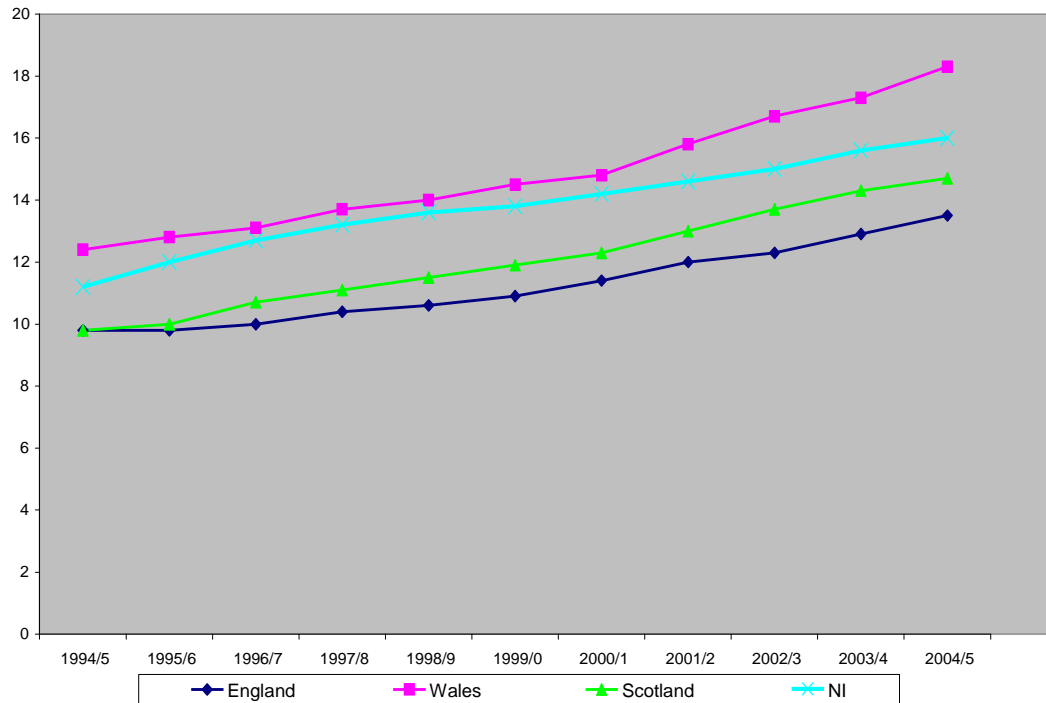
In Northern Ireland, 29,463,920 prescription items were dispensed in 2006/07. This figure excludes prescription items which were dispensed to general practitioners as stock for their medical cases or treatment rooms. The total primary care pharmaceutical costs were £408,770,633. The revenue in NI from charges in 2006/07 was £11,297,565 and a further £2,835,846 was received for purchase of prescription pre-payment certificates. This represents 3.5% of the primary care pharmaceutical costs. A comparison of the pharmaceutical costs/volume per capita in the four UK countries is shown in **Table 5.1** and **Figure 5.1** below.

Table 5.1 UK Comparative Prescribing Statistics 2006

	Northern Ireland	Scotland	England	Wales
Items /capita	16.65	15.71	14.81	19.96
Ingredient cost*/capita	£214.32	£188.10	£161.47	£193.52
Ingredient cost*/item	£12.87	£11.97	£10.90	£9.74

* Ingredient costs are before discount

Figure 5.1 Prescription items dispensed per capita by UK country from 1994/5 to 2004/05



The average annual growth rate of net ingredient cost per capita was 4.7% during the decade 1995 to 2005 in the UK. In NI, the equivalent figure was 4.1%. There are many factors which contribute to the growth in the number of prescriptions dispensed including population growth, changes in demographic structure, particularly the rise in the elderly population which is predicted to increase by 9% in the next five years and 41% over the next fifteen years whilst the number of children is projected to remain broadly constant over the next 15 years⁴⁸. The number of new medicines available and the expectations of the public also influence the growth. The number of prescriptions dispensed for both the elderly and those aged under 16 has increased and the number dispensed for the elderly has increased three fold over the past 25 years³.

It is estimated that 50% of the population are eligible to pay prescription charges. In 2006/07, 5.74% of the total items dispensed

attracted a prescription charge. In addition, approximately 5% of items were dispensed to holders of prescription prepayment certificates and the remaining 89% of items were dispensed free of charge. This figure is very similar to the percentage of items dispensed free of charge in England and Scotland. The current claimed exemption rates are as follows;

England	88%
Scotland	91%
Northern Ireland	89%

Wales introduced free prescriptions from April 2007.

5.3 Prescription fraud

It is estimated that £7.4m is lost annually due to patients falsely claiming entitlement to free prescriptions. This figure has been reducing from £18.8m in 1999/2000.

Each year, statisticians from the CSA's Information Unit independently calculate the estimated level of patient exemption fraud in Northern Ireland. The calculations are based on the results from a statistically random sample of exemption checks carried out by CFU. The methodology employed, and the calculation itself, are subject to rigorous and detailed scrutiny by the Agency's external auditors.

5.4 Analysis of exemptions claimed

As part of their role, the CFU analyse a random sample of 2,000 prescription forms where prescription charge exemption has been claimed. This analysis shows the exemption category claimed, number of prescription forms and the number of items dispensed to the patient. **Figure 5.3** and **Table 5.2** below show this information.

Figure 5.2 Graph of average number of items per prescription by each exemption claimed.

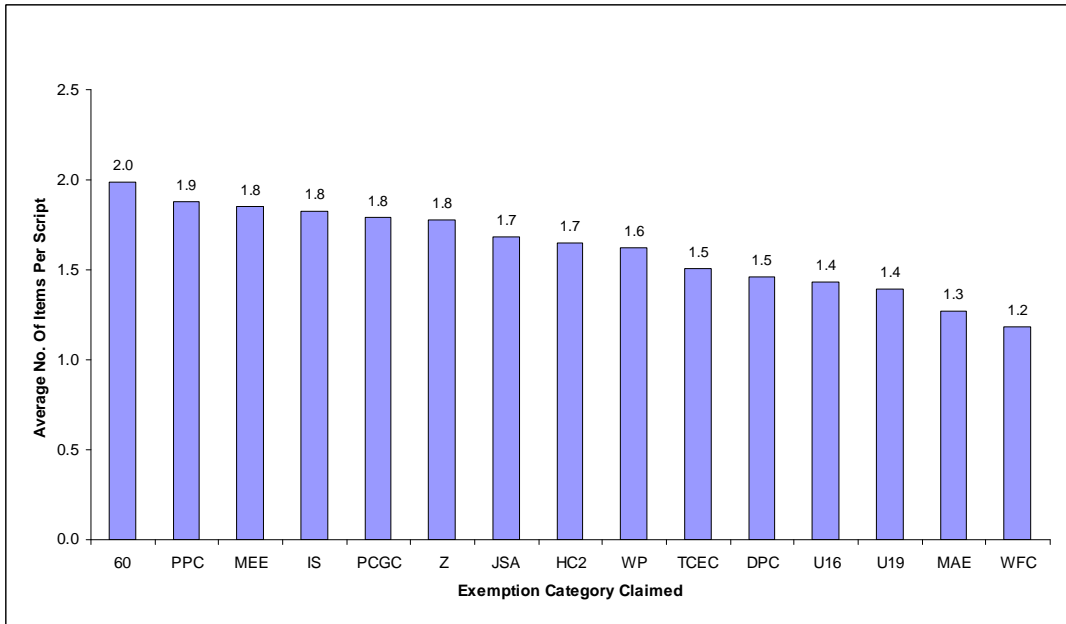


Table 5.2 Summary of exemption categories claimed from 2002/03 to 2007/08 in Northern Ireland.

Exemption Claimed	Description	Total Prescriptions (Scripts)	Scripts %	No of Items	Items%	Average No of items per prescription
60	60 years of age or over	5203	47.8%	10344	52.3%	1.99
PPC	Has a valid pre-payment certificate	478	4.4%	899	4.5%	1.88
MEE	Has a valid Medical Exemption Certificate	591	5.4%	1093	5.5%	1.85
IS	Gets, or has a partner who gets Income Support	1696	15.6%	3090	15.6%	1.82
PCGC	Has a partner who gets Pension Credit Guarantee Credit	29	0.3%	52	0.3%	1.79
Z	No Exemption Category Indicated	320	2.9%	568	2.9%	1.78
JSA	Gets, or has a partner who gets Jobseekers Allowance	287	2.6%	483	2.4%	1.68
HC2	Is named on a valid HC2 charges certificate	103	0.9%	170	0.9%	1.65
WP	Has a valid War Pension exemption certificate	21	0.2%	34	0.2%	1.62
TCEC	Is named on a valid NHS Tax Credit exemption certificate	458	4.2%	691	3.5%	1.51
DPC	In receipt of Disabled Persons Tax Credit (replaced by TCEC)	13	0.1%	19	0.1%	1.46
U16	Is under 16 years of age	1272	11.7%	1819	9.2%	1.43
U19	Is 16, 17, or 18 and in full time education	174	1.6%	242	1.2%	1.39
MAE	Has a valid Maternity Exemption Certificate	163	1.5%	207	1.0%	1.27
WFC	In receipt of Working Families Tax Credit (replaced by TCEC)	67	0.6%	79	0.4%	1.18
		10875	1	19790	1	1.82

In 2005, the elderly, i.e. men and women aged 60 and over, received approximately 58% of prescription items dispensed in England. This figure has increased from approximately 40% in 1995. The number of prescription items dispensed per capita for elderly people has also increased, from just over 20 items per capita in 1995 to approximately 38 items per capita in 2005. Statistics from the 2004 General Household Survey show that on average, each member of the population consults a GP four times a year. The greatest increase in the number of consultations over the period 1975-2004 has been for the elderly³.

Table 5.3 illustrates the differing levels of prescription items by exemption category. The average annual number of items per person for each exemption category has been imputed from the CFU sample for the exemption categories shown in the table. This cannot be done for all the exemption categories because population numbers are only available for some categories and individuals may qualify for more than one exemption category.

Table 5.3 Imputed items per person for selected exemption categories

	Exemption claimed	Imputed items per Person
1	60 years and over	46.8
2	Holds valid Maternity Exemption Cert.	12.7
3	Under 16 years	5.3
4	Aged 16, 17 or 18 years and in fulltime education.	5.6
5	NI all persons average	17.0
Key		
Population bases used (2006 mid-year estimate):		
1	60 + years	326,311
2	23,272 births	23,272
3	0-15 year olds	380,141
4	Estimated to be 70% of 16-18 year olds	55,000
5	Total NI Population	1,741,620

5.5 Administrative Costs

The majority of the administration costs for the prescription charges and exemption scheme are attributed to the following;

- Fees paid to Community pharmacists for point of dispensing checks and sales of Prescription Prepayment Certificates
- Administration costs incurred by the CSA for Prescription Prepayment Certificate sales and refunds
- Validation of exemption checks by the Counter Fraud Unit.

There are identifiable administration costs incurred by the Social Security Agency for the processing of claims for help with charges through the NHS Low Income Scheme. Abolition of prescription charges would have a limited effect in terms of administration costs for the Social Security Agency as they would still have to assess entitlement to travel costs, dental and optical charges under the Low Income Scheme.

CSA are also responsible for administration of the medical exemption certificate and maternity certificates. At 1 October 2007 there were 40,380 holders of medical and maternity exemption certificates in Northern Ireland. Any changes to the current arrangements would have limited effects in terms of administration costs for the CSA.

6.0 Options Framework

This section of the report describes the framework of options for the future of the prescription charges and exemptions that have been identified for analysis. It also details the issues which have been considered in identifying these options.

6.1 Benefit criteria

The benefit criteria outlined in **Table 6.1** have been drawn from the published literature. They also take into account the practicalities of

administration and the ease of understanding of any changes to the current system. The criteria have been used to assess the range of options identified in the review.

Table 6.1 Benefit criteria

Supports Programme for Government policy of reducing inequalities, improving access to healthcare (Investing for Health)
Promotes equal access for all
Reduces the financial barrier for patients to obtain medication which they need
Affordable for patients at the time of need
Improvement in Health
Removes anomalies in current system e.g. medical exemptions, pension age, multiple charges
Easy for public to understand
Contributes to the efficient and effective provision and use of primary care services including medicines
Places value on medication
Minimal impact on healthcare delivery e.g hospital admissions
Practicable to deliver

The framework analyses options in three broad categories;

- Abolition
- Reform of the current system of prescription charges and exemptions
- Introduction of a new system of prescription charges and exemptions

6.2 Abolition

There are a number of possible options for abolition of prescription charges;

Option 1	Abolish prescription charges. This could be phased over a defined period similar to the Wales and Scotland approaches
Option 2	Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21)
Option 3	Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21) and introduce top-up payments for premium priced alternatives

Option 1 Abolish prescription charges

There are a number of pros and cons of abolishing prescription charges. The main arguments in favour of abolition are that it will remove the financial barrier to patients obtaining the medication that they need, thereby resulting in health gain and reduced utilisation of other health care services e.g. hospital admission. Abolition of the charge will resolve the unfairness and inconsistencies that exist with the outdated 1968 exemption system. While this will benefit everyone who currently pays for prescriptions in Northern Ireland, it should particularly benefit those people on modest incomes and those who have chronic illnesses.

The other benefits of abolition include; elimination of fraud, reduced administration costs for CSA and DHSSPS and removal of the need for community pharmacists to carry out point of dispensing checks, collect charges and sell PPCs. Abolition of prescription charges will be popular with many professional groups including Pharmacists, Doctors and Nurses; with patients and their representative groups; and with those who have contacted the Minister and DHSSPS to lobby for free prescriptions.

The main arguments against abolition relate to the consequences of removing the financial barrier to accessing medication for all patients. There is little evidence available on the impact of removal of the charge on demand for prescriptions and subsequent increase in pharmaceutical expenditure. In Wales, the prescription charge was completely abolished from 1 April 2007 and there is insufficient data to analyse the impact of abolition on demand and prescription volume at this time. Estimates from the SPICE briefing suggest that the increase in volume of prescribing could range from 22% to 64%⁴⁹. This increase would only apply to chargeable items because it is assumed that patients who currently receive free prescriptions are already taking full advantage of their exemption.

If demand for prescriptions increases, this will have an impact on GP and community pharmacy workload. Additional costs will also be incurred by the CSA for processing an increased number of prescriptions for payment. There will be a loss of revenue from prescription charges, PPCs and the additional revenue expected from the new EPES scheme which is intended to reduce prescription fraud. It is also argued that completely removing the charge would reduce the value that patients place on their medications.

The removal of prescription charges will also have an impact on the NI Minor Ailment Scheme which reduces the pressure on GP time through enabling patients who are currently exempt to have a consultation with a pharmacist and, if necessary, receive the drugs they need to treat a limited range of common minor ailments. Removal of the charges would mean that patients who currently buy medication over the counter for common minor ailments would be able to access the Minor Ailments Service resulting in a higher number of consultations and increased drug costs. However, increased access to the Minor Ailments Service would be expected to curb some of the increased demand that may be experienced at GP surgeries.

Free prescriptions in Northern Ireland may be an incentive for residents of the Republic of Ireland to register with GPs in border areas of Northern Ireland contributing to list inflation. There could be a resultant increase the volume of prescriptions in Northern Ireland.

The cost of abolition in Northern Ireland is estimated to range from £13 million to £20 million or £24 million at growth rates for chargeable items of 0%, 22% and 35% respectively. These calculations take account of the opportunity cost of additional GP consultations and the cost of additional drugs and dispensing fees paid to community pharmacists. The 64% referenced in the SPICE briefing is considered to be too high and 22-35% is considered to be a more realistic estimate of range of the potential increase, however, at the time of writing, the true cost of abolition is unknown⁴⁹. Concern has been expressed that the challenging CSR targets for 2008 / 2011 may be undermined by the potential increase in volume of prescriptions as a consequence of abolition.

Attendees at the public engagement event were in support of abolition of prescription charges but were concerned about the potential increase in demand for prescriptions and the resultant loss of revenue and increased cost of drugs. They were particularly concerned about the impact of the cost of free prescriptions on access to health care overall.

Option 2 Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21)

Over the past three years, the Pharmaceutical Clinical Effectiveness Programme has developed methodology known as STEPS to assist with tendering for drugs and products within a number of clinical areas. This process has involved tendering for drugs and wound care products on the basis of evidence of cost effectiveness. In the case of

wound care products, this has resulted in changes to the current Drug Tariff. Further proposals have been made to develop this methodology and to adopt a Northern Ireland Drug Tariff rather than continuing to use the drug tariff from another devolved administration. The creation of a Northern Ireland Drug Tariff would enable Northern Ireland to determine the drugs and appliances that would be eligible for reimbursement on an HS21 prescription, using either a black list (i.e. disallowed) or a white list (i.e. allowed).

Systems of positive and negative lists exist in countries in Western Europe, North America, New Zealand and Australia, however, their health systems and charging systems differ from the UK NHS¹. Positive lists tend to limit what can be reimbursed to a greater extent than negative lists. This approach was supported in the public engagement event on the understanding that patients would be able to obtain safe and effective medicines whenever their doctor considered them to be clinically necessary. A policy paper from the Royal Pharmaceutical Society of Great Britain proposes a national formulary of medicines which the NHS could pay for or subsidise³⁸. Others have also proposed this type of approach, taking the view that patients could pay the full costs or make a payment towards the cost of particular types of drugs^{50, 51}. A study looking at the drug re-imbursement systems in France, Germany and the UK concluded that the number of products available to be prescribed in each of the countries did not explain the variation in drug expenditure between the countries, but that the variation was due to differences in doctor's prescribing behaviour⁵².

Other changes to the availability of medicines for re-imbursement on a prescription form (HS21) have also been suggested as a means of mitigating the potential increased demand for prescriptions. These included the exclusion of any medicines that are available over the counter or exclusion of medicines that cost less than a limited price. These suggestions would be more arbitrary and less robust than a

process of decision making for rational prescribing that is based on safety, quality and cost-effectiveness. Withdrawal of re-imburement for a drug may lead to unexpected and unwanted outcomes such as substitution of an alternative drug which may not lead to improved drug use overall¹⁹. If the lower cost medicines were removed from the prescriber's formulary, there would also be potential for more potent medications that are available without charge to be prescribed in favour of less potent, effective medicines that are available to purchase over the counter.

Introduction of a Northern Ireland Drug Tariff may be progressed independently of any decision about the future of prescription charges. In the event of abolition of prescription charges, the Northern Ireland Drug Tariff would provide some control on the potential growth in drugs expenditure and demand. In addition, the culture of rational prescribing based on quality, safety and cost effectiveness will be well established as a means to securing health gain and efficiencies. Considerable time and resources would be required to develop and administer a full formulary for NI in a way which is transparent, evidence-based and legally watertight.

Option 3 Abolish prescription charges and limit the drugs and appliances that can be prescribed on a prescription form (HS21) and introduce top-up payments for premium priced alternatives

This option is based on the introduction of a system based on the principles discussed in option 2 but offering patients the choice to make a top-up payment to obtain premium priced alternatives in situations where only the generic form of the drug is included in the NI Drug Tariff. The NHS Confederation proposed this in their evidence to the Inquiry into health charges conducted by the Parliamentary Select Committee on Health⁵³. Although this system would appeal to patients who would prefer to receive branded medicines, introduction of this system would be complex to administer and may affect stock

management systems in community pharmacy. An IT system would also be required to support the pharmacists in calculating the appropriate levels of top-up payments. It may also undermine the current DHSSPS generic prescribing policy and create the perception that premium priced products are of a superior quality to the generic drugs. It could also be perceived as creating a two-tier system in which those who could afford to pay would have more choice and be able to receive better quality medicines. There was some support at the public engagement event for this type of option however, those in favour of it were anxious to ensure that it would not create a two-tier system.

6.3 Options for reform of the current system of Charges and Exemptions

The current system dates from 1968, whenever prescription charges were re-introduced following a three year period during which charges were not levied. Some additional exemptions were added in 1974, 1975 and 1982³. It was reviewed again in 1998, however, no changes were made.

The criteria for exemption are based on age, income/benefits and medical conditions. There are a number of variables in each of these groups which could be varied to reform the current system. Most of the changes would deliver benefit to some sections of the population, however, there are significant issues associated with them as outlined in 6.3.2 to 6.3.5 below. Reform of the current charging and exemption system would deliver benefits for some groups of patients and the population.

6.3.1 Current arrangements

Option 4	Maintain the current arrangements
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Many patients, representative groups and professional bodies have called for change to address the anomalies and to reduce the financial barrier to obtaining medicines. The participants who attended the public engagement event echoed this call and cited examples of the impact of the current system on the lives of individuals. For these reasons, maintaining the status quo would not be popular with patients or professionals.

6.3.2 Age

Option 5	Extend exemption from prescription charges to include up to age 25
Option 6	Remove exemption from prescription charges for the 60-64 age group

The current age-related exemptions are;

- A person who is under 16 years
- A person who is aged 16, 17 or 18 and in qualifying full time education
- A person who is aged 60 or over.

In NI, age-related exemption is estimated to account for 62.3% of items dispensed for which an exemption is claimed.

The upper age limit of 60 could be increased to 65 in line with State Pension age, when that takes effect from 2010, on the grounds that individuals over 60 but still in employment have the ability to pay. The number of medications prescribed for individuals aged over 65 is significantly higher than the rest of the population. This is a growing proportion of the population with increasing health needs. The number of people of current pensionable age is projected to increase by around 9% in the next five years and by around 40% over the next fifteen years⁴⁸.

There are currently 87,000 individuals aged between 60 and 64 and the estimated financial impact of a change would be additional revenue of £4.7million. Individuals in this age group who were on means tested benefits such as pension credit or qualified for another exemption would continue to receive their prescriptions free of charge. The EPES pilot data indicates that 24% of items dispensed to individuals aged 60-64 will be for holders of PPCs and therefore will be exempt. This is substantially higher than the average proportion of items that are exempt due to PPCs in the whole population. The purchase of additional PPCs by this group will increase the income derived from this option but it is not possible to calculate the additional income using the data that is currently available.

The possibility of raising the upper age limit from 60 to 65 was discussed at the public engagement event and there was support for it, however, it may not be popular as it would not deliver a benefit to those in this age-group. It would also mean that a group which is exempt under the current system would be required to pay prescription charges in the future. Local research into willingness to pay for GP services found that in Northern Ireland, where GP charges do not currently exist, patients were opposed to charging for GP consultations. This supports the view that those who do not currently pay will be unwilling to pay for prescriptions in the future⁵⁴. It may also be difficult to collect charges from individuals in this age group who live in nursing or residential homes and do not qualify for another exemption. If introduced, patients who are currently aged between 60 and 64 and therefore exempt, should retain their exemption status through protection.

The National Assembly for Wales provided free prescriptions to 16-25 year olds from April 2001. This change was quoted as benefiting an age group whose disposable income is less than

that for the 25 to 59 age groups. This would particularly benefit young couples with children and students under 25 in higher education. Minimal change in patient behaviour and prescription cost was noted as a result of the introduction of the freeze on prescription charges or the extension of exemption to the 16-25 age groups. **Appendix 6** shows the actual prescription items dispensed per capita and the cost per capita in Wales and Northern Ireland from 1994/5 to 2004/5 and the trend line for predicting growth based on the period 1994/5 to 2000/1. The volume of prescriptions dispensed increased following the change in policy in April 2001, however, the ingredient cost per capita does not show a similar increase. This suggests that, although the volume of prescription items increased, the growth in cost was contained. Other policy changes may have contributed to minimising the impact of the policy change on prescription charges and exemptions.

A similar change in NI would affect approximately 176,000 individuals. It is not possible to accurately determine the number of prescription items that are currently dispensed as exempt for this age-group. The financial impact of this change is broadly estimated to be a reduction in revenue ranging from £750,000 to £1.5 million. This group is largely healthy and their utilisation of medication is low. Therefore no increase in prescription volume would be anticipated. Extending the lower age group up to 25 would benefit those in employment and those in education or training, however, mature students are more likely to be outside this age-group and would still need to apply for help with charges through the NHS Low Income Scheme.

6.3.3 Income/benefits

The criteria for exemption from prescription charges on the grounds of income are effectively a proxy for low income as they

are all means tested benefits. The current income related exemptions are based on means tested criteria that are applied at a UK level. Individuals and their families who are in receipt of certain benefits are entitled to free prescriptions. Individuals who apply for help with charges under the NHS Low Income Scheme and receive a HC2 form are also entitled to exemption from prescription charges. The benefit entitlements are applied on a UK wide basis and cannot be altered for Northern Ireland because Social Security Agency benefits is not a devolved issue.

A woman with a valid exemption certificate issued by the CSA because she is an expectant mother or has given birth within the last twelve months is exempt from prescription charges. It is estimated that 1% of exempt items in NI are for maternity exemption certificate holders. This exemption certificate is UK wide and confers benefit in relation to other health charges and therefore it cannot be altered for NI.

The current system exempts a person receiving a War or MOD Disablement Pension holding a valid exemption certificate issued by the Secretary of State from prescription charges in respect of the supply of drugs and appliances for the treatment of the accepted disablement only. It is estimated that 0.2% of items for which exemptions are claimed in NI are for those holding a war pension exemption certificate⁵⁵. This benefit is also a UK-wide benefit and cannot be altered for NI.

6.3.4 Prescription Prepayment Certificate

Option 7	Make Prescription Prepayment Certificates available retrospectively on provision of EPES proof of receipt of a qualifying number of
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	prescriptions
Option 8	Enable Prescription Prepayment Certificates (PPC) to be purchased by monthly instalment

Holders of PPCs qualify for free prescriptions. PPCs address the issue of affordability to some extent. For people who are not exempt on the grounds of income or other criteria, but require many or frequent prescriptions, the PPC presents a more affordable way of paying for those prescriptions. In order to buy a PPC, the patient needs to have sufficient funds available. Patients at the lower end of the income scale may find that the need to pay this sum all at once acts a barrier to utilising the PPC and realising the benefits. Approximately 4-5% of exempt items are currently dispensed to holders of a PPC. The EPES sample suggests that the uptake of PPCs is higher in older age groups. It is assumed that patients who choose to purchase a PPC have medical conditions which require them to take multiple medicines on a regular basis. Alteration of the PPC system to make it more affordable, e.g. through monthly instalments, would be most likely to benefit those who have chronic illness. Payment by monthly instalments would spread the cost of an annual PPC, making it more affordable than a lump sum payment.

A cap on the amount that a patient pays for prescription medication over a given period of time is the most common type of cap in use elsewhere in Western Europe, North America and Australasia¹. In some countries a cap is placed on costs for certain groups or services only and in others the cap is applied as a reduced payment for high users.

The PPC acts as a monetary cap on expenditure on prescription charges, however it does not operate retrospectively. A system

to allow retrospective application of a monetary cap would be more effective in reducing the financial barrier to access to medicines. However, it is likely to be a greater administrative burden than the sale of a prepayment certificate. The cap would need to be administered at individual patient level and would therefore be most effective if it could be applied at the point of dispensing. The administration of a retrospective cap could be a feasible option as 83% of patients who have regular medication needs in Northern Ireland currently use the same pharmacy routinely to have their medication dispensed. This increases to 90% in patients over 65 years of age⁵⁶. Administration of a monetary cap would require a record of dispensed medicines during the qualifying period which would ideally be achieved through registration of patients with the pharmacy of their choice for that period. This would not be popular with community pharmacists and may be inconvenient for some patients, however it is similar to the Drugs Payment Scheme in the Republic of Ireland⁸. An alternative means to administer such a cap would be through patient-held records or via a process which would require patients to claim back the prescription charges that were in excess of the capped amount. The new EPES system will provide an individual patient receipt which could be used as evidence for a retrospective claim for a PPC which could be processed through the CSA.

It is not possible to estimate the financial impact of these options on revenue, prescription volume or administration because there is currently no reliable information which could be used to estimate future uptake of PPCs.

6.3.5 Medical Condition

Option 9	Extend the medical exemptions to include patients suffering from a greater range of chronic illnesses
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The main argument to amend the current system of prescription charges stems from the anomalies that exist in the list of the medical exemptions. At present, anyone who qualifies for exemption because they have one of the specified medical conditions does not have to pay prescription charges for any of their medication regardless of whether the medication is related to the specified medical condition or not. There are no known criteria or definitions for inclusion of a medical condition in the current list. There is also no definition of a chronic condition or disease in legislation. The Regional Strategy, *A Healthier Future*, identifies a list of seven chronic condition management programmes which will be developed in addition to the cancer network¹⁰. However, this list is not comprehensive and does not include many of the specific conditions which have been identified by individuals and organisations in their correspondence with the Minister.

Developing a new list of conditions which would confer exemption from prescription charges would require agreement with the medical profession. The BMA statement on prescription charges in March 2007 explained that, although the BMA acknowledged the anomalies in the current medical exemptions, it did not wish to see the specific clinical categories increased⁵⁷. The view of BMA NI is that they welcome a review of the current system. The BMA's stated position is that they want the Government to abolish this charge in the interests of equity for all patients. However, they have also indicated that they would give due consideration to alternative proposals and that although they may consider a degree of flexibility within the

current system, they are primarily looking for a fairer system that does not tax illness.

In trying to develop a new list of medical exemptions, the main issue is “where to draw the line”. Any new list would be arbitrary and likely to produce inequity unless a clear definition could be developed. The experience from Scotland and Wales is that defining chronic conditions is a very complex task and fraught with issues of equality, legality and justice. In Wales, their assessment was that it would not be practically possible or equitable to rank chronic medical conditions in terms of clinical need for medication and that exempting all chronic medical conditions would be almost equivalent to abolishing prescription charges altogether. The medical profession agreed with this assessment. Their conclusion was that a new list of chronic conditions would not have the legal robustness required for a new initiative.

Additional GP and pharmacist workload would potentially ensue from administration of a more comprehensive list of medical exemptions. An analysis of current prescribing in NI conducted for this review found that medications which are associated with treatment of long term medical conditions are estimated to account for more than 77% of items dispensed. This analysis looked at the normal indications of the drugs and did not take account of medications that may be required to treat additional illness which may be associated with a long term condition. The analysis of the data could not link prescribing to diagnosis.

Although it is appealing to suggest an extended list of medical conditions which would be eligible for exemption, in practice, defining a fair and inclusive list is a complex process which will substantially increase the number of items which will be dispensed free of charge. A new list will require a process for

continuous review of the conditions included. It will be essential to have support of the medical profession for any new list and for the processes which will be required to maintain it.

In order to reduce the anomalies in the current system, it has been proposed that medical exemptions be restricted to treatments for the exempted condition only. This would mean that patients who currently receive all their medication free of charge would have to pay for some items in the future. Whilst this proposal was supported by those who attended the public engagement event, it would be unpopular with patients who currently hold a valid medical exemption certificate. There would also be difficulties in administration of this proposal because it would be difficult for a doctor or pharmacist to identify the prescribed treatments which related to an exempted condition only. Implementation of this proposal would potentially cause some friction for the doctor-patient and pharmacist-patient relationships which would be undesirable and make this proposal unworkable.

Many conditions can vary in their severity both between patients and during the lifetime of individual patients. Some conditions may require many medications whereas others may require relatively few and this can vary over time. In addition, some patients may require a lot of medication over a relatively short period of time to treat a short term condition. Any new list of medical exemptions could be subject to challenge under Human Rights legislation by patients who believe that their disease is equally deserving but omitted from the list. It would be simpler and more effective to provide benefit for patients who require multiple medications to manage short or long-term conditions through an alternative means such as changes to the PPC or abolition of charges.

In the Scottish consultation, there was universal support for provision of immediate exemption for patients who are terminally ill and hold a DS1500 certificate which fast-tracks them for immediate receipt of Disability Living Allowance or Attendance Allowance⁴. This would provide an additional level of support for patients such as cancer sufferers, during a very distressing period for them and their families. Multiple medications which frequently change are necessary during this period in order to manage symptoms and exemption from charges would relieve the financial burden at this time. This would benefit approximately 420 patients per year in Northern Ireland.

6.4 Options for introduction of a new system of Prescription Charges and Exemptions

Option 10	Introduce a new prescription charge system with a low fee (80p) per item and exemptions based on ability to pay and means tested benefits only
Option 11	Introduce a new prescription charge system with a low fee (80p) per item and exemptions based on ability to pay, means tested benefits and age only

There are many anomalies within the current prescription charge system as discussed in earlier sections. It is commonly understood that the aim of prescription charges is to deter unnecessary demand and to raise revenue^{19,38}. Research studies confirm that increasing prescription charges reduces medicine consumption. There is also a commonly held belief that people do not value something that they do not pay for. However, representation has been made that the current level of the prescription charge is too high. Historically, the prescription charge has closely tracked the United Kingdom rate of inflation (RPI) from its introduction until the late 1970's. Thereafter, it increased sharply (fivefold) until the mid-1990s. The rate of increase of

prescription charges above inflation since then has tapered off. Whilst no link exists between the costs of medication and the prescription charge, it is worth noting that the current UK charge still only covers half the cost of the average Northern Ireland prescription item.

Responses to the Scottish Consultation on prescription charges supported the idea that exemption to prescription charges should be based on ability to pay alone⁴. A lower charge with fewer exemptions has been proposed as an alternative to the current prescriptions charges and exemptions^{19,58}. If the only exemptions included were income and passport benefits (i.e. maternity certificate, war pensioner certificate and NHS Low Income Scheme HC2 holders), more people would be paying prescription charges and therefore the prescription charge could be set at a much lower level. As a consequence, the financial barrier for patients to access their medicines would be reduced. In order to maintain current revenue from prescription charges, this charge could be set at £0.80 per item. At this level of charge, patients would receive eight prescription items for the current price of a single prescription charge (£6.85).

Over 60% of exemptions claimed are age-related. If those aged under 16 and aged 65 and over were entitled to exemption, the number of people eligible to pay prescription charges would be significantly reduced and the charge could be set at £2.20 per item. This would equate to three prescription items for the current price of a single prescription charge. Alternatively the charges could be kept at the lower level of 80p per item and the resultant cost could be a loss of revenue of £8.7 million.

Despite the low level of the prescription charge in both options, some form of monetary cap would still be required to provide financial assistance for those who require multiple medications as described in 6.3.5 above. In the future, EPES data should provide data to allow the number of prescription items dispensed per patient to be determined.

This would enable more sensitive analysis of the most appropriate threshold for application of a monetary cap.

The benefit of these two proposed options would be to maintain charges in the system which would deter unnecessary demand and encourage people to value their prescribed medication. The proposals may be unpopular with individuals who currently receive all their medication free of charge and may object to making any financial contribution as discussed in 6.3.1 above⁵⁴. This would impact on those in the following exemption categories; medical, prepayment certificate, under 16, and aged 16, 17 or 18 and in full-time education and aged 60 and over. There may be a need to protect those currently in receipt of exemption for a period of time after introduction of a new system.

Both of these options may increase workload in community pharmacy because more patients will be eligible to pay the much reduced fee, however the number of patients for whom point of dispensing exemption checks is required would be expected to reduce accordingly.

The figures quoted for these two options do not take into account any possible increase in demand for prescriptions as a result of implementing this policy. There is no experience from elsewhere to provide evidence of the impact of either option on the demand for prescriptions.

If either of these options is chosen, further work could be done on the level of the charge which could be applied.

6.5 Impact on Prescription Fraud

Prescription fraud by patients will be eliminated through the abolition of prescription charges. The options that include the extension of exemptions within the current system could potentially reduce the level

of fraud. The introduction of a much reduced prescription charge will reduce the financial value of the income that is lost through evasion of charges. It is not known whether the level of fraud will change as a result of the introduction of a significantly reduced prescription charge.

The following tables summarise the position on the options:

List of Options

Option 1	Abolish prescription charges
Option 2	Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21)
Option 3	Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21) and introduce top-up payments for premium priced alternatives
Option 4	Maintain the current arrangements
Option 5	Extend exemption from prescription charges to include up to age 25
Option 6	Remove exemption from prescription charges for the 60-64 age group
Option 7	Make Prescription Prepayment Certificates available retrospectively on provision of EPES proof of receipt of a qualifying number of prescriptions
Option 8	Enable Prescription Prepayment Certificates to be purchased by monthly instalment
Option 9	Extend the medical exemptions to include patients suffering from a greater range of chronic illnesses
Option 10	Introduce a new prescription charge system with a reduced fee (80p) per item and exemptions based on ability to pay and passport benefits only
Option 11	Introduce a new prescription charge system with a reduced fee (80p) per item and exemptions based on ability to pay, passport benefits and age only

These options can stand alone or be combined into a package of measures.

Summary Table 1: Estimated benefit of each option on the specific patient group targeted by the option

Benefit Criteria	Options										
	1	2	3	4	5	6	7	8	9	10	11
Supports Programme for Government policy of reducing inequalities, improving access to healthcare (Investing for Health)	✓	✓	✓	x	✓	x	✓	✓	✓	✓	✓
Promotes equal access for all	✓	✓	x	x	x	x	✓	✓	x	✓	x
Reduces the financial barrier for patients to obtain medication which they need	✓	✓	✓	x	✓	x	✓	✓	✓	✓	✓
Affordable for patients at the time of need	✓	✓	✓	x	✓	x	✓	✓	✓	✓	✓
Improvement in health	✓	✓	✓	x	✓	x	✓	✓	✓	✓	✓
Removes anomalies in current system eg medical exemptions, pension age, multiple charges	✓	✓	✓	x	x	✓	✓	✓	?	✓	✓
Easy for public to understand	✓	✓	x	?	✓	✓	✓	✓	?	✓	✓
Contributes to the efficient and effective provision and use of primary care services including medicines	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Places value on medication	x	✓	✓	✓	x	✓	✓	✓	x	✓	✓
Minimal impact on healthcare delivery eg hospital admissions	✓	✓	✓	?	✓	x	✓	✓	✓	✓	✓
Practicable to deliver	✓	x	x	✓	✓	✓	x	x	x	?	?

Key

✓ Positive impact x Negative impact ? Questionable impact

Summary Table 2: Estimated cost and impact of each of the options identified

	Option	Net income from current arrangements	Estimated new net prescription income	Estimated change from current	Patient groups that benefit	Equality implications
Abolition	1. Abolish prescription charges *	£13.1m	-£6.9m to - £11.0m	-£20.0m to -£24.1m	Full population	Benefits everyone regardless of income or health status
	2. Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21)	£13.1 m	Financial impact not costed	Financial impact not costed	Full population	Benefits everyone regardless of income or health status
	3. Abolish prescription charges and limit the drugs and appliances that can be prescribed on prescription form (HS21) and introduce top-up payments for premium priced alternatives	£13.1m	Financial impact not costed	Financial impact not costed	Full population	2-tier system that could be perceived as allowing wealthy to have greater choice

Reform of current system	4. Maintain the current arrangements	£13.1m	£13.1m	£0	Only those currently exempt	Disadvantages those on modest incomes who are chronically and terminally ill
	5. Extend exemption from prescription charges to include up to age 25	£13.1m	£11.6m to £12.3m	-£0.75m to -£1.49m	Under 25s only	Disadvantages those on modest incomes who are chronically and terminally ill
	6. Remove exemption from prescription charges for the 60-64 age group	£13.1m	£17.8m	£4.7m	none	60-65 who are not exempt for another reason
	7. Make PPCs available retrospectively on provision of EPES proof of receipt of a qualifying number of prescriptions	£13.1m	Financial impact not costed	Financial impact not costed	Acute illnesses Chronic illness that flare up Those with modest incomes	none
	8. Enable PPCs to be purchased by monthly instalment	£13.1m	Financial impact not costed	Financial impact not costed	Acute illnesses. Chronic illness that flare up Those with modest incomes	none
	9. Extend the medical exemptions to include patients suffering from a greater range of chronic illnesses	£13.1m	Financial impact not costed	Financial impact not costed	Those patients within the new exemption list	Some patient groups will still not be exempt

New system	10. Introduce a new prescription charge system with a reduced fee (80p) per item and exemptions based on ability to pay and passport benefits only	£13.1m	£13.8m	£0.7m	All who currently pay or use PPC	Removal of current exemptions will impact on Medical exemption and Age groups
	11. Introduce a new prescription charge system with a reduced fee (80p) per item and exemptions based on ability to pay, passport benefits and age only	£13.1m	£4.4	-£8.7m	All who currently pay or use PPC	Removal of current exemptions will impact on Medical exemption and those aged 60-64

* projected increased growth in prescription items of 22% and sensitivity analysis of 35%

The detailed costing for each option is outlined in **Appendix 7**

7.0 Implementation

7.1 Phasing of Changes

In Wales, free prescriptions were introduced in April 2007. This followed a period of yearly reductions in the level of the prescription charge from September 2004. In Scotland, there is a commitment to free prescriptions by 2011. The cost of a single prescription is to be cut by more than 25% in 2008, from £6.85 to £5, and will be further reduced by £1 in each of the two subsequent years before abolition, whilst the cost of a 1 year PPC will be cut over the same timescale, from £98.70 to £48, then down to £38 and finally £28, before all prescription charges are abolished⁵.

Theoretically, it would be possible to introduce all of the options in an incremental way however this would be administratively difficult for several options.

The benefits of introducing the changes slowly would be to manage the financial impact and to engage with the public. In addition, a phased approach would allow any necessary infrastructure to support the changes to be implemented. A phasing in period would also allow the developments in rational prescribing planned for the next three years to be well established in advance of significant changes to prescription charges.

Any changes to the current list of exemption categories would require amendment of the back of the prescription form and possibly some editing of leaflets notifying the public about the exemptions. The time to process these amendments would need to be built into the phasing timetable. Work carried out as part of the EPES project highlighted large volumes of unused prescription forms which were being stored by GP practices. Additional resources may be required to remove old style forms from the system and to undertake destruction.

There may a need to provide protection of current benefit for individuals in receipt of exemption who may not qualify under a new system. If this is necessary, it would be beneficial to phase the introduction of changes in line with the protection period.

There are a number of possible ways to deliver benefits to those requiring prescriptions during a period of phased changes. Some possibilities are:

1. Extend exemptions to include patients who are terminally ill and hold a DS1500 certificate
2. Freeze the existing charge for a defined period eg 5 years.
3. Extend exemptions to additional groups incrementally.
4. Retain exemptions and reduce charges incrementally to a lower level.
5. Introduce some of the proposed options over a defined period of time as part of an overall package of measures.

During the period in which charges were reduced in Wales, from £6 per item in April 2003 to £3 in April 2006, there is no reported increase in demand for prescriptions, although one piece of research identified a downward pattern in sales of paracetamol in pharmacies in Wales compared to similar areas in England⁵⁸. The impact of abolition of charges on prescription volumes and cost will not be known until sufficient data is available to conduct statistical analysis. First impressions of the impact of abolition were reported by a small number of GPs and pharmacists after six months and indicated that they were not aware of a major change in prescribing or patient behaviour⁵⁹. Research into the impact of the policy change is being conducted by Bangor University. A timetable of phased changes would also allow the policy changes to take account of the impact of abolition in Wales.

7.2 Further analysis and refinements of costs associated with implementation of options

7.2.1 Workload considerations

It would be essential to give due consideration to the need to minimise bureaucracy and maximise efficiency for all parties involved in the future administration of any new systems designed to deliver the chosen option for collection of prescription charges. Any proposals should be practical to deliver and easy for the public and professionals to understand. The specific workload implications for community pharmacy and general practice are discussed below.

7.2.2 Community Pharmacy workload

It is anticipated that implementation of some of the options may result in an increase in workload for community pharmacists associated with collecting additional prescription charges, carrying out additional exemption checks and increased volume of prescriptions. The community pharmacy remuneration arrangements separately identify fees for exemptions checks, sale of PPCs and dispensing. The value of contractor's time taken to collect charges is not separately identified.

An estimate of additional dispensing fees associated with any increased volume of prescriptions has been factored into the costing of the abolition option; however the projected increase in volume is based on limited data on the effects of abolition. Further analysis of the impact of abolition in Wales and the experience of phasing abolition in Scotland from April 2008 will be necessary for this costing to be further refined.

Additional fees for sale of PPCs have been calculated for the options in which there is a projected increase in purchase of PPCs.

Where exemption checks are likely to remain, the point of dispensing fees have been retained for all items. The Pharmaceutical Contractors Committee have indicated that options which increase the number of people eligible to pay charges would increase the costs incurred by community pharmacists for cash, credit card and debit card transactions and for staff time to collect charges. An increase in the number of prescription items attracting a charge would be offset by a decrease in the number of exempt items, thereby reducing the burden of point of dispensing checks which are currently remunerated as part of the dispensing fee for all items dispensed.

The quantum and cost of any increase in community pharmacy workload as a result of changes to the prescription charges system cannot be defined at this stage and is dependent on the detailed design of any new systems which may be implemented in community pharmacy to support any of the options. This workload and associated cost would need to be identified and negotiated between the Department of Health, Social Services and Public Safety for Northern Ireland and Community Pharmacy Contractors.

7.2.3 GP workload

If the volume of prescribing increases as a result of abolition of prescription charges, there will be an increase in GP consultation rates. This will result in an opportunity cost associated with patients using GP appointment slots to seek medication that will be free of charge rather than purchasing

those medications over the counter. This may have an impact on the GP access targets. As the Welsh experience with abolition develops, further information will be available to enable refinement of the calculations of lost GP appointment slots.

8.0 Conclusions

- 8.1** It is not possible to determine if the current system of prescription charges directly impacts on health gain.
- 8.2** There has been a call for change to address anomalies in the current system and to reduce the financial barrier to access to medicines. Feedback from the public engagement conducted for this review suggests that the option of status quo i.e. no change to the current system, will be unpopular with patients and professionals.
- 8.3** An extended list of medical exemptions has been proposed. It will be difficult to achieve a new list that is comprehensive, consistently up to date, equitable and legally defensible. It would be simpler and more effective to provide benefits for patients who have multiple medication needs through administration of a monetary cap on an annual or monthly basis or via abolition.
- 8.4** Extension of exemption to include holders of a DS1500 certificate could be easily achieved and is likely to be universally popular.
- 8.5** Raising the upper age limit for exemption from 60-65 would be in line with recently announced changes to the state pension age. Individuals in this age group are high users of medicines and over 50% of the items prescribed for this age group will qualify as exempt under another exemption category.

- 8.6** Abolition of prescription charges would provide benefit to all of the population and as such would also benefit those who can continue to afford to pay prescription charges.
- 8.7** The volume of prescriptions is likely to increase in response to abolition of prescription charges. Measures to control the increase in volume and cost may be required. A restricted list of drugs and appliances which may be prescribed would be effective if developed on the principle of safety, quality and cost-effectiveness. Further analysis of the feasibility and cost of a restricted list for NI would be required.
- 8.8** It is questionable as to whether the existing exemption categories accurately target those patient groups who may experience prescription charges as a barrier to access to medicines.
- 8.9** Implementation of any of the options, except abolition, will require a new system of administration in community pharmacy, CSA and possibly General Practice. Any new system will require a full analysis of the inherent costs for all relevant parts of the service.

GLOSSARY OF TERMS

CSR	Comprehensive Spending Review
DHSSPS	Department of Health, Social Services and Public Safety
DPS	Drug Payment Scheme
Drug Tariff	The Drug Tariff provides information on what will be paid to contractors for NHS Services including both reimbursement (eg the cost of drug and appliances supplied against an HHS Prescription form) and remuneration (eg professional fees/allowances)
DS 1500	A certificate, issued by a GP or consultant to a patient who may be suffering from a potentially terminal illness, that confers entitlement to Attendance Allowance or Disability Living Allowance under the Special Rules arrangements to fast track claims for these benefits.
DSD	Department for Social Development
EPES	Electronic Prescribing and Eligibility System
Formulary	A list of medicines to which prescribers re encouraged or required to adhere
GP	General Practitioner
HC2	Low income scheme certificate issued for full help with health costs
HC3	Low income scheme certificate issued for partial help with health costs. The certificate tells you who is covers and how long it lasts
HS21	A community prescription form in Northern Ireland
LTI	Long Term Illness Scheme
NHS	National Health Service
NHS Low Income Scheme	A scheme to provide help with health service charges for those on low income
NI	Northern Ireland
NISRA	Northern Ireland Statistics and Research Agency
PCC	Pharmaceutical Contractors Committee
PSIP	Pharmaceutical Services Improvement Programme: A programme in NI designed to deliver better quality, safety, improved efficiency and value for money in relation to medicines management by March 2008.
QOF	Quality and Outcomes Frameworks (General Medical

	Services)
RPI	Retail Price Index
STEPS	Safe and Therapeutic Evaluation of Pharmaceutical Product Selection

Appendix 1

MEMBERSHIP OF PRESCRIPTION CHARGE REVIEW PROJECT BOARD

Christine Jendoubi, Chair	Director of Primary and Community Care, DHSSPS
Deirdre Tunney	Director, Pharmaceutical Services, SHSSB
Kathryn Turner	Head of Professional Pharmacy Services, CSA
Brian Dunn	Northern Ireland General Practitioners Committee
Neil Gordon	Pharmaceutical Contractors Committee*
Gerard Greene	Pharmaceutical Contractors Committee*
Stella Cunningham	Southern Health & Social Services Council representing patients*
Maggie Reilly	Western Health & Social Services Council representing patients*
Kathryn Booth	Senior Medical Officer, DHSSPS
Lesley Edgar	Pharmaceutical Branch, DHSSPS
Tom Robinson	Pharmacy & Prescribing Branch, DHSSPS
Olive Smith	Pharmacy & Prescribing Branch, DHSSPS

(* deputising arrangement)

MEMBERSHIP OF PRESCRIPTION CHARGE REVIEW SUBGROUP

Deirdre Tunney	Director of Pharmaceutical Services, SHSSB
David Clarke	Economist, DHSSPS
Olive Smith	Pharmacy & Prescribing Branch, DHSSPS

TERMS OF REFERENCE FOR THE PROJECT

- To carry out a cost and benefit review into prescription charges in NI, including the implications of abolition and options short of full abolition, taking into account developments in the rest of the UK and other countries, as relevant;
- In so doing, to review the list of conditions which currently confer entitlement to free prescriptions; and
- To report back to the Minister by the end of the year.

References

1. Scotland. Department of Health. Review of NHS Prescription Charges and Exemption Arrangements in Scotland. January 2006. Available from <http://www.scotland.gov.uk/Publications>
2. Hansard. HC Deb 15 May 2007
3. Office of Health Economics. Available at www.ohe.org
4. Scotland. Department of Health. Review of NHS Prescription Charges and Exemption Arrangements in Scotland. Analysis of Responses received. April 2007. Available from <http://www.scotland.gov.uk>
5. Story from BBC news. Staged end to prescription charges. <http://news.bbc.co.uk/1/hi/scotland/7127997.stm>
6. House of Commons. Health Committee. NHS Charges. Third Report of Session 2005–06. Available at www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/815/815-i.pdf
7. Great Britain. Government Response to the Health Committee's Report on NHS Charges. Presented to Parliament by the Secretary of State for Health. October 2006. Available at www.tso.co.uk/bookshop
8. Prescribed Drugs and Medicines in Ireland. <http://dhssps/frames/contentdohc.html>
9. <http://www.theyworkforyou.com>
10. Northern Ireland. Department of Health, Social Services and Public Safety. A healthier future. 2005. Available from <http://www.dhsspsni.gov.uk/healthyfuture-main.pdf>
11. Tudor Hart, J. The Inverse Care Law. *The Lancet*;1: 405-412 (1971)
12. McBride, M. Your Health Matters, The annual report of the Chief Medical Officer for Northern Ireland. 2006
13. Kennedy, J. et al. Drug affordability and prescription non-compliance in the United States; 1997-2002. *Clin Ther.* (2004)
14. Kennedy, J. & Morgan S.A cross-national study of prescription nonadherence due to cost: data from the joint Canada-United States Survey of Health. *Clin Ther.* 2006 August 28(8):1217-24
15. Piette, J.D. *et al.* Cost-related medication underuse among chronically ill adults: the treatments people forgo, how often and who is at risk. *Am J Public Health.* (2004) Oct; 94 (10) 1782-7
16. Piette, J.D. *et al.* Cost-related medication underuse; do patients with chronic illnesses tell their doctors? *Arch Intern Med.* (2004) Sep 13; 164(16): 1749-55
17. Huttin, C. The use of prescription charges. *Health Policy* 27 (1994) 53-73.
18. O'Brien, B. The effect of patient charges on the utilisation of prescription medicines. *Journal of Health Economics* 1989; 8: 109-132. North-Holland
19. Freemantle, N & Bloor, K. Lessons from international experience in controlling expenditure. 1: influencing patients. *BMJ.* 1996; 312: 1469-1471.
20. Schafheutle, E.I. *et al.* Access to medicines; cost as an influence in the views and behaviour of patients. *Health Soc Care Community.* 2002; 10(3): 187-95
21. Jones, N. The effects of user charges on the dispensing of prescription

- medicines; a survey of prescription charge payment in the Wellington region. *New Zealand Medical Journal*. 1993; 106: 225-6
22. Watt, J *et al*. The effect of the increased prescription charges on the collection of asthma drugs. *New Zealand Medical Journal*. 1992; 105: 153-4
 23. Hughes, D. & McGuire, A. Patient charges and the utilisation of NHS prescription medicines; some estimates using a co-integration procedure. *Health Economics*. 1995; 4: 213-220
 24. Lundberg, L. *et al*. Effects of user charges on the use of prescription medicines in different socio-economic groups. *Health Policy*. 1998; 44: 123 - 134
 25. Smith, A.J. Prescription charges and the evaluation of health policies. *The Medical Journal of Australia*. 1991; 154: 303-304
 26. Piette, J.D. *et al*. Medication Characteristics beyond cost alone influence decisions to underuse pharmacotherapy in response to financial pressures. *J Clin Epidemiol*. 2006; 59(7): 739-46
 27. Goldman, Dana P. PhD. *et al*. Pharmacy benefits and the use of drugs by the chronically ill. *JAMA*. 2004 May 19; 291 (19): 2344-2350
 28. Soumerai, Stephen B. *et al*. Effects of limiting medicaid drug reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia. *NEJM*. 1994 September 8; 331(10), 650-655
 29. Tamblyn, R. *et al*. Adverse events associated with prescription drug cost sharing among poor and elderly persons. *JAMA*. 2001; 285: 421-429
 30. Lexchin, J. & Grootendorst, P. Effects of drug users fees on drug and health service use and on health status of vulnerable populations; a systematic review of the evidence. *International Journal of health Services*. 2004; 34(1): 101-122
 31. Cole, J.A. *et al*. Drug copayment and adherence in chronic heart failure: effect on cost and outcomes. *Pharmacology*. 2006; 26(8): 1157-64
 32. Kozyrskyj, A.L. *et al*. Socioeconomic status, drug insurance benefits, and new prescriptions for inhaled corticosteroids in schoolchildren with asthma. *Arch Pediatr Adolesc Med*. 2001; 155(11): 1219-24
 33. Kozyrskyj, A.L. *et al*. Income -based drug benefit policy: impact on receipt of inhaled corticosteroids prescriptions by Manitoba children with asthma. *CMAJ*. 2001; 165(7): 897 -902
 34. Dormuth, C.R. *et al*. Impact of two sequential drug cost-sharing policies on the use of inhaled medications in older patients with chronic obstructive pulmonary disease or asthma. *Clin. Ther*. 2006; 28(6): 964-78;
 35. Schneeweiss, S. *et al*. Adherence to statin therapy under drug cost sharing in patients with and without acute myocardial infarction: a population-based natural experiment. *Circulation*. 2007; 115(16): 2128-35. (Epub 2007 Apr 9)
 36. Gibson, T. B. PhD. *et al*. Impact of statin copayments on adherence and medical care utilization and expenditures. *Am J Manag Care*. 2006; 12: SP11-SP19
 37. Breisacher, BA. *et al*. Patients at risk for cost-related medication nonadherence: a review of the literature. *J Gen Med*. 2007 Jun;22(6):864-71. (Epub 2007 Apr 5)
 38. Royal Pharmaceutical Society of Great Britain. Prescription charges - should they be abolished? January 2005

39. Watt, J *et al.* The effect of the increased prescription charges on the collection of asthma drugs. *New Zealand Medical Journal* 1992; 105: 153-4
40. Schafheutle, E.I. *et al.* Non-dispensing of NHS prescriptions in community pharmacies. *The International Journal of Pharmacy practice.* 2002: 311-16
41. Atella, V. *et al.* Affordability of medicines and patients' cost-reducing behaviours; empirical evidence based on SUR estimates from Italy and the UK. *Appl Health Econ Health Policy.* 2005; 2 (1): 23-35
42. National Association of Citizens Advice Bureaux, *Unhealthy Charges*, 2001
43. Heisler, M. *et al.* Clinical identification of chronically ill patients who have problems paying for prescription medications. *Am J Med.* 2004 Jun 1; 116(11): 753-8
44. Hassel K *et al.* Cost to the patient or cost to the healthcare system? Which one matters the most for GP prescribing decisions? A UK-Italy comparison. *Eur J Public Health.* (2003); 13(1): 18-23
45. Kasje, W.N. *et al.* Dutch GPs' perceptions: the influence of out-of-pocket costs on prescribing. *Soc Sci Med.* 2002; 55(9):1571-8
46. Huttin, C. & Andral, J. How the reimbursement system may influence physicians' decisions results from focus groups interviews in France. *Health Policy.* 2000 Nov 17; 54(2):67-86
47. Bradley, F. *et al.* Influence of prescription charges on repeat prescribing in primary care. *J Clin Pharm Ther.* 2007 Jun; 32(3): 269-75
48. Northern Ireland Statistics and Research Agency – Statistics Press Notice – 2006-Based Population Projections – October 2007
49. Abolition of NHS Prescription Charges (Scotland) Bill, Robson K (2005) SPICe briefing. Available from <http://www.scottish.parliament.uk/business/research/briefings-05/SB05-33.pdf>
50. Walley, T. Prescription charges: change overdue? *BMJ.* 1998 August 22; 317: (487-8).
51. Ramsay-Baggs, P. Rationing. Introduce new category of prescription charges, "full cost medicines". *BMJ.* 1998 Nov 28; 317: 7171
52. Nguyen-Kim, L. *et al.* The politics of drug reimbursement in England, France and Germany. Institute for Research and Information in Health Economics. October 2005; No 99.
53. O'Dowd, A. Abolishing prescription charges for generic drugs should be considered, NHS Confederation says. *BMJ.* 2006 Feb 18; 332:384
54. O'Reilly, D. *et al.* Patients' attitudes to co-payments for general practitioner services; do they reflect the prevailing system? *Journal of Health Services Research & Policy.* 2007; 12 (4): 197-201
55. War Pensions Agency, Norcross, Blackpool
56. Northern Ireland. Department of Health, Social Services and Public Safety. February 2004. *Making it Better, A Strategy for Pharmacy in the Community.* Available from www.dhsspsni.gov.uk/makingitbetter.pdf
57. BMA. *Caring for the NHS. Funding prescription charges.* Briefing paper. March 2007. Available from <http://www.bma.org.uk/ap.nsf/Content/FundingPrescriptionCharges>
58. Gallagher, C & Bailey-Flitter, N. What can the NHS learn from health care provision in other countries? *The Pharmaceutical Journal.* 2007; 279: 210-213
59. Dhippayom, T. & Walker, R. Impact of the reduction of the prescription

- charge in Wales on the prescribing and sales of paracetamol. Proceedings of the British Pharmaceutical Conference. 2006, September. Manchester, U.K.
60. Moberly, T. First impressions of free prescriptions. *The Pharmaceutical Journal*. 2007; 279: 378

PRE-CONSULTATION PUBLIC ENGAGEMENT EVENT.

The Health and Social Services Councils facilitated this event and produced a summary of public opinion on possible options for changes to prescription charges Held on 18 October 2007 in the Glenavon House Hotel, Cookstown.

The attendees participated in discussion groups facilitated by the Chief Officers of the Health and Social Services Councils. Five possible options were presented and discussed by the groups. Each group discussed abolition of prescription charges and maintaining the current arrangements. In addition, each group considered one further option. The HSSCs collated all the feedback for each option and provided the summary below.

Option 1- Abolition:

Advantages

- Easy to administer with low admin costs and straightforward for the community pharmacists.
- Parity with the rest of the UK.
- NI has strong argument for free prescriptions due to the economic circumstances of the population.
- Advantage to those on low income who are not currently exempt - fairer system.
- Medicines by prescription 'free' to everyone.
- Improvement in health of population as people attend GP and medicate as prescribed.
- Less time off work.
- for those who pay but find current charges a burden, can reduce reluctance to attend GP for fear of charge attached to each item prescribed (health can suffer or deteriorate).
- Less likelihood of inappropriate self-medicating or using drugs prescribed for another person.
- Learn lesson from countries which have already abolished charges.
- Consider long & short term benefits to patients.
- GPs must prescribe responsibly particularly if there is no prescription charge.
- There may not necessarily be abuse of the system because prescriptions are free.
- Consider the cost of chasing fraud in the current system.
- Too expensive to abolish charges altogether.
- There is a risk people will 'play on it'.
- Experience is that people will over-order.
- Risk of pressure on GPs to prescribe because it is free.
- Free = consumer contempt.
- There should at least be a nominal cost – not total abolition.

- Extend over the counter drugs BNF (British National Formulary) & availability of generic drugs.
- Lot of patients prefer to buy over counter – increased awareness of drugs (via internet).
- Medicines bought cheaper in Europe?
- **In one workshop of approximately 15 people, there was a show of hands to indicate support for total abolition of charges. The result was that one person was in favour of abolition**
- Consider evidence that the system will be abused if charges are abolished:
 - Wales – too early to say what impact is – political decision – no review was carried out
 - Scotland (2012) – no history
 - Therefore no hard evidence for decision making
- Ageing population will require increase in revenue to support them.
- **In one workshop of approximately 15 people, there was a show of hands to indicate support for maintaining the status quo. The result was that no one was in favour of maintaining the status quo**
- There is a need to review the medical conditions included in the list of exemptions.

Disadvantages

- May encourage greater take-up of medication when not necessarily needed.
- Cost - where would the money come from?
- Additional pressure on GPs to prescribe not based on medical need.
- Prescription may not be valued so much if it is not paid for.
- Loss of £14.1m income currently received through charges.
- Total cost of drugs (and appliances) may rise as expectations increase (GPs need to exert some control).
- Less intrinsic value attached to 'free' items.
- More wastage/stock piling.

Option 2: - Abolition plus restricted availability

Advantages:

- Impacts on prescribing behaviour.
- Opportunity to pay extra for brand drugs if generic one not wanted.
- Opportunity to reduce drug bill.
- Proven effectiveness of items on a 'white' list.
- Other items available on private prescription.
- Greater purchasing power for NHS and greater competition among suppliers (drives down cost, financial savings).

- More prescribing of generic drugs.
- Eliminates selective exemption categories.

Disadvantages:

- Generic prescribing may be seen as second best.
- May be difficult to maintain list of drugs that can be prescribed.
- Patient choice restricted to items on the list.
- Public education programme required to combat commercial marketing.
- Private prescriptions disadvantages the less well off.
- Pharmaceutical Research and Development could be affected.
- Need to challenge people's beliefs and attitudes about effectiveness of cheaper generic drugs.
- Confusion over change of familiar long term medication to another drug. (People familiar with colour, shape, size of pills not names).
- Prolonged consultation and agreement on the 'white list' content – this option would take time to introduce.

Option 3 - Design new system ie blue sky thinking

- If you have to pay, what about being able to claim off income tax?
- Any system should be simple and non-bureaucratic
- Charge for script and not for item - although recognise that this may put pressure on GPs to 'load up' scripts
- A flat rate charge would encourage people to value the medicine
- Need for greater equity of what is available such as Alzheimer drugs.
- System should encourage thrift and not punish those who have worked and been thrifty etc
- System should discourage stocking of medication in bathroom cabinets and associated waste
- There should be flat rates with no exemptions - age exemption means that older people with a good income get the same benefit as those managing on a small income.
- Exemption on basis of condition seems unfair if you can afford to pay while others without an exemption will have to pay even if they are on a low income.

Option 4 - Retain charge and reform exemptions

- Medical exemptions are unfair and should be reviewed
- Income based exemptions are unfair as those on the borderline feel disadvantaged
- Is it worth charging if the income generated is minimal due to so many exemptions?
- Perceived lack of equity may contribute to fraud/discontent with the system.
- Under 16 – IMPORTANT TO KEEP
- Increase upper age limit → 65 All in favour

- Increase lower age limit → 25 All in favour
- Prescription charge per item too high – reduce prescription charge - All agreed

REVIEW LIST OF MEDICAL EXEMPTIONS

- Extend exemptions to include other conditions? – too difficult to decide what to include/omit
- Exemption for drugs related to exempted condition only – too difficult to identify what is related to condition & what is not – would it be worth the effort/cost trying to administer this?
- Pressure on GPs/pharmacists – who decides what is related to condition? – very difficult – could affect patient/doctor relationships

CONCLUSIONS

- Review list of medical exemptions
- Retain free prescriptions for under 16s
- Raise exemption age to 25
- Raise exemption age to > 65
- Reduce prescription charge
- Also to consider – Extend range of over the counter medicines
- Reduce waste
- Over prescribing
- Return of medicines

Option 5 - No change

Advantages

- Generates some income
- Community pharmacies add value to the system
- People who can afford it should make a contribution
- Familiarisation with current system

Disadvantages

- Unfair for some people excluded from exemptions
- Admin heavy and dependent on pharmacy goodwill
- Threshold for payment is too low so those on the margins are disadvantaged
- Information on exemption categories is complicated and isn't always correctly noted on the back of the script.
- 40 years out of date.
- exemptions not reviewed.
- young adult students (19+) disadvantaged.
- some treatments for non-exempt conditions now extend life expectancy.

- NI out of sync with rest of UK.

Other Comments

- Need a system where abuse is penalized e.g. prescribing chocolate/cakes
- Need to challenge GPs regarding their prescribing patterns and gather and present them with evidence
- Need to address patient expectations about what can/should be prescribed
- Present system not working – the range of exemptions needs reviewed
- Maintain close links with other UK countries
- Raise income tax to fund prescription income

Post it Notes

- Create an exemption for people in further and higher education as it is a major issue within the student body
- Consider the impact on adult students over 25
- Restrict the number of items for prescription and reduce the cost per item
- Lower the charge per item (e.g. £1/£2) but retain exemptions which need to be reviewed/reformed
- Have a flat charge with exemptions. How can bringing in money not be worth the effort?

EXEMPTION CATEGORIES IN NORTHERN IRELAND

Age related

Patients in the following age categories are exempt from prescription charges:

- under 16
- aged 16, 17 or 18 in qualifying full-time education
- aged 60 or over

Specified Medical condition

A person with a valid exemption certificate issued by the Central Services Agency because they have one or more of the following conditions are exempt from charges:

- Permanent fistula (including caecostomy, colostomy, laryngostomy or ileostomy) requiring continuous surgical dressing or an appliance;
- Forms of hypoadrenalism (including Addison's disease) for which specific substitution therapy is essential;
- Diabetes insipidus and other forms of hypopituitarism;
- Diabetes mellitus except where treatment is by diet alone;
- Hypoparathyroidism;
- Myasthenia gravis;
- Myxoedema (Hypothyroidism);
- Epilepsy requiring continuous anti-convulsive therapy;
- Continuing physical disability which means you cannot go out without help from another person and holds a valid exemption certificate

Pregnancy

A woman with a valid exemption certificate issued by the Central Services Agency because she is an expectant mother or has within the last twelve months given birth to a live child or a child registered as stillborn.

Income or benefit related exemptions

Exemption from prescription charges is available to patients if they or their partner gets the following benefits:

- Income Support
- Income-based Jobseeker's Allowance
- Pension Credit Guarantee Credit
- are entitled to, or named on, a valid NHS tax credit exemption certificate
- are named on a valid HC2 certificate Support,

Incapacity Benefit and Disability Living Allowance do not count, as they are not income related.

Contraceptives / treatment for a sexually transmissible disease, (STDs) or Tuberculosis, (TB).

Prescription charges are not levied for items prescribed for contraceptive use. In the interest of public health there is no cost associated with dispensing of medicines used for the treatment of STDs or TB.

NHS In-patients

Prescription charges are not levied when a patient is in an NHS hospital.

War pensioners

A person receiving a War or MOD Disablement Pension holding a valid exemption certificate issued by the Secretary of State in respect of the supply of drugs and appliances for the treatment of the accepted disablement only is exempt from paying prescription charges.

Figure 1: Prescription items dispensed per capita in Wales and Northern Ireland from 1994/5 to 2004/5

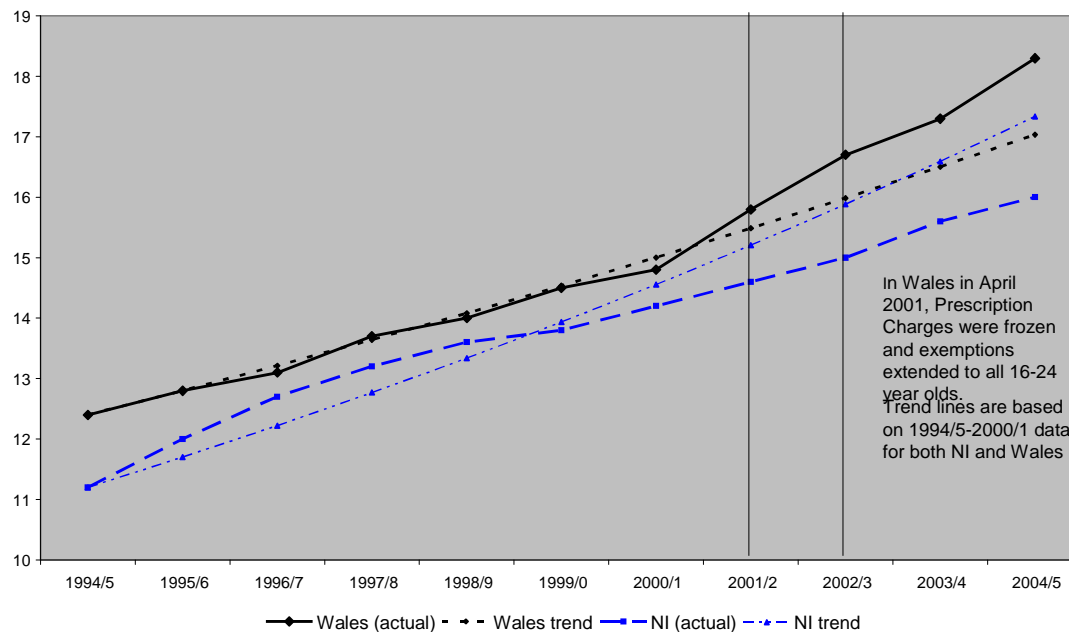
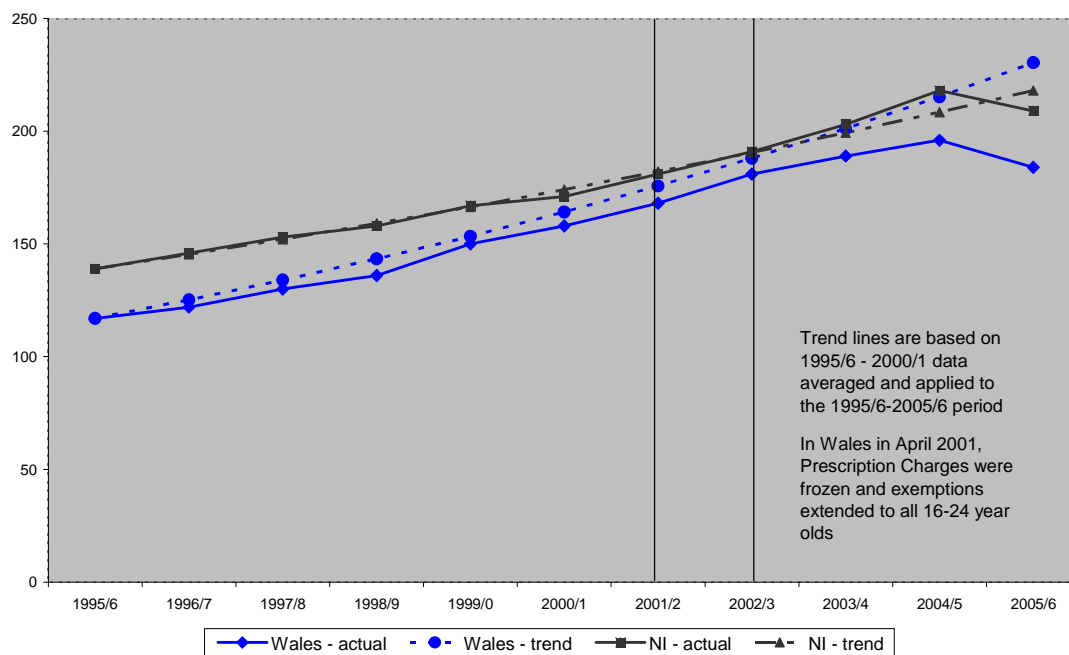


Figure 2: Net ingredient cost per capita (£) (2005 cash prices) of prescriptions dispensed in Wales and Northern Ireland from 1995/6 to 2005/6



Appendix 7

DETAILED ESTIMATED COSTINGS FOR OPTIONS 1, 4, 5, 6, 10 & 11

Option No. 1

Full Abolition of Prescription Charges

	<u>2006-07</u>	<u>Sensitivity 2006-07 (c.)</u>
Gross Baseline Primary Care Pharmaceutical Costs (£)	408,770,633	408,770,633
<hr/>		
Administration Costs Saved (£)		
Pre-Payment Certificates:		
Fees Paid to Pharmacy Contractors	212,808	212,808
CSA Admin. Costs	23,000	23,000
Pharmacy Contractor Fees (2p per Item)		
Fees paid to Pharmacy Contractors for Point of Dispensing Checks	591,983	591,983
Counter Fraud Unit Costs		
Admin. Costs	210,000	210,000
Total Administration Costs (£)	1037791	1037791
Lost Income Generated from Prescription Charges (£)		
Prescription Charges	11,297,565	11,297,565
Pre-Payment Certificates	2,835,846	2,835,846
Total Income (£)	14133411	14133411
Net Income Lost from Prescription Charging (£)	13095620	13095620
Additional Dispensing Fees Paid to Community Pharmacists (d)		
(£1.09 excl. PoD check fee of 2p/Item)	407,392	648,124
GP Opportunity Costs (a)	2,080,909	3,310,526
Estimated Increase in Prescribing (b)	4,455,148	7,087,739
Total Estimated Annual Costs of Abolition (£)	<u>20,039,069</u>	<u>24,142,009</u>
<hr/>		
Post-Abolition Primary Care Pharmaceutical Costs (£)	428,809,702	432,912,642
<hr/>		

- (a) Based on a 22% (SPICe paper) increase in the demand for currently paid for Prescriptions and assuming an average of 3.7 Items are issued in NI per GP consultation with an average cost per NI GP Consultation of £20.60 (NI HPSS average cost for 2006/07). This is an opportunity cost in the sense that the additional GP consultations will give rise to a resource demand on the Health Service of this magnitude.

Economics Branch calculation:

29,463,920 NI Prescription Items; Paid For Items, 1,698,882 X 22% increase = 373,754 Additional Items Prescribed / 3.7 Items per GP Consultation = 101,015 Additional GP Consultations X £20.60 Average Cost per Consultation = £2,080,909.

- (b) Based on a 22% (SPICe paper) increase in the demand for currently paid for Prescriptions and assuming an average NI Net Prescription Cost of £11.92

Economics Branch calculation:

1,698,882 Chargeable Items x 22% increase = 373,754 Additional Items prescribed x average gross NI Prescription Cost of £11.92 = £4,455,148.

- (c) Hitiris (2000) accepts the median value of a range of studies, of +35% increase in demand for Prescriptions, as a potential result of Abolition of Charges. The calculations here reflect a 35% increase rather than the lower end 22%

Option No. 4

Status Quo - Maintain the Current Charging & Exemption arrangements

2006-07

Gross Primary Care Pharmaceutical Costs (£) **408,770,633**

Prescription Administration Costs (£) (a)

PrePayment Certificates:	Fees Paid to Pharmacy Contractors	212,808
	CSA Admin. Costs	23,000

Pharmacy Contractor Fees (2p per Item)	Fees paid to Pharmacy Contractors for Point of Dispensing Checks	591,983
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Counter Fraud Unit Costs	Admin. Costs	210,000
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Total Administration Costs (£) **1037791**

Income Generated from Prescription Charges (£) (a)

Prescription Charges	11,297,565
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Pre-Payment Certificates	2,835,846
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Total Income (£) **14133411**

Net Prescription Income from Current Arrangements (b) **13,095,620**

Net Primary Care Pharmaceutical Costs (£) **395,675,013**

CSA Estimated Pharmaceutical Prescription Fraud (£) (c.) *7,400,000*

Source:

(a) CSA - FPS Information & Research Unit

(b) Economics Branch calculations.

(c) CSA Counter Fraud Unit estimate of uncollected Prescription Charges.

Option No. 5

Maintain current level of Prescription Charge with:
Lower Age Limit extended to include those under 25 years.

		<u>2006/07</u>
Total NI Prescription Items #		29,463,920
Total Standard Charge Items	5.77%	1,698,882
Total Items Exempt from Standard Charge (Incl. PPC's)		<u>27,765,038</u>
Less Free of Charge Contraceptives ~		154,686
Total Items Less Chargeable Items & Free Contraceptives (Incl. PPC's)		<u>27,610,352</u>

2006/07 CFU Sample % applied to Exempt Items

<u>Exemption claimed</u>	<u>%</u>	<u>Imputed Items</u>
60 years and over	55.26	15258005
Has a HC2 Certificate	1.02	282288
On Income Support	12.82	3539095
On JSA	3.02	833142
Has a valid Maternity Exemption Cert.	1.07	296066
Has a valid Medical Exemption Cert.	6.31	1741992
Has a Pension Credit	0.50	137720
Has a valid PPC	4.04	1115431
Has a Tax Credit	5.96	1645605
Under 16 years	7.31	2017406
Is 16, 17 or 18 years and in f-t education.	1.12	309843
Has a valid War Pension Cert.	0.22	61958
Exemption category unclear	1.35	371801
Total	100.0	<u>27610352</u>

Proposed Exemption Changes:

16, 17 & 18 years in f-t education changed to all aged 16-24 years.

Results from the initial EPES Pilot indicate that 3.17% of all Items dispensed are dispensed to 16-24 year olds. EPES Pilot data also indicates that of this quantity of Items, 12.0% are paid for by 16-24 year olds. This information has been extrapolated to the NI level below and yields the following volumes.

Impact on Prescription Item Exemption volumes:

Introduction of the 16-24 year blanket exemption (3.17% * 29,463,920):	934,006
16-24 year old Paid For Items (12% * 934,006)	112,081
Total 16-24 year olds New Exempt Items	112,081

Impact on Prescription Income (£6.65 / Item):

	<u>No. of Items</u>	<u>£</u>
2006/07 Chargeable Items	1,698,882	11,297,565
2006/07 PPC Income	-----	<u>2,835,846</u>
		14,133,411
Assuming that the majority of 16-24's would pay the Standard Charge (not use PPC's)		
Additional Exempt Items for 16-24's:	112,081	745,337
New Estimate for Prescription Income		13,388,074

Sensitivity:

If New Exempt Items for 16-24 year olds doubled from the level in the EPES Pilot (12% to 24%):	224162	1490674
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Option No. 5 *continued*

Maintain current level of Prescription Charge with:
Lower Age Limit extended to include those under 25 years.

	<u>2006-07</u>	<i>Sensitivity</i>
Gross Primary Care Pharmaceutical Costs (£)	408,770,633	408,770,633
<hr/>		
Prescription Administration Costs (£) (a)		
Pre-Payment Certificates (d):		
Fees Paid to Pharmacy Contractors	212,808	212,808
CSA Admin. Costs	23,000	23,000
Pharmacy Contractor Fees (2p per Item) (e) Fees paid to Pharmacy Contractors for Point of Dispensing Checks	591,983	591,983
Counter Fraud Unit Costs (c) Admin. Costs	210,000	210,000
Total Administration Costs (£)	1037791	1037791
Income Generated from Prescription Charges (£) (a)		
Prescription Charges	10,552,228	9,806,891
Pre-Payment Certificates	2,835,846	2,835,846
Projected Total Income (£)	13,388,074	12,642,737
Projected Net Prescription Income (b)	12,350,283	11,604,946
<hr/>		
Projected Net Primary Care Pharmaceutical Costs (£)	396,420,350	397,165,687
<hr/>		

Notes:

- (a) Prescription Charge is held constant at £6.65 per item (2006/07).
Under this Option, prescription income would fall from £11,297,565 currently, to £10,552,228 assuming that the majority of young people would not be users of PPC's. PPC income has therefore been held constant.
- (b) Economics Branch calculations.
- (c) Counter Fraud Unit costs are assumed to remain at the current level.
- (d) PPC contractor fees and admin costs are assumed to remain unchanged.
- (e) The number of PoD checks, and, PoD Fees are assumed to remain unchanged.

Option No. 6

**Maintain current level of Prescription Charge with:
Exemptions removed for the 60-64 year olds.**

		2006/07
Total NI Prescription Items #		29,463,920
Total Standard Charge Items	5.77%	1,698,882
Total Items Exempt from Standard Charge (Incl. PPC's)		27,765,038
Less Free of Charge Contraceptives ~		154686
Total Items Less Chargeable Items & Free Contraceptives (Incl. PPC's)		27,610,352

2006/07 CFU Sample % applied to Exempt Items

<u>Exemption claimed</u>	<u>%</u>	<u>Imputed Items</u>
60 years and over	55.26	15258005
Has a HC2 Certificate	1.02	282288
On Income Support	12.82	3539095
On JSA	3.02	833142
Has a valid Maternity Exemption Cert.	1.07	296066
Has a valid Medical Exemption Cert.	6.31	1741992
Has a Pension Credit	0.50	137720
Has a valid PPC	4.04	1115431
Has a Tax Credit	5.96	1645605
Under 16 years	7.31	2017406
Is 16, 17 or 18 years and in f-t education.	1.12	309843
Has a valid War Pension Cert.	0.22	61958
Exemption category unclear.	1.35	371801
Total	100.0	27610352

Proposed Exemption Changes:

60 years and over changed to 65 years and over.

There are 15,258,005 Items attributable to those aged 60 years and over.

Initial data from the EPES Pilot indicates that approx 15% of Items dispensed to the over 60's is consumed by those aged 60-64 years. Extrapolating this to the NI level yields the following volume: 15% * 15,258,005 = 2,288,701 Items.

Impact of other Exemption Categories for 60-64's (based on EPES pilot data for 50-60's):

Initial data from the EPES Pilot for those aged 50-60 years on Income Support & JSA has been used as a predictor of Pension Credit Exemption Item levels for those aged 60-64 years. Similarly, EPES Pilot data for PPC and HC2 holders and Medical Exemptions for 50-60 year olds has been used as a predictor of Exemption Items for 60-64 year olds. The EPES pilot data has been extrapolated to the NI level:

Medical Exemption: 23.7% of Exempt Items are Medical Exempt Items.

Income Support/J.S.A./Pension Credit: 20.5% of Exempt Items are due to I.S./J.S.A./Pension Credit.

PPC Holders: 24.4% of Exempt Items are dispensed under PPC's.

HC2 Holders: 0.4% of Exempt Items are due to HC2 exemptions.

War Pensions: Counter Fraud Unit data has been used to estimate War Pension Exemption Items due to the very small numbers yielded by the EPES sample. Approximately 0.06 Items are dispensed per person aged 20-59. Additional War Pension exemptions for those aged 60-64 years = 86,694 persons * 0.06 = 5,202 Items to be subtracted from Chargeable Items for 60-64's.

Impact on Prescription Item Exemption volumes:

Raising the age for Exemptions from 60 to 64 years:	2,288,701	
Less Medical Exemptions for 60-64's	542,422	
Less I.S./J.S.A./Pension Credit Exemptions for 60-64's	469,184	
Less PPC's for 60-64's	558,443	
Less HC2 Exemptions for 60-64's	9,155	
<u>Less War Pension Exemptions for 60-64's</u>	<u>5,202</u>	
Total Additional Items no longer Exempt		704,295

Impact on Prescription Income (£6.65 / Item):

	<u>No. of Items</u>	<u>£</u>
2006/07 Chargeable Items	1,698,882	11,297,565
2006/07 PPC Income	-----	<u>2,835,846</u>
		14,133,411
Total Additional 60-64 year Chargeable Items:	704,295	
Total Additional Income from 60-64 year olds (704,295 x £6.65)		4,683,564
Total Prescription Income (£)		18,816,975

Notes

Total NI Prescription Items figure excludes GP Stock Items as these are not charged for.

~ EPES Pilot data for November 2007 has been used to generate an estimate of the number of FOCC Items.

Option No. 6 *continued*

Maintain current level of Prescription Charge with:
Exemptions removed for the 60-64 year olds.

		<u>2006-07</u>
Gross Primary Care Pharmaceutical Costs (£)		408,770,633
<hr/>		
Prescription Administration Costs (£) (a)		
Pre-Payment Certificates (e):	Fees Paid to Pharmacy Contractors	212,808
	CSA Admin. Costs	23,000
Pharmacy Contractor Fees (2p per Item) (f)	Fees paid to Pharmacy Contractors for Point of Dispensing Checks	591,983
Counter Fraud Unit Costs (d)	Admin. Costs	210,000
Total Administration Costs (£)		1037791
Income Generated from Prescription Charges (£) (a) (c)		
Prescription Charges (£11,297,565 + £4,683,564) (b.)		15,981,129
Pre-Payment Certificates (b)		2,835,846
Projected Total Income (£)		18,816,975
Projected Net Prescription Income (£) (c)		17,779,184
<hr/>		
Projected Net Primary Care Pharmaceutical Costs (£) (c)		390,991,449
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Notes:

- (a) Prescription charge is held constant at £6.65 for 2006/07.
- (b) Prescription charge income is projected to increase from £11,297,565 to £15,981,129 through standard charges. Pre Payment Certificate income is assumed to increase as 60-64 year olds would be significant users of PPC's. It is impossible to calculate the increase from current levels under current data constraints. PPC income has been held constant at current levels and this provides a very conservative estimate of future PPC income.
- (c) Economics Branch calculations.
- (d) Counter Fraud Unit costs are assumed to remain at the current level.
- (e) PPC contractor fees are held constant at current levels. PPC admin costs are assumed to remain unchanged.
- (f) It is assumed that the number of PoD checks remain at current levels and PoD fees are unchanged.

Option No. 10

**Introduction of Reduced Fee (80p per Item) with "Passport" exemptions,
War Pension Exemption & Maternity Exemption only.
(Retain Prescription Income of £14m)**

		<u>2006/07</u>
Total NI Prescription Items #		29,463,920
Total Standard Charge Items	5.77%	1,698,882
Total Items Exempt from Standard Charge (Incl. PPC's)		<u>27,765,038</u>
Less Free of Charge Contraceptives ~		154686
Total Items Less Chargeable Items & Free Contraceptives (Incl. PPC's)		<u>27610352</u>

2006/07 CFU Sample % applied to Exempt Items

<u>Exemption claimed</u>	<u>%</u>	<u>Imputed Items</u>
60 years and over	55.26	15258005
Has a HC2 Certificate	1.02	282288
On Income Support	12.82	3539095
On JSA	3.02	833142
Has a valid Maternity Exemption Cert.	1.07	296066
Has a valid Medical Exemption Cert.	6.31	1741992
Has a Pension Credit	0.50	137720
Has a valid PPC	4.04	1115431
Has a Tax Credit	5.96	1645605
Under 16 years	7.31	2017406
Is 16, 17 or 18 years and in f-t education.	1.12	309843
Has a valid War Pension Cert.	0.22	61958
Exemption category unclear.	1.35	371801
Total	<u>100.00</u>	<u>27610352</u>

Proposed Exemptions for those with:

	<u>Imputed Volumes</u>
"Passport" type Exemptions (I.S Items: 3,539,095 + JSA Items: 833,142 + HC2 Items: 282,288 + Tax Credit Items: 1,645,605 + Pension Credit Items: 4,324,320) (1.)	10762171
War Pension Certificates	61958
Maternity Exemption Certificates	296066
Total Proposed Exemptions	<u>11120194</u>

Proposed Chargeable Items (27,610,352 - 11,120,194) **16,490,158**

Total Chargeable Items incl. Current (16,490,158 + 1,698,882) **18,189,040**

Standard Charge Level Required to Maintain £14.1m of

Prescription Income = £14,133,411 / 18,189,040 **£0.78**

Prescription Charge of 80p results in Income of:	£	14,551,232
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Notes:

Total NI Prescription Items figure excludes GP Stock Items as these are not charged for.
~ EPES Pilot data for November 2007 has been used to generate an estimate of the number of FOCC Items.

1 Pension Credit exempt Items figure is based on current persons on Pension Credit of 92,400 multiplied by CFU-based exempt Items per person in NI aged over 60 years = 92,400 * 46.8 = 4,324,320 Items.

Option No. 10 *continued*

**Introduction of Reduced Fee with "Passport" exemptions,
War Pension Exemption & Maternity Exemption only.
(Retain Prescription Income of £14m)**

	<u>2006-07</u>
Gross Primary Care Pharmaceutical Costs (£)	408,770,633
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Prescription Administration Costs (£) (a)	
Pre-Payment Certificates (d):	
Fees Paid to Pharmacy Contractors	0
CSA Admin. Costs	0
Pharmacy Contractor Fees (2p per Item) (e)	
Fees paid to Pharmacy Contractors for Point of Dispensing Checks	591,983
Counter Fraud Unit Costs (c.)	
Admin. Costs	210,000
Total Administration Costs (£)	801983
Projected Income Generated from Prescription Charges (£) (b)	14,551,232
Projected Net Prescription Income (b)	13,749,249
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Projected Net Primary Care Pharmaceutical Costs (£)	395,021,384
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Notes:

- (a) CSA - FPS Information & Research Unit.
- (b) Economics Branch calculations.
- (c) Counter Fraud Unit costs are assumed to remain at the current level.
- (d) Under this Option the standard charge is reduced to 80p per Item. There may be a need to combine this Option with inclusion of a cap on charges at an annual or monthly level to ensure that patients who have multiple medication needs will only pay a maximum amount. There is currently no reliable information which could be used to estimate future uptake of PPC's under this Option.
- (e) The number of PoD checks, and, PoD Fees are assumed to remain unchanged.

The financial impact of patient-related Pharmaceutical Prescription Fraud could be assumed to reduce significantly under this Option from the current level of £7.4m per annum, due to the reduced prescription charge (80p) in this Option. However, the reduced charge could alter patient behaviour and may well lead to an increase in the rate of fraudulent behaviour if the public perception is that CSA may not follow up offenders as keenly under the lower charge. The actual level of fraud is difficult to project due to changing patient behaviour and the introduction of the new EPES system. Assuming that the incidence of patient prescription fraud remains unchanged, the level of fraud could reduce from the current level of £7.4m (2006/07) to approximately £0.9m p.a. with the reduction in the prescription charge from £6.65 to 80p per Item.

Option No. 11

Introduction of Prescription Charge of 80p per Item with "Passport" Exemptions, War Pension Exemption, Maternity Exemption, Under 16 Exemption and Exemption for those over 65 years.

		<u>2006/07</u>
Total NI Prescription Items #		29,463,920
Total Standard Charge Items	5.77%	<u>1,698,882</u>
Total Items Exempt from Standard Charge (Incl. PPC's)		27,765,038
Less Free of Charge Contraceptives ~		<u>154686</u>
Total Items Less Chargeable Items & Free Contraceptives (Incl. PPC's)		<u>27610352</u>

2006/07 CFU Sample % applied to Exempt Items

<u>Exemption claimed</u>	<u>%</u>	<u>Imputed Items</u>
60 years and over	55.26	15258005
<i>Has a HC2 Certificate</i>	1.02	282288
<i>On Income Support</i>	12.82	3539095
<i>On JSA</i>	3.02	833142
<i>Has a valid Maternity Exemption Cert.</i>	1.07	296066
<i>Has a valid Medical Exemption Cert.</i>	6.31	1741992
<i>Has a Pension Credit</i>	0.50	137720
<i>Has a valid PPC</i>	4.04	1115431
<i>Has a Tax Credit</i>	5.96	1645605
<i>Under 16 years</i>	7.31	2017406
<i>Is 16, 17 or 18 years and in f-t education.</i>	1.12	309843
<i>Has a valid War Pension Cert.</i>	0.22	61958
<i>Exemption category unclear</i>	1.35	371801
Total	<u>100.0</u>	<u>27610352</u>

Proposed Exemptions for those with:

	<u>Imputed Volumes</u>
"Passport" type Exemptions (income support, pension credits, JSA, HC2 certificate holders, NHS Tax credits)	6437851
War Pension Certificates	61958
Maternity Exemption Certificates	296066
Under 16 years	2017406
60-64 year olds Exemption (see calculation in Option 6: 15,258,005 - 1,262,738 Items) (1.)	<u>13995267</u>
Total Proposed Exemptions	<u>22808547</u>
Proposed Chargeable Items (27,610,352 - 23,366,990)	4,801,805
Total Chargeable Items incl. current (4,243,362 + 1,698,882)	<u>6,500,687</u>

Prescription Charge of 80p results in Income of :		
(5,942,244 Chargeable Items x 80p per Item)	£	5,200,550

Notes:

Total NI Prescription Items figure excludes GP Stock Items as these are not charged for.

~ EPES Pilot data for November 2007 has been used to generate an estimate of the number of FOCC Items.

1 Exempt Items for those aged 60-64 years has been calculated through the same methodology as that used for Option 6, with the figures for PPC Items subtracted, as Option 11 does not propose the use of a PPC system.

Option No. 11 *continued*

Introduction of Prescription Charge of 80p per Item with "Passport" Exemptions, War Pension Exemptions, Maternity Exemption, Under 16 Exemption & Exemption for those Over 65 years.

		<u>2006-07</u>
Gross Primary Care Pharmaceutical Costs (£)		408,770,633
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Prescription Administration Costs (£) (a)		
Pre-Payment Certificates (d.):	Fees Paid to Pharmacy Contractors	0
	CSA Admin. Costs	0
Pharmacy Contractor Fees (2p per Item) (e)	Fees paid to Pharmacy Contractors for Point of Dispensing Checks	591,983
Counter Fraud Unit Costs (c)	Admin. Costs	210,000
Total Administration Costs (£)		801983
Projected Income Generated from Prescription Charges (£) (b)		5,200,550
Projected Net Prescription Income (£) (b)		4,398,567
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Projected Net Primary Care Pharmaceutical Costs (£)		404,372,066
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Notes:

- (a) CSA - FPS Information & Research Unit.
- (b) Economics Branch calculations. In order to retain current Prescription Income levels of £14m p.a., the standard prescription charge would need to be set at £2.17 per Item.
- (c) Counter Fraud Unit costs are assumed to remain at the current level.
- (d) Under this Option the standard charge is reduced to 80p per Item. There may be a need to combine this Option with inclusion of a cap on charges at an annual or monthly level to ensure that patients who have multiple medication needs will only pay a maximum amount. There is currently no reliable information which could be used to estimate future uptake of PPC's under this Option.
- (e) The number of PoD checks, and, PoD Fees are assumed to remain unchanged.

The financial impact of patient-related Pharmaceutical Prescription Fraud could be assumed to reduce significantly under this Option from the current level of £7.4m per annum, due to the reduced prescription charge (80p) in this Option. However, the reduced charge could alter patient behaviour and may well lead to an increase in the rate of fraudulent behaviour if the public perception is that CSA may not follow up offenders as keenly under the lower charge. The actual level of fraud is difficult to project due to changing patient behaviour and the introduction of the new EPES system. Assuming that the incidence of patient prescription fraud remains unchanged, the level of fraud could reduce from the current level of £7.4m (2006/07) to approximately £0.9m p.a. with the reduction in the prescription charge from £6.65 to 80p per Item.