

Do patients cash prescriptions? An audit in one practice

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SUMMARY. It has been suggested that up to 20 per cent of patients do not cash their prescriptions. To investigate this possibility, the rate of uncashed prescriptions in a group practice was measured. Out of 1,395 prescriptions studied, 89 (6.4 per cent) were uncashed. An association between having to pay prescription charges and prescriptions being uncashed was shown. Measurement of the rate of uncashed prescriptions deserves to be more widely used as a means of self-audit.

Introduction

MOST general practitioners suspect that some of their prescriptions remain uncashed, and there is both factual and anecdotal evidence to support this. A recent study suggested that up to 20 per cent of patients do not cash their prescriptions.¹ This seemed a disturbing possibility and the author decided to measure the rate of uncashed prescriptions in his own practice. Whether the patient was paying prescription charges or just needed a sickness certificate have been suggested as possible causal factors in noncashing of prescriptions.

Method

Six partners and a locum in a semi-urban group practice used no-carbon-required duplicate prescription pads for all face-to-face consultations throughout the month of May in 1982.

The patient's status regarding exemption from prescription charges and whether or not a sickness certificate was issued were recorded on the duplicate prescription form. The Prescription Pricing Bureau returned the original prescriptions six months later. Original prescriptions were then matched with duplicates. Unmatched duplicates were assumed to represent uncashed prescriptions.

Results and Discussion

Rate of uncashed prescriptions

A total of 1,508 prescriptions were written during the month of the audit. No originals were returned for 113

consecutive prescriptions from one doctor and these prescriptions were excluded. The remaining 1,395 prescriptions were studied further: 89 of these were uncashed, giving a rate of uncashed prescriptions of 6.4 per cent for the month. This is close to the 7.1 per cent of uncashed prescriptions reported by Waters² from a practice in a mining area of Yorkshire but strikingly different from the 20 per cent claimed by Rashid¹ for three urban practices in Preston. Both the Waters study and the present one used the Prescription Pricing Bureau to collect used prescriptions. Although the Prescription Pricing Bureau returned a few prescriptions from other months or other practices in error and did not return 113 consecutive prescriptions from one doctor, the estimated size of the error in tracing, other than those noted, was less than 2 per cent. It is difficult to distinguish between an untraced prescription and an uncashed one. Rashid reported that he inspected more than 100,000 prescriptions to trace the 162 included in his study,¹ but his method may have led to a falsely high estimate of the number of uncashed prescriptions. This and the small sample size of 162 may explain the unexpectedly high rate found by him.

Prescription charges

This item was not coded on 105 duplicates, which left 1,290 prescriptions to be studied. Two doctors could account for most of the uncoded duplicates: the proportion of their patients recorded as paying prescription charges was similar to that for the other doctors.

It appeared that patients who were required to pay prescription charges were less likely to cash their prescription (9.1 per cent) than those who were exempt (3.1 per cent) (Table 1). There was a strong association between exemption status and the cashing of prescriptions ($\chi^2 = 19.2$, 1 df, $P < 0.001$).

Exemption from prescription charges covers those patients who are over pensionable age, under the age of 16 years, on a low income, pregnant, housebound or war pensioners. It also covers patients with certain chronic illnesses, and those with prepayment certificates. More than half the patients receiving a prescription were exempt from the prescription charge, which was £1.30 per item at the time of the study. Exempt

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patients differed from nonexempt patients in age, social class, duration of illness and symptoms presented, and these were major confounding variables.

Some of the drugs that are available across the counter, such as glyceryl trinitrate, antacids and some antihistamines, may cost less than the prescription charge: 16 out of 90 uncashed items would have been cheaper as a straightforward purchase. If these prescriptions are excluded, patients liable for the prescription charge are still twice as likely to have an uncashed prescription as those who are exempt.

In a pilot study such as this one, no conclusion can be drawn about causality, but the association between having to pay prescription charges and not cashing prescriptions merits further investigation. Despite a long political debate about prescription charges, no convincing research has been published on the effects of such charges on patients' behaviour.

Sickness certificates

Sickness certification was not recorded on 23 duplicates, leaving 1,372 which could be studied. There was no significant association in this practice between sickness certification and the cashing of prescriptions ($\chi^2 = 0.70$, 1 df, $P = 0.40$) (Table 2). Waters found the highest rate of uncashed prescriptions in 'younger working men, particularly miners'.² He attributed this to the possibility that the consultations were for sickness certification rather than for treatment, but he did not measure the association directly.

Table 1. Prescription charges and the cashing of prescriptions.

	Prescriptions cashed		Prescriptions not cashed		Total
	Number	(%)	Number	(%)	
Patients exempt from prescription charge	653	(96.9)	21	(3.1)	674
Patients not exempt	560	(90.9)	56	(9.1)	616
Total	1,213	(94.0)	77	(6.0)	1,290

Table 2. Sickness certification and the cashing of prescriptions.

	Prescriptions cashed		Prescriptions not cashed		Total
	Number	(%)	Number	(%)	
Patients given certificate and prescription	64	(91.4)	6	(8.6)	70
Patients given prescription only	1,231	(94.5)	71	(5.5)	1,302
Total	1,295	(94.4)	77	(5.6)	1,372

Table 3. The doctor and the cashing of prescriptions.

Doctor	Prescriptions cashed		Prescriptions not cashed		Total
	Number	(%)	Number	(%)	
A	215	(92.7)	17	(7.3)	232
B	315	(94.3)	19	(5.7)	334
C	205	(92.8)	16	(7.2)	221
D	303	(95.9)	13	(4.1)	316
E	91	(84.3)	17	(15.7)	108
F	88	(94.6)	5	(5.4)	93
G	89	(97.8)	2	(2.2)	91
Total	1,306	(93.6)	89	(6.4)	1,395

Table 4. Prescribing rate and the cashing of prescriptions.

Doctor	Prescribing rate (%)	Prescriptions not cashed (%)
A	77	7.3
B	82	5.7
C	48	7.2
D	79	4.1
E	37	15.7
F	53	5.4
G	43	2.2

In the present study overall, only one patient per doctor per month who received a sickness certificate did not cash a prescription. Perhaps the doctors have been able to identify the patients who consult for a sickness certificate alone and to avoid prescribing unwanted medication.

Other factors

The difference between the rates of uncashed prescriptions for the seven doctors was significant ($\chi^2 = 22.27$, 6 df, $P = 0.001$) (Table 3).

Each doctor sees a population that differs in age, sex, personality and symptoms presented, which in part reflects his or her own style of practising. Without controlling for these variables it is impossible to say how much of the variation is doctor-related and how much is due to differences in patients who choose to consult particular doctors.

Prescribing rate

There was also a wide range of prescribing rates, from 37 to 82 per cent (Table 4). Prescribing rate did not significantly correlate with rate of uncashed prescription (Spearman rank correlation coefficient = 0.285, $P > 0.05$). There was a trend towards noncashing of prescriptions for symptomatic remedies rather than those for more therapeutically active drugs.

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Self-audit using uncashed prescriptions

Studies of uncashed prescription have to date concentrated on patient characteristics such as age, sex and social class. An alternative approach is to use the uncashed prescription as an indicator of the quality of the consultation. Is it a satisfactory consultation that leads to an uncashed prescription? Has the doctor discovered the real reason for the consultation? Does the patient feel that the treatment is necessary, safe and effective? Used in this way, the method described here offers an assessment of how effectively the doctor has communicated with the patient and provides an insight into what happens when the patient leaves the consulting room.

References

1. Rashid A. Do patients cash prescriptions? *Br Med J* 1982; **284**: 24-26.
2. Waters WHR, Gould NV, Lunn JE. Undispensed prescriptions in a mining general practice. *Br Med J* 1976; **1**: 1062-1063.

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Who is the patient?

An article in the *Journal of Family Practice* presents a family case study of a recurrent dilemma in family medicine. The ethical dilemma involves what role the physician should play in mediating a conflict in a family when the health needs and wishes of the individual patient do not parallel those of the other family members. Who is the patient, the individual or the family? It is the authors' conviction that in meeting the needs of the presenting patient, the family context is of great importance. To this end, the authors delineate a framework for analysing ethical conflicts of this nature, utilizing key ethical principles in combination with a systems perspective to aid in the clarification of such choices. Exploration of these factors allows the physician a comprehensive and logical approach for resolving such conflicts. Such a framework, however, can only provide guidance; it does not guarantee easy or uniformly acceptable alternatives to difficult issues.

Source: Williamson P, McCormick T, Taylor T. Who is the patient? A family case study of a recurrent dilemma in family practice. *J Fam Pract* 1983; **17**: 1039-1043.