

Expecting patients to buy medicines OTC:

is it fair?

In March 2018, NHS England published guidance for care commissioning groups listing conditions for which over-the-counter (OTC) items should not routinely be prescribed in primary care.¹ Published alongside this guidance was the underpinning report from the OTC public consultation.² GPs are at the endpoint of this work, informing patients that they will have to purchase some of their medications.

An obvious concern is the potential financial and health consequences for the most vulnerable of the cohort of patients entitled to free prescriptions. How far did the research that underpins this guidance explore and dispel these concerns?

MOST VULNERABLE

As well as consulting on the three target areas of proposed reduction in prescribing, the report from the OTC public consultation surveyed different perspectives regarding the impact of the proposals on equality and health inequalities. Of almost 2600 survey responders, 37% agreed that groups protected by the Equality Act 2010 would be disproportionately affected. Key groups identified as most vulnerable to the changes were older patients (79% of responders) and patients with disabilities (75% of responders).

In the themes extracted from the qualitative data an additional group of vulnerable people were identified: those from low-income households (not protected by the Equality Act hence invisible in the quantitative data). The same concerns are echoed by all responder types: that disabled and older patients who require considerable care may be unable to access medicines; that patients from a lower socioeconomic background will be unable to afford treatments; and that patients with multiple comorbidities and long-term conditions may have difficulty in paying for prescriptions rendering them unable to care for themselves.

The concept that certain vulnerable groups would be disproportionately affected by the proposals leads to a disturbing notion of spiralling health inequalities in some of the qualitative summaries.



The report was followed by an analysis on how the guidance would impact equality and health inequalities.³ Where the report concluded that groups protected by the Equality Act might be disproportionately affected, the analysis reassures us *'changes were made to the exceptions in the guidance ... to ensure those most vulnerable were not at risk.'*

This equality analysis does not consider those on low incomes that do not fall into any of the other categories protected by the Equality Act. The exceptions listed in the guidance state that patients prescribed an OTC treatment for a long-term condition should continue to have their treatment prescribed. Additionally, the exceptions allow escalating to prescribed treatments if patients fail OTC treatments. The exceptions give the prescriber the autonomy to 'judge' where *'exceptional circumstances exist that warrant deviation from the recommendation to self care'* but emphasise that *'being exempt from prescription charges does not indicate that you would automatically be exempt from this guidance.'*¹

VARIATION IN PRACTICE

An issue identified by the consultation is that without clarity on how prescribers make clinical and financial assessments of patients on low incomes there could be variation in practice leading to further inequality. Meanwhile, patient representative

organisations identified that 'a blanket approach is not suitable for all'² and that the nuances of each patient's case, with different financial and health pressures, would be relevant in assessing whether they ought to be exempt from paying.

While the report shows widespread acknowledgement that the guidance could lead to better use of limited NHS resources, some of the feedback strikes at the very core of the NHS: *'The proposed changes are contrary to the NHS Constitution/GPs' duty of care/NHS Act's aim to reduce health inequalities.'*² Beyond the scope of this article are further concerns regarding the reliability of the clinical recommendations in the guidance.

It is easy to see how this guidance could impact patients' health; as well as on the doctor-patient relationship. Unlike other guidelines that are evidence based, both in terms of the science and the economic consequences (to the extent that QALYs are useful) can GPs really back this guidance? Or have they become the frontline apologists for a top-down policy lacking robust research behind it? It is unclear how the economic and health consequences of this guidance will be monitored on a local or national level.

While the immediate concern is the duty of care for the patient in front of us, we also have a responsibility to challenge guidance that impacts us and our patients.

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