Estimating the cost of abolishing prescription charges

About 18 months ago, the HealthGroup was asked to send a representative to a working group set up to produce a report proposing possible policies on the pharmaceutical industry for the Labour Party. The invitation probably arose out of our long standing links with Jerry Shulman, a pharmacist who has been involved both with political activity on the issue and in pioneering radical ideas in his own practice.

Three of us, on different occasions, went to meetings of the group. In general, we did not have much to contribute to the proposals, which came under the headings of patient welfare, postgraduate medical education, support for drug research, promotion of medicines, drug costs, controlling the drugs available on prescription and drugs and the third world. Needless to say, we stressed the need for properly designed trials with large enough samples, but we were preaching to the converted as far as the other members of the group were concerned.

The deliberations were bedevilled by the confusion generated among people on the left by the government's introduction, in April 1985, of a 'limited list' of medicines prescribable under the NHS. The government was clearly interested only in saving money and in reinforcing trends towards a two tier health service - 'blacklisted' products can still be prescribed privately.

There are, however, other arguments for having a 'limited' or 'selected' list of medicines, and this was quite common in hospitals even before the government's action. As many products on the market are of unproven benefit or efficacy and some are known to be actually harmful, a 'selected list' which also applied to the private sector and over the counter sales would be of benefit to patients and probably also to the NHS budget.

This is what the group's report recommended, while at the same time roundly condemning the way the government had compiled and operated its list. The group's report also pointed out the need for an appeals procedure for individual special cases and an adequate procedure for revising the list, neither of which the government has provided, of course.

One of the group's detailed recommendations was to abolish prescription charges, and this gave rise to the question of how much it would cost. The information required to estimate this was not readily available from published and even the data they did contain was out of date. In addition, England, Wales, Scotland and Northern Ireland each published, or failed to publish, different data, some of which were grouped into financial years and some into calendar years. In the end, the only way to elicit consistent and up to date data was to get parliamentary questions asked. These had to be asked separately for each of the four countries and they each gave their answer in a slightly different form! Even with this information, many factors remained unknown.

The article which follows was produced as an appendix to the group's report, which is now being considered by some part of the Labour Party machine. It therefore remains to be seen whether it is adopted as policy, yet alone whether it is implemented if Labour gets back in office.

Meanwhile, the present government has just increased prescription charges to £2.20, compared with the charge of 20p which applied when it was elected in May 1979.

THE COST OF ABOLISHING PRESCRIPTION CHARGES

Any estimate of the future costs of abolishing prescription charges has to take into account a number of recent trends. Firstly there was a rise in the numbers of prescriptions dispensed under the NHS between 1980 and 1985. In England and Wales, 345.0 million prescriptions written by general practitioners were dispensed in the financial year 1984-85 compared with 319.6 million in 1980-81. This is hardly surprising given the increasing numbers of elderly people. At the same time, the cost per prescription rose ahead of general inflation (Hansard 20/2/85 col 502).

Over the same period the percentage of the cost of prescriptions in the United Kingdom which was raised from charges to patients rose from 3.2 in 1978-79 to 7.3 in 1980-81 and 7.7 in 1983/84 (Annual Abstract of Statistics 1985), while the proportion of prescriptions subject to charges decreased. The percentage of prescriptions in England which were exempt from charges rose from 58.5 in 1973 to 64.8 in 1979 and 77.9 in 1983 (Health and Personal Social Services Statistics for England, 1985), although this includes the growing number paid for by prepayment certificates (Hansard 14/3/84 col 183). The position varies within the United Kingdom. In 1984-85, the percentage of prescriptions exempt from charges ranged from 78 in Scotland to 85.6 in Northern Ireland.

On April 1 1985, prescription charges were raised by 25 per cent from £1.60 to £2.00 and the limited list was introduced for certain classes of medicines. Around this time, there were reductions in the prices charged to the NHS for some medicines. Since April 1 1985, as Table 1 shows, the numbers of NHS prescriptions dispensed have fallen in all four countries of the United Kingdom, compared with the corresponding quarter of 1984. In Scotland and Northern Ireland the total cost has fallen, while in England and Wales it has continued to rise, but not as fast as previously. In Wales and Northern Ireland, where data are available for the third (July to September) quarter of 1985, they suggest that the effects were smaller than in the second (April to June) quarter, which immediately followed the changes (Hansard 12/12/85 and 13/1/86).

Revenue from charges

The revenue for the whole United Kingdom from prescription charges was £120 million in 1983/84 and £131 million in 1984/85 as Table 2 shows. Added to this, the government obtained a further £13 million in 1983-84 and £15 million in 1984-85 from the sale of prepayment certificates. DHSS told the Social Services Committee that its anticipated revenue from prescription charges in England for the year 1985-86 was £6.8 million in the Hospital and Community Health Services and £143 million in the Family Practitioner Services (1984-85 Report p 42), an increase of 23 per cent compared with 1984-85. If the total revenue raised from patients is assumed to have increased by the same amount compared with 1984-85, then the total for the United Kingdom for 1985-86 can be estimated as £180.5 million. Data for the second quarter of 1985 suggest, however, that the increase in costs to patients in the UK was 6.7 per cent. If this was maintained for the whole financial year, then total costs to patients would be £155 million for the UK.

This would be the cost of abolishing prescription charges in the current financial year. Abolition of charges would bring about small savings in eliminating the need to produce and distribute literature about exemption from charges, inspect for fraud in claiming exemption and administer the sale of prepayment certificates. Government accounting methods do not, however, allow these costs to be identified separately, apart from the costs of producing the explanatory leaflet P11 for England, Wales and Scotland and a poster for display in England and Wales. These cost £75,669 in 1983-84 and £83,088 in 1984-85 (Hansard 17/12/85).

The administrative costs of collecting prescription charges do not fall directly on the NHS. The reply to a parliamentary question on the subject was 'Prescription charges collected by pharmacist contractors are retained by them against NHS payments due to them. This is a highly effective system which operates at minimum cost' (Hansard 22/3/84 col 581). Although abolishing prescription charges would not result in an identifiable saving to the NHS in the cost of collecting them, it could release pharmacists' time for more useful work, such as informing customers about the medicines prescribed for them.

While abolishing prescription charges would increase the cost to the Exchequer of the NHS pharmaceutical services, other proposals in our report would lead to savings.

Generic substitution

Estimates of the possible savings from generic substitution vary according to the assumptions made and the person making the. In 'The wrong kind of medicine', Charles Medawar suggests estimates can range from £20 million to £200 million per year. For example, Kenneth Clarke stated in February 1983, 'If all prescriptions dispensed in 1981 had been dispensed generically, savings would have been £23 million', while one month later, Geoffrey Finsberg said 'The NHS could save £30 million if just nine top brands were prescribed generically'. This, according to Charles Medawar, is equivalent to a saving of £40 million in 1984.

An estimate of a similar order was made in a study in the Daily Telegraph in November 1979. This suggested that a saving of £25 million could be made by substituting generic versions of thirteen brand name pharmaceuticals which cost the NHS £60 million in 1978. In a paper presented to the Council of the Pharmaceutical Society of Great Britain, Mr A Smith of the Pharmaceutical Services Negotiating Committee, claimed that savings of £29 million could be made by substituting eleven major branded medicines.

Much larger estimates have also been produced. Based on figures provided by Geoffrey Finsberg, Andrew Veitch of the Guardian stated that generic prescribing would produce theoretical savings of £170 million annually. This is on a similar level to Professor M Rawlins' estimate in a letter (January 1 1983) to the Pharmaceutical Journal, that annual savings of £200 million could be made if a wider range of generics were available. Figures from the Northern Region showed that 47 per cent of prescriptions were for branded products whose patent lives had expired and for which generic substitutes could therefore be made available.

One problem in estimating possible savings is predicting how pharmaceutical companies would react. Charles Medawar quotes from a private communication from DHSS dated December 1 1982 'Pharmaceutical manufacturers do not set the price of individual products in isolation. Rather, they adopt a pricing policy for their entire range of products designed to produce a given return on capital. If sales of a particular branded product declined substantially there could well be a compensating increase in the cost of some other produce for which there is no generic equivalent'.

Substantial savings could be made by action to reduce the hidden profits produced by transfer pricing. Fifty four of the 65 companies supplying the NHS are foreign based and they supply two thirds of NHS pharmaceuticals. The New Statesman claimed that the profits of these companies are understated by transfer pricing between subsidiaries and parent companies. This was confirmed when the House of Commons Public Acoounts Committee suggested in May 1983 that up to £200 million profit could be concealed by transfer pricing.

Limited list

Our reasons for supporting the principle of a limited list and proposing that it is extended to other classes of medicines and to the private sector are based on potential benefits to patients rather than on financial considerations. Nevertheless, there would certainly be savings, although it is not possible to make any estimate of their extent without going through the detailed process of drawing up a proposed list.

Our policy for a limited list would also be likely to lead to a small amount of additional expenditure, compared with the way it is operated by the present government. Firstly, some funds would be needed to inform the public as fully as possible about the reasons for having a limited list and about the appeals procedure.

It is also possible that extending the limited list to the private sector would mean that people who have chosen to pay privately for the cost of medicines blacklisted by the present government would bring their problems back to the NHS. For some, it would be appropriate to invoke the appeal procedure or to prescribe different medicines under the NHS.

Others, however, may be taking medicines such as 'tonics' which are of dubious pharmacological value but have important placebo effects for the person concerned. The present position, in which people, many of whom are elderly and can ill afford to do so, feel the need to go to the expense of buying such preparations is one we deplore. This is a health education problem which has received only scanty attention and requires additional resources.

Problems in estimating the combined effects of the proposed changes

It is unrealistic to try to assess the economic effects of our proposals to abolish prescription charges, introduce generic substitution and widen the use of a limited list in isolation from each other, as they are likely to interact in a way which is

difficult to predict. An added problem is the dearth of published data and we should want a future Labour government to see that fuller and more informative statistics are published on this subject, among many others.

Interestingly, DHSS officials who have access to much fuller data seem to be in a similar quandary as their evidence in the 1984-85 report of the Social Services Committee makes only too apparent, for example, they are uncertain about the accuracy of the Secretary of State's claim that introducing his limited lists would save £75 million, and in reply to a question about the accuracy of estimates of costs of the pharmaceutical service, Geoffrey Hulme, Principal Finance Officer at DHSS said:

'We have done what we said we would do, which was to improve the technical forecasting, to develop better mathematical models for the elements in the pharmaceutical services and those formulae, those models are in fact better than the ones we had before. What we cannot do is change or get rid of uncertainties in the real world....' (1984-85 Report p 81).

DHSS has told the Social Services Committee that it is monitoring the savings achieved by the introduction of the present limited list and the Committee recommended that the Government lays the detailed results of this exercise before Parliament. We urge the Parliamentary Labour Party to press it to do so, and make them known more widely.

Meanwhile, we can only reach the following tentative conclusions about the financial implications of our proposals.

1. Abolishing prescription charges would be likely to cost between £155 million and £180 million a year for the United Kingdom as a whole at 1985-86 prices, based on estimated data. It would have cost £146 million in 1984-85 and £133 million in 1983-84.

2. Estimates of savings from generic substitution range from £20 million to £200 million per year, and would depend on the extent of action against transfer pricing and the introduction of generics to replace branded products which are out of patent.

3. Although proposed for other reasons there would be some savings as a result of our proposals for a limited list, but we are not in a position to estimate how much.

Table 1

Comparison of numbers and costs of prescriptions in 1984 and 1985.

Percentage change between 1984 and 1985	Quarter 1 (Jan-Mar)	2 (Apr-June)	3 (July-Sept)
Numbers of prescriptions			
England	3.6	- 5.3	
Wales	2.5	- 5.5	-0.6
Scotland	3.2	- 5.5	
N. Ireland	6.7	-12.3	-4.9
UK	3.6	- 5.5	
Total cost			
England	11.7	4.3	
Wales	11.1	3.3	6.9
Scotland	9.8	- 0.5	
N. Ireland	10.8	- 4.4	0.0
UK	11.4	3.5	
Cost to public funds+			
England	11.9	4.1	
Wales	11.1	2.0	6.6
Scotland+	9.8	- 0.8	
N. Ireland	10.7	- 4.6	0.0
UK+	11.6	3.2	

+ Revenue from prepayment certificates in Scotland not deducted.

Cost to patients			
England	9.0	6.3	
Wales	11.1	26.7	11.8
Scotland	10.3	3.0	
N. Ireland	12.5	0.0	0.0
UK	9.3	6.7	

Source: Derived from written parliamentary replies, Hansard December 12 1985 and January 13 1986.

Table 2

Prescriptions dispensed under the NHS and their cost 1983-84 and 1984-85.

	England	Wales	Scotland	Northern Ireland	United Kingdom
1983-84					
Prescriptions dispensed, millions	337.0	26.108	35.94	13.503	412.6
Per cent of prescriptions exempt from charges+	78.0	82.3	77	84.4	78.4
Average gross cost, £	4.28	4.03	4.56	4.60	4.30
Total cost, £millions	1442.5	105.3	163.77	62.14	1773.7
Payments from public funds, £millions	1331.8	98.4	151.06	59.01	1640.3
Payments by patients, £millions	99.8	6.0	11.60	2.92	120.3
Revenue from sale of prepayment certificates, £millions	10.9	-.93	1.11	.20	13.1
Total cost to patients, £millions	110.7	6.9	12.71	3.12	133.4
1984-85					
Prescriptions dispensed millions	345.4	26.562	36.69	13.900	422.6
Per cent of prescriptions exempt from charges+	79.3	83.9	78	85.6	79.7
Average gross cost, £	4.52	4.30	4.81	4.75	4.54
Total cost, £millions	1562.5	114.1	176.32	66.05	1919.0
Payments from public funds, £millions	1441.0	106.9	162.42	62.66	1773.0
Payments by patients, £millions	109.1	6.2	12.64	3.14	131.1
Revenue from sale of prepayment certificates, £millions	12.4	.99	1.28	.27	14.9
Total direct cost to patients, £millions	121.5	7.2	13.9	3.38	146.0

+ Includes those covered by prepayment certificates

Source: Hansard December 12 1985 and January 13 1986.