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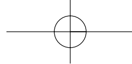
a fairer prescription for NHS charges

THE SOCIAL MARKET FOUNDATION
HEALTH COMMISSION – REPORT 1



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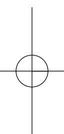
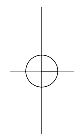
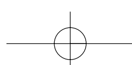
The Commission wishes to thank Sally Williams, our wonderful Secretary, for the industry and steadfastness under pressure she has brought to her task; and Jessica Asato, at the SMF, for providing the vital organisational and research underpinning for our work.







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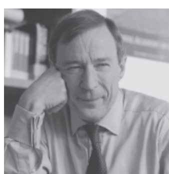

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The Social Market Foundation

The Foundation's main activity is to commission and publish original papers by independent academic and other experts on key topics in the economic and social fields, with a view to stimulating public discussion on the performance of markets and the social framework within which they operate.

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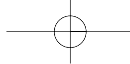

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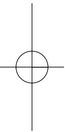
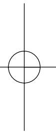
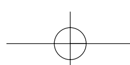






Chairman's introduction

The main report of the Social Market Foundation's Health Commission, to be published later this year, will centre on issues of finance and organisation. In the course of that inquiry, we will examine the case for raising more revenue for health by increased levels of user charges.

Some advocate, for example, charging people to see their doctor or levying on them a share of the cost of their operations or charging people who fail to turn up for GP appointments. There are compelling arguments in favour of such charges. They might raise substantial, though not huge, additional sums for health care. They might make people aware of the value of the services that they consume, and perhaps deter them from making excessive demands for them.

On the other hand, there are powerful arguments against such charges. They might deter people from seeking the care they need. That might lead to higher costs, as disease that could have been treated cheaply early is neglected by patients seeking to save money and has to be treated later, at greater expense. They are expensive to administer. They are probably unpopular.

Moreover there is an important general argument that applies to all schemes to charge individuals for their health care. It is, simply, that sickness is often not the fault of the individual, any more than is their sex or colour. Some people therefore argue that it is always and everywhere wrong to levy charges for the treatment of sickness, whether those charged are poor or as rich as Croessus.

We do not consider these arguments here. We shall return to them when we publish our main report. However, in the course of exploring such arguments, we have come across a set of issues, a by-way to be sure, but a by-way that could lead somewhere important.

At present, even under a National Health Service (NHS) purportedly 'free at the point of use', many charges are levied. The 1948 system was in retreat from the moment prescription charges were imposed by Hugh Gaitskell in 1952, precipitating Aneurin Bevan's resignation from the cabinet. Many people have, for example, to pay for prescriptions, for dentistry, for eye testing and for spectacles. All these charges are subject to elaborate systems of exemptions and exclusions.

Ministers maintain that the present level of charges is generally accepted and has stood the test of time. But is this true also of these exemptions or exclusions? Or are they rather like some ancient cathedral, the original structure now practically impossible to see for the gothic additions attached down the generations? More prosaically, if we take the revenue raised by charges as a given, are they organised in an optimal way?

Our examination leads to the opposite conclusion. The present system is a dog's dinner, lacking any basis in equity or logic and stuffed with anomalies and inconsistencies.

Much detail about the failings of individual charging schemes and exemptions is to be found in this report. Here, however, are some examples:

- At 65 years of age Lord Muck is cruising the oceans while his son, Muckle, completes his education at Eton. Both get their prescriptions free. Meanwhile, 58-year-old Mr Grind, earning an income just above the exemption threshold, has to pay for his prescriptions in full, despite the fact that he has heart failure and chronic bronchitis. If he had diabetes and chronic bronchitis, Grind, like Muck, would pay nothing.

- Three pensioners, Alias, Smith and Jones travel from home to hospital for treatment. Smith is a war pensioner. He pays nothing where the treatment is for his pensionable disability. Jones has venereal disease and lives over 15 miles from the genito-urinary medicine clinic where he receives treatment. He pays nothing. Alias is disabled neither by war nor by sex. Unless he is on a low income, he has to pay his travel costs in full.

- Mrs Robinson is very hard of hearing; Mrs Crusoe has very poor sight. Yet Mrs Robinson gets her hearing tested free and now even a free NHS digital hearing aid. Mrs Crusoe has to pay for her eye-test and pays through the nose for her glasses.

One approach to sorting out these problems would be to abolish charges altogether. This would not be the simple solution it sounds. If, for example, we got rid of prescription charges, would more people seek to get over-the-counter medicines (such as paracetamol or aspirin) by prescription, crowding out their doctors' waiting rooms? Would complementary therapies, such as aromatherapy or homeopathy, be free? What about costs to the patient that are not at present subsidised but which in a free-for-all regime arguably should be: for example, loss of earnings while a patient visits the doctor or is in hospital?

In any case, zero charging would clearly involve a substantial extra burden on health expenditure. Prescription charges in England alone generate over £400 million and together with charges for NHS dental treatment amount to 1.8 per cent of total NHS expenditure. It might increase the demand for some treatments – especially the less unpleasant ones, such as physiotherapy – hugely. We do not pursue this approach further in this report.

Instead, we seek to set out a few principles that we feel should be applied to all charging regimes. We then set out in detail how those principles might apply to one controversial area: prescription charges. We examine in rather less detail an area where we feel that charging should, for most people, be on a cost-recovery basis, namely dentistry. We then pass more cursorily over some other areas of charging, which we believe could benefit from the same systematic examination as we give to prescription charges. We have focused our investigation on England, though Wales in particular has different arrangements under devolution. We have drawn, where appropriate, on other European systems.

One preliminary point needs to be made. It would be convenient if there was some single, simple principle which would unambiguously set what is the right level of charges, and who should and who should not have to pay them. Unfortunately, the real world defies such simple remedies. It is not realistic to think that there is some universal approach to all charging that will eliminate all anomalies and inequities; nor indeed is there one scheme that will cover the myriad of different charges and subsidies. That is partly because different treatments are medically important to different extents. While, for example, any scheme to help people with the costs of dentistry might acceptably be relatively ungenerous, few would be similarly *insouciant* about a scheme to help with the costs of, say, tamoxifen to treat breast cancer. It is also partly because we are where we are. We do not start with a *tabula rasa*, able to impose a new system from scratch. We have to operate in the real world, proposing only such changes as seem, though radical, politically possible.

However, it is possible to set out some principles which must be regarded and weighed in assessing an appropriate regime for charges. The first and overwhelmingly the most important of these must be this. No-one should be denied access to truly essential treatment – that is to say treatment without which they will be in danger of death or serious suffering because they cannot afford it. If it is appropriate to charge at all for such essential treatments, it should be on a basis that ensures that they are affordable, even if sometimes at a pinch, by those who could benefit from them.

In an ideal world, this principle might be extended. At present, charges are flat-rate and usually independent both of the cost of the treatment and of the likely benefits to be expected from it. We could envisage a world in which what the patient pays would in part depend on the value to their health of what they got. So, in the case of prescriptions, a drug that could add greatly to their life span and to the quality of that life span might cost them little. A drug that is marginally effective or even ineffective would cost them more. Equally, there is some case to be made for establishing some relationship between the cost of a drug and what the patient pays for it, if only to discourage the excessive consumption of expensive, but only marginally more effective drugs.

A full-blown system of this kind would be hard to design and even harder to administer. However, we suggest some moves in this direction in our recommendations on prescription charges that follow.

The case of children requires special attention, both because they lack the resources to purchase medical care for themselves and because under-treatment of the young may lead to many years of suffering and expense. In general, it will be appropriate for some treatments to be free to children that should not be free to all adults.

Another special group is the chronically sick. Though the charges for individual items of treatment may seem low, some people will require many such items to deal with their complex needs. It is vital to ensure that the cumulative costs of this do not become unaffordable even if the costs of each individual treatment are quite modest.

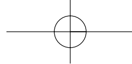
It follows from this that any charging should exempt altogether, or at least favour, those on low income. Though in general the way to deal with poverty must be to increase the incomes of the poor, people on low income who also have the misfortune to be sick will never be rich enough to afford expensive treatments from their own resources. An income-related scheme to assist them is essential. It should be made as administratively simple as possible, for example by giving passported benefits for those in receipt of certain state benefits.

There is, however, a concomitant of this: that it will not generally be appropriate to give benefits to categories of people defined by non-income criteria. Some older people are on low incomes but some are well-off. There is no reason why the latter should get favoured treatment just because of their age.

The thrust of our proposals generally is to broaden the base of charges, so more people pay them. It follows from this that, as our proposals are meant to be revenue-neutral overall, the level of many charges, including prescription charges, should fall appreciably.

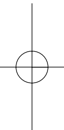
Any system of charges and exemptions should balance the dangers of encouraging over-consumption (for example, of GP visits by the worried well) with the dangers of causing under-consumption (for example, of GP visits by the truly sick). We do not here make the mistake of thinking that the structure of charges is the main cause of the ills of the current system. Again, to take the example of prescriptions, one of the main problems with the present system is over-prescribing by doctors of medicines of doubtful efficacy, often the wrong drugs, at the wrong time, for the wrong illness. That malaise of our health system requires systematic treatment of the kind that the National Institute for Clinical Excellence (NICE) is pioneering. However, a well-judged system of charges can contribute to such an end. In particular, if there is no disincentive to the individual to consume prescriptions, their demand on their doctor to supply them is likely to be greater.

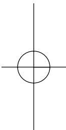
This approach may seem simple, even obvious. But when applied to the present mess, it turns out to

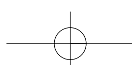


have radical implications, amounting to a root-and-branch reform of the present system of charges and exemptions. Not only do we urge the government to examine the particular scheme we put forward for prescriptions, with a view to putting it into practice. We hope that parallel inquiries will be set up into other areas of charging and exemptions, some of which are identified in our report. Reform would best be advanced a step at a time, a subject at a time. A big bang would be too controversial. But in time, a more rational system could emerge, with immense benefits for patients, especially less well-off patients, and for taxpayers.

David Lipsey
Chairman, SMF Health Commission







The prescription charge

The prescription charge has a long history. It was first introduced in 1952, at a cost of one shilling (5 pence) per prescription form. Since then the prescription charge has been abolished and reintroduced again and the number of prescriptions has risen and fallen respectively.

Today, the prescription charge in England is £6.30. Scotland and Northern Ireland normally adopt the same level of charge. In Wales, the charge has been frozen at £6.00 for three consecutive years. In England alone, prescription charges are expected to raise in the region of £446 million for the NHS in 2003-2004 (Department of Health 2003a). This is despite the fact that 85 per cent of prescription items are dispensed free of charge.

The burden of prescription charges falls mainly on the working age population, with 80 per cent of people in England aged between 18 and 60 having to pay them (Hansard 07/02/01 column 571). Overall, about 50 per cent of the population are eligible for free prescriptions (Department of Health and National Statistics 2002). This includes anyone aged 60 or over, children and young people in full-time education, women who are pregnant or who have had a baby in the last 12 months and war pensioners, where the treatment is for the pensionable disability. Others exempt from the charge include people in hospital, people receiving some income-related benefits such as Income Support and people with a listed medical condition or certain continuing physical disabilities. There is also means-tested support through the NHS Low Income Scheme, which entitles holders of an HC2 certificate to free prescriptions.

Many commentators have called for a review of prescription charges. Consumerists rail against them. The National Association of Citizens Advice Bureaux (NACAB) (2001) has called for consideration to be given to abolishing prescription charges altogether. This view is echoed by other patient advocacy organisations (Ford et al 2002, Eversely & Sheppard 1998). More soberly, the Wanless Review (2002) concluded that the rules on exemptions should be examined 'as the policy ought to be more closely aligned with the principles of the NHS.' The Royal Pharmaceutical Society of Great Britain (2003) has also called for a review of the current charging system in the belief that it is at variance with the Government's policy on equal access for all to healthcare services. The British Medical Association (BMA) has described the system as 'outdated', with 'many unacceptable inequities and anomalies' and has called for a fundamental review.

The National Assembly for Wales has appeared receptive to these concerns and, in March 2003, the Health Minister for Wales announced plans for a review group to look at the existing arrangements for prescription charges, exemptions and remissions.

Illogical exemption arrangements

The rationale behind exemptions is unclear and illogical. They make for a system that is fundamentally unfair and out of touch with modern day medical practice. The clearest example of unfairness is the way certain chronic conditions exempt people from prescription charges (including for routine illnesses wholly unrelated to the reason for exemption), while others must pay for life-saving medication. The list of exempt conditions includes diabetes mellitus, diabetes insipidus, a permanent fistula requiring continuous surgical dressing or an appliance and epilepsy requiring continuous antiepileptic therapy. The list is arbitrary and excludes many equally serious conditions. For instance, people with transplants, asthma, Parkinson's disease, cystic fibrosis or certain types of epilepsy, must pay for all the prescriptions they need.

The impact prescription charges can have on people with chronic illness was highlighted in a Ten Minute Rule Bill presented to Parliament by Liberal Democrat MP Paul Marsden in 2002. He described the case

of a woman living with severe long-term asthma who claims incapacity benefits of £369 per month but must pay a monthly prescription bill of £124. If short of cash, she does without her medication, risking a worsening of her condition, which could mean her being admitted to hospital at great expense to her and the NHS (Marsden 2002).

Another group hit hard by prescription charges is those on low incomes just above the threshold for help. They suffer a double whammy – a greater likelihood of becoming ill, together with a lesser ability to pay for the medicines such illness necessitates. As a flat rate fee, the prescription charge affects lower income groups disproportionately. The charge is not tapered as income increases and so those with incomes just a few pence above the threshold for help must pay the full cost. Someone off work for a number of weeks due to illness may see a serious reduction in their income and yet still have to pay for prescriptions.

The result is that people on lower incomes feel they have no option but to limit, delay or forgo treatment with prescription medicines. For example, evidence from NACAB (2001) suggests that around 750,000 people in England and Wales fail to get their prescription dispensed simply because of the cost. A survey of NACAB clients showed that 28 per cent of those having to pay prescription charges fell into this category. Of these, 16 per cent were on Incapacity Benefit or other disability and sickness benefits and likely to have long-term requirements for medicines. Indeed, people with long-term health problems were particularly affected, representing 37 per cent of those failing to get all or part of their prescriptions dispensed.

Further evidence comes from GPs. They report that patients often ask which of two or more items on a prescription form are the most important, as they cannot afford to pay for more than one at a time (BMA 2002).

On the other hand, some of those currently exempt from prescription charges could easily afford to pay. This includes many people who are exempt on the grounds of age (the over 60s). New mothers are another group whose blanket exemption needs rethinking. The BMA (2002) has argued that women no longer need to be exempt from prescription charges during the year following childbirth as the health hazards that used to apply are much less common nowadays. This would suggest that this universal benefit is ill-targeted.

Low take-up of season tickets

Take-up of the scheme to help with the cost of prescriptions is low. For example, NACAB (2001) found that only 5 per cent of people surveyed who had paid for a prescription in the previous year had bought a prescription pre-payment certificate (season tickets for people who need several or regular prescription items).

The way the scheme is administered creates problems. Specifically, the immediate outlay of £90.40 for a 12-month certificate (or £32.90 for a four-month certificate) can make them inaccessible to the very people they are designed to help.

Recognising these problems, the National Assembly for Wales recently launched a new scheme that will identify patients who might benefit from the season ticket but who may have difficulty paying the annual fee (£86.20 in Wales) up front. A Credit Union will advance the money needed to buy the season ticket. The patient will become a member of the Credit Union and pay back the money advanced in the usual way. Once the patient joins the scheme their medication will be reviewed to ensure that there is a clear clinical rationale for the treatments they are being prescribed (National Assembly for Wales 2003).

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This is an ingenious scheme, but it would seem less cumbersome to deal with the problem by obviating the need for hefty pre-payment.

Complex proof of exemption arrangements

Pharmaceutical patient fraud costs the health service £69 million each year (Department of Health 2003b). Demonstration of entitlement to exempt status is therefore crucial to ensure that money is not wasted on people who could afford to pay charges. Since 1999 point of dispensing checks have operated in pharmacies and involve asking patients who are claiming free prescriptions to provide evidence to support their claim to exemption and, should no evidence be available, noting this on the prescription.

Arrangements to prove exempt status can be, however, unnecessarily complex. The process of getting free prescriptions can involve obtaining a bewildering array of forms to prove entitlement. Sometimes different proof is required for the same category of person to qualify for exemption from prescription charges and dental charges, for example. Not only does this have the potential to confuse patients, the many different forms of proof may undermine moves to get pharmacists to police entitlement.

Since October 2002, a Patients Checks Compliance Unit has been visiting pharmacies to ensure that exemption checks are being made and there is a support line for pharmacists to report any difficult cases. To encourage vigilance, the reward to pharmacists for reporting prescription fraud was recently increased to £70. Since 2001 penalty charges for people wrongly claiming exemption have been in operation and by the end of 2002 nearly 75,000 of these had been issued (Department of Health 2003b).

Inefficiencies

Some of the deficiencies with the current set-up might be tolerable if they were accompanied by efficiency gains. But here, also, the prescription charge falls short. Its ability to dampen patient demand for medicines is limited. GPs are gatekeepers to prescription drugs and it is they who control the amount of medicines prescribed. The charge often discourages the take-up of prescriptions altogether, creating inefficiencies in the system by discouraging early diagnosis and treatment. As a result, treatment is diverted to more costly parts of the system or delayed to a point at which it is more expensive. People who limit their use of drugs to control their asthma, for example, are more likely to make visits to Accident and Emergency and require hospitalisation.

The prescription charge, being flat rate, does little to make people aware of the cost of the medicines they take. At the same time, it penalises those needing medicines that cost less than the £6.30 charge. The Government makes a profit out of patients who require medicines and yet prevents them from purchasing the medicine privately. GPs could be in breach of their terms of service if they issued a private prescription or, in the case of over-the-counter medicines, advised a patient that they could buy the drug more cheaply without a prescription (BMA 2002).

Another example of how the charge can undermine adherence to drug regimes concerns the rules around combination packs, for which a prescription covers two or more drugs that have to be taken in association with each other. Each item attracts the full charge. The variable duration for which medicines are prescribed, which dictates the frequency with which an individual must pay for another prescription, compounds the problem.

Inconsistency across the UK

The rationale behind prescription charges and exemption arrangements is further confused by variations across the UK as a result of devolution. The increase in the cost of a single prescription in England has been 10 pence for five years now. In Wales prescription charges have been frozen for three consecutive

years. There are also variations in the exemption arrangements. Young people in Wales can receive free prescriptions until their 25th birthday. By contrast, young people in England must start paying prescription charges on their 16th birthday, unless they are under 19 and in full-time education (Department of Health 2002). Scotland largely has similar exemption arrangements to England.

A MORE RATIONAL SYSTEM

The current arrangements for prescription charges have little to commend them. They fail to meet the principles that we believe should underpin any system of user charges. First, exemption arrangements are inappropriate, outdated and fundamentally unfair. Second, the system creates inefficiencies and does nothing to engender price-consciousness about medicines amongst British citizens. Third, there is evidence that prescription charges are deterring access to valuable medicines.

We do not propose abolishing prescription charges altogether. For one thing, the revenue implications of this would be significant (more than £400 million), a sum moreover that would tend to benefit the better off.

Equally, our objective is not to generate extra revenues or ration the use of more expensive medicines (although heightening price sensitivity might be desirable). Instead, our intention is to rid the system of some of its anomalies and inequities and provide a more rational framework within which it can operate. In doing so, we strive to broaden the base on which prescription charges fall, helping the poorest and making it easier for everyone else to afford the cost of these charges.

The key features of our proposed system are to:
- Create a simpler framework for exemptions
- Replace the season ticket with an annual limit on the outlay patients should make on prescription charges
- Replace the national flat rate charge with different rates according to the therapeutic value or efficacy of the drug.

Simpler exemptions

We propose simplifying the exemption arrangements, by ridding the system of irrelevant qualifications for free prescriptions. We recommend that prescriptions are provided free to children and to others on the basis of low income only. There may be exceptions and anomalies that require further consideration (such as whether young people in full time education should automatically be exempt), but our overall drive is to simplify.

We see no reason why there should be automatic exemption for pregnant women, nursing mothers or older people. With regard to the latter group, we believe that those older people who can afford to pay for prescriptions should do so. This would bring substantial revenues into the health service. In 2001-2002 around 322 million prescription items were dispensed in the community in England free to people aged 60 and over, with an estimated net ingredient cost of £3,218 million (Lords Hansard 08/04/03 column WA26).

It is true that pensioners are more likely to be at the lower end of the income distribution than the population as a whole (Department for Work and Pensions 2002). However, it is also the case that in 2000-2001, there were 210,000 pensioner units (single men or women over state pension age or couples where the man is over state pension age) with annual net income, before housing costs, exceeding £30,000 (Pensions Analysts Division of the Department for Work and Pensions 2003).

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Those older people unable to afford charges would qualify for exempt status under the low income rules. This mirrors changes in the Danish system, where special rules for pensioners have been abolished, although pensioners who find it difficult to pay for medicines can apply for assistance (European Observatory on Health Care Systems 2001). The revenues gained by charging older people could be used to reduce the level of prescription charges and make the reforms more palatable.

Some assessment of the income level below which exemption from charges should apply, the impact benefits have on income levels and the relative rate at which means-tested and non-means-tested benefits are uprated each year, may be necessary. For example, NACAB (2001) has demonstrated that chronically sick people receiving Incapacity Benefit are disadvantaged by the fact that this benefit is paid at levels only slightly above Income Support. People can also lose entitlement to free prescriptions when their health deteriorates and their income drops if they move from a means-tested tax credit to a contributory benefit. However, it is beyond the remit of this Commission to determine whether existing benchmarks of low income are appropriate or whether Income Support and other benefits are set at the right levels. For simplicity, criteria for low income in relation to exemption from prescription charges should be determined as far as possible using existing indicators, such as Income Support.

Annual maximum limit

Protection from escalating prescription bills could be given by introducing an annual limit on the amount an individual should pay on prescription charges. This would particularly benefit the chronically ill in need of multiple prescriptions. Once the limit has been reached, the state would pick up the tab for any further prescription items needed. Subject to proper review, the prescription pre-payment certificate scheme – which is effectively a prescription cost limit for anyone who pre-pays – should be abandoned and replaced by the annual ceiling.

For the sake of simplicity, the ceiling could be set at the same level for everyone. We anticipate that the ceiling would be set at a level not much higher than the cost of an annual prescription pre-payment certificate. This means that nobody would pay more than around £90 per year in prescription charges.

There is a seductive case for making the ceiling variable on the basis of individual income, with higher earners having a higher ceiling than lower earners. However, this would undermine the principle that redistribution of wealth should operate through the tax system. It would also be hopelessly clumsy to administer. We rule it out for the immediate future.

In order to assess when an individual has met the ceiling, a mechanism to record annual outlay is needed. This could be as simple as a card carried by the individual, which the pharmacist signs each time a prescription is dispensed. A possible alternative is a patient-held smartcard that could hold information about exemption status, where applicable, as well as indicating when the ceiling has been reached.

We have considered the need for tapered help for people on low incomes just outside the threshold for exemption. The introduction of a ceiling on the total outlay on prescriptions mitigates the problems of the less well off, so new mechanisms of tapered support, which would be costly to administer, may not be needed.

A shift to charges that reflect value

We recommend abolishing the arbitrary flat rate national charge and replacing it with varying prescription charges. This would bring the UK more into line with other European countries where the fee paid tends to vary between different classes of medicines or according to other variables.

We have considered a number of options – linking the charge to the therapeutic value (efficacy) of the treatment, to the cost of the drug and to individuals' total spending on drugs. A further device, which we start with, is reference pricing: identifying the drug in a given class that the state will pay for and setting its price.

Reference pricing

One option is to vary the rate of cost-sharing between the patient and the NHS under a system of reference pricing. The reference drug in a given class is identified as the drug of choice that the state will pay for. Consumers can choose to have another drug, but in doing so must pay the difference between the actual price and the reference price. Germany's system revolves around reference pricing (although the prescription cost also varies according to the pack size).

One way to translate reference pricing into the UK context would be for NICE to create two bands of drug. It would identify the reference drug in a given class that the NHS would pay for. This drug would be classed as a Band A drug and would be charged for at the reference price. Exemptions would apply for those who could not afford to pay. Band B drugs would be available to consumers willing to pay the difference between the reference price and the actual price. Such payments would fall outside the annual ceiling we have proposed.

Non-steroidal drugs are a good example, as there are many different products of similar clinical effectiveness on the market. The NHS could, say, include four or five such products in Band A; the other twenty or so would be assigned to Band B. However, the NHS would need to be careful to ensure that drugs on Band A were not seen as sub-standard. For instance, it would not be acceptable to include drugs that are clinically effective but which may have more side effects than comparative drugs on Band B. How easy a drug is to take or how well it is tolerated, particularly by people with chronic conditions, would be important factors in the therapeutic equation.

While it is not a key objective of this report to seek revenue gains, we recognise the potential of this system to bring about efficiency savings. NICE would continue to consider cost-effectiveness as well as clinical effectiveness. If a number of clinically effective drugs in a given class were identified, it is likely that the cheapest in the class would be chosen as the reference drug. Over time this would probably have the effect of bringing down the cost of drugs – in Germany, most pharmaceutical companies set prices at the reference price (European Observatory on Health Care Systems 2002). Furthermore, reference pricing would discourage the excessive consumption of expensive drugs that are only marginally more effective than the drug of choice. Some within the pharmaceutical industry also believe that reference pricing could stifle innovation and delay patients' access to medicines.

Linking the charge to the cost of the drug

One way to foster price-consciousness amongst consumers is to link the amount they pay for medicines to the cost of the drug to the NHS. In Finland, patients pay a flat rate fee plus 50 per cent of the remainder of the price of the drug. In Spain, patients pay 40 per cent of the cost of the drug, with a reduced rate (10 per cent) for the chronically ill (Robinson 2001).

The attraction of this kind of set up is that the link between the charge to the patient and the cost of the drug to the service is more transparent. However, patients in need of costly drugs could lose out under this approach. Even where a reduced rate is applied to those with chronic illness, it still means walking the tightrope of defining which conditions should be included on the list of deserving chronic conditions. We do not advocate it here.

Linking the charge to expenditure levels

Under the Danish and Swedish systems the rates of charges are tapered according to expenditure levels. In Denmark, for instance, individuals pay 100 per cent of the cost up to DKr500 per year, 50 per cent for DKr501-1200, 25 per cent for Dkr1201-2800 and 15 per cent for over DKr2800. Chronically ill patients can apply for full reimbursement of any expenditure above an annual ceiling of Dkr3600. The Swedish system is similar, with a maximum liability in any 12-month period (Robinson 2001). Tapering mechanisms are administratively complicated. However, the idea of introducing a cost ceiling is very attractive.

Linking the charge to efficacy

Another option is to link the prescription charge to the therapeutic value of the medicine. In a number of European countries drugs used to treat life-threatening diseases, or which have major therapeutic effects, are typically subject to lower rates of cost-sharing than those offering more marginal improvements in quality of life. For example, in Belgium, the rate is 0 per cent, 25 per cent, 50 per cent and 60 per cent of the cost, depending on the therapeutic value of the drug. Price ceilings apply and there are reduced rates for low-income groups. In France, there are rates of 0 per cent, 35 per cent and 65 per cent depending on the category of drugs (the latter for drugs of debatable therapeutic value). Luxembourg, Portugal and Italy similarly have three categories of drugs that are subject to varying rates (Robinson 2001).

Patients in Luxembourg pay up front for medicines and then seek reimbursement from their social health insurer. The sickness funds cover 80 per cent of the cost of most drugs. Medicines that have a precise therapeutic purpose, usually with regard to long-term or particularly serious illnesses (such as cancer or severe hypertension) are 100 per cent reimbursable. There is a reduced rate for drugs classed as for comfort purposes, such as minor painkillers and anti-flu drugs, where the sickness funds will cover 40 per cent of the cost. Certain drugs are not reimbursable at all, including contraceptives, vitamin supplements and tonics (European Observatory on Health Care Systems 1999). Categorising contraceptives in this way might not be appropriate in the UK. However it demonstrates one approach to categorising medicines according to therapeutic value.

In Portugal the amount patients pay for medicines is similarly based on efficacy and effectiveness criteria, with full payment required for those treatments thought to have no clinical value. Category A drugs are those considered vital for survival or used to treat chronic diseases: no out-of-pocket payment is required for these. Category B drugs (the bulk of drugs consumed) are those used to treat serious illness requiring prolonged therapy. Patients pay 30 per cent of the cost of these drugs. Category C refers to non-priority medicines with confirmed therapeutic value. For these, patients pay 60 per cent of the cost. For drugs of little or no proven therapeutic value, the full cost of the drug must be met by the patient. Pensioners pay at a reduced rate on category B and C drugs and the chronically ill are exempt from having to pay for certain courses of medicines. Low income people are exempt from user charges, along with ‘special’ patient groups such as pregnant women, children up to 12 years of age, drug addicts in rehabilitation and patients with chronic mental illness (European Observatory on Health Care Systems 1999b). Again, these are fairly crude categories, but they would represent an improvement on a system where a flat rate is applied to all medicines, regardless of their benefit.

Such arrangements better protect the chronically ill, as medicines necessary to sustain life or manage an ongoing illness attract lower cost-sharing rates, even down to 0 per cent. This would benefit people with cystic fibrosis and other conditions currently excluded from the exemption arrangements in the UK. Society benefits from encouraging the take-up of certain prescription medicines amongst some groups (such as people with mental health conditions) and these medicines could also attract low cost-sharing rates.

NICE is well placed to advise on the categorisation of drugs according to therapeutic benefit. This might involve considering the safety, effectiveness and cost effectiveness of medicines. It might draw on Quality Adjusted Life Years (QALYs), the tool of health economists, as a means of attaching value to each drug. A drug with a high QALY rating would cost the patient little; one with a low rating would cost more. Any such categorisation would require regular review as new drugs came onto the market and the value of existing drugs changed.

A pitfall of this system is the complexity of categorising drugs in this way. For example, the same drug could have a different therapeutic value according to the condition it is being used for. However, an advantage is that it would not necessitate altering the actual cost of drugs. Instead, the cost of the drug would remain the same – only the proportions paid by the patient and the state would alter. This system also makes prescription charges more rational – the cost reflects the value of the drug to the patient. The use of medicines of marginal value would be discouraged by higher charges.

A framework for change

Linking prescription charges to the therapeutic value, or efficacy, of the drug is the most attractive option. In countries that operate social insurance systems, patients tend to pay a percentage of the cost of the drug, according to the band the drug falls into, with the social insurance fund meeting the rest of the cost. The outlay for the patient can be significant and supplementary or top-up insurance schemes to cover the cost of these out-of-pocket payments are common across Europe.

Another approach, and one that we favour, is to assign a nominal flat rate charge to each band of drug. So, for instance, band A medicines might be defined as those that are vital to life or for chronic conditions and provided cheap or free to patients. Band B drugs might be defined as medicines that treat serious illnesses. These would be expected to be charged at a lower rate than the current prescription charge. Band C medicines might be ones that are not considered such high priority but are still efficacious. The charge for these medicines may be around or a little higher than the current prescription charge level. Band D might include medicines that the NHS does not consider a priority, such as lifestyle treatments. Patients would pay the full cost to the NHS of these medicines.

There are difficult issues to address, not least how to define efficacy. However, these need not impede introduction of the other reforms we advocate – specifically, simpler exemptions and an annual ceiling.

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Dental charges

User charges for NHS dental treatment have been in operation for almost as long as the NHS itself. These were capped at relatively low levels until the 1980s. Since 1989 charges have also applied to dental check-ups.

Patient charges contribute about 30 per cent to general dental services revenue. In England, in 2000-2001, patient charges for general dental services amounted to £454.6 million, out of a total of more than £1.5 billion (Department of Health and National Statistics 2002).

Patients treated under the NHS pay 80 per cent of the cost of a course of treatment up to a maximum, currently £372. The state meets the remaining 20 per cent. The cost of a basic examination, for example, is £5.32. At the other end of the scale, a full set of plastic dentures starts at £115.16 and a precious metal crown means an outlay of at least £73.28 (Department of Health HC12 form).[1]

More than 25 per cent of adult courses of treatment are delivered free or at a reduced charge (Department of Health and National Statistics 2002). Those entitled to free NHS dental treatment in England include children and young people in full time education, pregnant women and women who have had a child in the 12 months before treatment, NHS in-patients and out-patients and people on some benefits. In contrast to prescription arrangements, the over 60s are not automatically exempt. Some element of means-tested help is available through the NHS Low Income Scheme. A HC2 certificate grants entitlement for full help with dental charges; the HC3 for limited help, by entitling the holder to pay either what appears on the certificate or the actual charge, whichever is the lesser.

Three-quarters of adults receive no help with the cost of dental treatment. The proportion is higher for adults aged 60 years and over – 82 per cent in this age band receive no help (Hansard 09/02/01 column 715). The Dental Practice Board (2001), which audits NHS dental treatment, has identified an underlying downward trend in the proportion of treatment claims related to patients entitled to remission of, or exemption from, charges since December 1995. In 1999-2000, the average charge for a course of NHS treatment for adults was £21.82 (Hansard 09/02/01 column 715).

All NHS registered patients have access to a set level of service (i.e. services for which the NHS will pay a percentage of the cost). The NHS list includes 300 different treatments that dentists are obliged to provide to NHS patients. Cosmetic treatments, such as teeth whitening, are not included. Dentists carrying out treatment on the NHS receive the same amount of payment for each treatment, regardless of the length of time they spend with the patient (Office of Fair Trading 2003).

Confusing charging arrangements

There is a lack of understanding about the system of charges for NHS dental care. For example, research commissioned by the British Dental Association (BDA) (Land 2000) identified a lack of awareness that NHS patients pay 80 per cent of the cost of treatment.

This research also revealed (not surprisingly) that patients would prefer to pay less. Many advocated a 50/50 split or a reversal of the current ratio to a 20 per cent patient contribution. However taxpayers might be less enthusiastic. Based on 1999-2000 figures the Government estimates it would cost £155 million to reduce to 50 per cent the percentage of dental charges paid by patients in England for a course of NHS treatment (Hansard 20/03/01 column 137).

1 Charges based on fee rates 1 April 2002; subject to change during 2003.

Patients often report that they are confused about whether they have had private or NHS treatment. This is also not surprising since most private dentistry is provided by dental practices that also provide NHS treatment. The situation is complicated by the fact that a patient may incur both NHS and private charges in one course of treatment (for example, a check-up as an NHS patient and then root canal work as a private patient). Treatment plans, designed to set out the costs and whether any private treatment is required, are not always used, with the result that patients can face unexpectedly large bills.

Some patients have little option but to seek all their dental care privately as they are unable to register for NHS treatment. Around seven million UK consumers regularly receive private dental treatment (Office of Fair Trading 2003). Private dentists have been found to charge up to six times the NHS rate (Which? 2001). The Office of Fair Trading (OFT) recently completed its investigation into private dentistry and concluded that this market needs to be more consumer-oriented. One of the key problems it identified was insufficient information about what services are available on the NHS, about treatment options and costs.

Barrier to accessing care

Cost is one of the main barriers to accessing dental care. The BDA (2002) has described 'the damaging effect patient charges at their current level have on patient attendance'. It maintains that many patients hold off completing their treatment because the total cost is too high.

Further evidence comes from NACAB (2000). For example, 14 per cent of those interviewed said cost was the main reason they had not had a check-up in the previous year.

Patient charges are not the only financial barrier. Charging refundable deposits in advance of NHS treatment can prevent access for people entitled to free treatment. NACAB (2001) cites the case of a pensioner charged a deposit of £300 for the provision of NHS dentures. It also reports that some dentists insist on a private consultation for which a refundable deposit is charged before they decide whether to accept a patient.

A Department of Health task group on dental care sums up the overall situation: 'Dental disease is related to socio-economic factors and at present, those in greatest need are least likely to access the service and often pay the most for their dental care' (Department of Health 2002).

Inefficiencies

Dentists are mostly reimbursed on a fee per item basis, according to a scale of NHS fees. The BDA (2002) has drawn attention to the numerous small fees and complicated calculations that have to be made, the demand for small change at the reception desk that results and the problem of bad debts that fall on the shoulders of the NHS practitioner. There are also concerns that the piecework system creates incentives to over-treat or influence the type of treatment given to certain patients. This wastes NHS funds.

The Audit Commission (2002) maintains that at least £150 million in England is wasted through 'over-frequent examinations for many people whose dental health is generally good – and on treatment that is not of proven benefit to health, or that is cosmetic'. It highlights the example of the scaling and polishing of teeth, which accounts for 11 per cent of NHS family dentist expenditure. The Audit Commission argues that, for most people, this procedure is mainly of temporary cosmetic benefit and rarely prevents or cures gum disease.

Likewise, most dentists encourage people registered for NHS care to attend a check-up every six months. They are no longer paid a fee for NHS patients who do not attend within 15 months (after which time

their registration lapses). According to the Audit Commission, most experts believe a more appropriate interval between appointments would be two to three years for most adults and one to two years for children, with more frequent visits for higher risk patients.

The extent to which the NHS offers 'wasteful' dental treatments is a contentious issue. While it is the case that some treatments are not clinically based, this does not necessarily make them clinically ineffective. Until further research evidence is obtained – NICE is considering the recall interval between routine dental examinations and is expected to report in 2004 – it is difficult to assess the degree of waste with any certainty. What is clear, however, is that the NHS should prioritise funds for those treatments that are proven to have greatest impact on oral health.

Reform underway

Changing the way dentists are paid in order to overcome some of these problems is one element of proposals for a new dental service in England published by the Chief Dental Officer (Department of Health 2002). The plans include simplifying the system of NHS charges and payments, principally by severing the direct link between the remuneration of dentists and patient charges. Options include changing the present system so that charges fall into a range of bands reflecting the complexity of the treatment, in preference to the precise calculations required where charges are an exact proportion of fees per item. Work to tackle patient charges is due to begin shortly.

A focal point of the new service is expected to be a standard oral health assessment, available to all, and carrying an NHS charge. This would comprise three elements: diagnosis, prevention and treatment planning. There would be no scope for mixing NHS with private treatment at this stage, so the patient would know exactly what they were getting and paying a charge for.

In reviewing primary dental care services, the Audit Commission (2002) welcomed these proposals, including work to define what dental examinations and treatments the NHS will pay for because they are proven to improve dental health and what will only be available privately. However, it concluded that change has been too slow. It argued that initiatives to empower patients – specifically, information about which treatments are necessary and which cosmetic, about charges for treatment and treatment plans with written estimates of cost – should not wait for reform of the whole system.

The Audit Commission recommended that the NHS should emphasise prevention and that the piecework system should be replaced with one that concentrates funds on prevention and treatments that are of proven value to dental health. Patients at high risk of decay and gum disease should receive more frequent check-ups than those with generally good oral health. It also called for the charging system to ensure that people on lower incomes are not deterred from seeking necessary dental healthcare.

A PREVENTIVE APPROACH

We support calls for a greater focus on prevention and to prioritise the treatments that should fall under the NHS banner according to clinical effectiveness. We would like to see full cost recovery for other treatments that, although they may still have some clinical value, should fall outside the NHS because they are not necessary in order to treat a medical condition.

The key elements of our proposals are to:

- improve access to preventive and clinically necessary dental care and make other treatments subject to full cost recovery
- encourage participation in dental capitation schemes.

Encouraging prevention and full cost recovery for other treatments

Check-ups offer an opportunity to assess dental health and the need for treatment, as well as take a preventive approach to oral disease. The components of the Department of Health's proposed comprehensive oral health assessment include lifestyle advice such as smoking cessation, oral health education, oral cancer screening and discussion of treatment options. Such assessments, together with preventive treatments and medically essential treatments, should be readily accessible to all on the NHS.

We have considered a number of options. These include offering check-ups and preventive care free of charge. It is estimated that making check-ups alone free to every adult in England would cost approximately £87 million at 2002-2003 charge rates and current demand. Additional costs would rise if there were any associated increase in the overall number of dental examinations (Lords Hansard 08/04/03 column WA27).

Another option is to charge a low rate for check-ups and preventive treatment and a higher rate for other treatments. This is what happens in Finland, where the patient pays 10 per cent of the cost for dental examinations and preventive treatment and 40 per cent for other treatments (under 18s go free). Likewise, in France, co-insurance is 30 per cent for preventive care and treatments and up to 80 per cent for dentures and orthodontics (Robinson 2001).

Our favoured approach is for the NHS to pay for everyone to have a free check-up at reasonable intervals (as decided by NICE). Ideally, preventive and clinically necessary treatments (i.e. those to treat serious medical problems strictly defined) would also be free to patients. If this is too costly, we recommend that consideration be given to lowering the cost-sharing percentage that patients pay for these types of treatments. Beyond this, everyone would pay the full cost of treatment, except for children and people on low incomes.

This type of system operates in the Netherlands, where there are no charges for children under 17 or for preventive and specialist dental care, but all other treatments are subject to full cost pricing. Also, in Spain, check-ups for children are free and free tooth extractions are available in the public sector but there is full cost pricing for other services (Robinson 2001).

Under such a system, community dentists would provide private services and seek reimbursement from the NHS for services for which the state picks up all or part of the bill. Registration with one dentist would not be necessary. In practice most consumers would develop a relationship with one dentist – and dentists would have a commercial motivation to cultivate their customers.

As more dentistry would be provided privately, the need for this sector to become more customer-oriented and provide clearer information about treatment options and costs would be all the greater. We would also expect the profession to do more to clamp down on dentists who exploit patients' ignorance for financial gain.

Encouraging dental capitation schemes

Greater use could be made of dental capitation schemes, such as Denplan, where consumers pay fixed monthly payments that take away the worry of unexpectedly large bills. Some dentists operate their own capitation schemes for private patients having regular treatment.

Government endorsement of these schemes and better consumer information about this market could encourage membership. There could be mileage in considering arrangements whereby the state pays some or all of the costs of enrolment in a capitation scheme for people on low incomes.

The bigger picture

Change is already underway, although progress to date has been limited. In a climate where questions are being raised over the clinical value of some dental treatments, it seems only common sense that NHS funds are focused on treatments that are both clinically effective and that encourage a preventive approach to dentistry. It is with this in mind that we recommend a system based on free dental check-ups and low cost preventive and medically essential treatments, with patients bearing the full cost of all other treatments.

There would appear to be potential for greater use to be made of dental hygienists, dental therapists and dental technicians in providing preventive services. Currently there are regulatory restrictions on the supply of dentistry services by such professionals. They are accessible only though the dentist who collects their fees. We support the conclusion by the OFT (2003) that these professionals should be able to supply their services directly to patients.

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Optical charges

The inception of the NHS meant free eye tests for all. This entitlement was abolished forty years later, except for certain groups. A decade on, free eye tests for the over 60s were introduced. However, today, for most people, the cost of a sight test, plus the purchase of glasses and contact lenses, is a private transaction.

The groups entitled to free NHS sight tests include people aged 60 or over, children under 16 and young people in full time education, diagnosed glaucoma patients and people at increased risk of glaucoma. People who are diabetic, registered blind or partially sighted, who need complex lenses, whose sight test is carried out through a hospital eye department, on certain benefits, or who are named on an HC2 certificate (designed to give full help to people on low incomes) also get their tests free. People in receipt of an HC3 certificate (and therefore entitled to partial help) will pay whatever they have been assessed as being able to contribute to their NHS sight test, up to £16.72. For everyone else, the cost of a private sight test will vary.

NHS vouchers are available to people on low incomes to help with the cost of glasses or contact lenses. These are for pre-set amounts, dependent on the type of lens required and the assessment of an individual's financial circumstances. NHS vouchers range from £31.30 to £146.30 for single vision lenses, and from £54.00 to £160.90 for bifocals. Voucher supplements are available where clinically necessary for tint, photochromic and special frames. Exceptionally, people will be entitled to a voucher for repair or replacement of glasses (Department of Health HC12 form).

In 2001-2002 an estimated 3.6 million vouchers for spectacles and 0.4 million applications for repairs and replacements of spectacles were reimbursed by health authorities in England, at a cost of £139 million (Lords Hansard 08/04/03 column WA27).

Sight test charges undermine a preventive approach

As with other charges, there is evidence to suggest that optical charges discourage take-up of services. Before free eye tests were introduced for people aged 60 and over, research by the Royal National Institute for the Blind (RNIB) (1997) indicated that around half a million people in this age band were not having their eyes tested regularly because of the cost and were leaving longer gaps between eye tests. Widespread confusion about exemption categories for free eye tests was also identified – many of those who were eligible for a free test were unaware of this.

Ford *et al* (2002) quote figures showing that the number of sight tests carried out on the NHS fell from 12,493 in 1989 to 5,280 the following year, after a change in the eligibility rules. The impact of this on eye health is unclear. However, Mossialos and Dixon (2001) cite research showing that, after charges for sight tests were introduced in the UK, 19 per cent fewer patients were identified as requiring treatment or follow-up for potentially blinding glaucoma.

The picture is complex, however. It has been suggested that the take up of sight tests hasn't increased dramatically since the introduction of free tests for the over 60s. Many people within this age group are still not getting tested, despite the fact that it is cost free, suggesting that other factors are at play. Indeed, the RNIB argues that the cost of glasses is the real issue – and not just for older people. Many children are reported not to have sight tests because their parents fear the cost of glasses (A Lightstone and D Vale, RNIB, personal communication, 2003).

The price of glasses is artificially inflated

The cost of sight tests has a knock-on effect on the price of glasses. Optometrists are reimbursed at a

rate of £16.72 for each NHS sight test carried out (and the difference between this amount and the patient contribution for holders of an HC3 certificate). According to the profession, this fee is about 50 per cent of that needed to cover the optometrist's overheads (D Craig, Association of Optometrists, personal communication 2003). It therefore creates perverse incentives for optometrists to inflate the price of glasses artificially in order to recoup their costs.

Few optometrists recoup their costs through the private sight test. In general this costs more than the NHS test, but often only marginally so. Some charge nothing at all for private sight tests. Again, optometrists mark up the cost of glasses in order to make their money.

Most patients have to cover the costs of glasses themselves. NHS vouchers to help with the cost of glasses are available to people on low incomes. People on income support are entitled to full vouchers. However, there is invariably a shortfall between the help available and the charge made by the private optometrist. Too often the value of optical vouchers doesn't cover the cost of the cheapest glasses available. For example, NACAB (2001) cites the case of a pensioner on Income Support, whose voucher was worth £50 but the cost of the cheapest glasses available was £90, a shortfall he could not afford to meet. Another man, also on Income Support, had to pay £159.49 for bifocals even after deducting the value of the voucher.

The Department of Health's figures (2003a) show that only 37 per cent of a sample of vouchers reimbursed by health authorities and Scottish Health Boards during July 2001 was redeemed for spectacles priced within the voucher value. Well under half (40 per cent) of vouchers redeemed to children were for spectacles priced within the voucher value, compared to 36 per cent for adults on benefits, 39 per cent for HC2 low income certificate holders and 35 per cent for students.

A MARKET IN NEED OF REVIEW

Glasses can be a fashion accessory and the market is dominated by designer brands in a way that doesn't happen with other physical aids. Consumers are vulnerable in this market and the charging structure for sight tests would appear to drive up the cost of glasses.

The key elements of our proposals here are to:
- Encourage take-up of sight tests
- Make spectacles and contact lenses more affordable.

Encourage a preventive approach

Sight tests are a valuable mechanism for early detection of potentially blinding eye diseases, particularly glaucoma. It is therefore important that people are not dissuaded from getting a sight test on the grounds of cost. The simplest way to guarantee this, and the approach that we favour, is to make sight tests available to everyone, paid for by the NHS. This echoes the approach we advocate for dental check-ups.

The cost of providing sight tests free to the entire population – and in doing so encouraging early diagnosis and treatment – will be offset, at least in part, by the health and social care savings from preventing advanced eye disease.

The cost of extending NHS sight tests to people who currently have private tests would be an additional £80 million for England (Lords Hansard 08/04/03 column WA27). It is not possible to estimate to what extent such a change would lead to additional sight tests being undertaken, though there is bound to be some increase, which we would welcome.

This proposal could be considered as part of a review under way in the Department of Health of what sight tests should cover.

Make glasses more affordable

There is a real issue about affordability in relation to glasses. We have not been able to get to the bottom of the anomalies within the spectacles market and to understand why there are apparently so many outlets charging such high prices for glasses. We recommend that the OFT considers conducting a review of this market. Such a review should consider the system of reimbursement to optometrists for carrying out NHS sight tests and, specifically, any perverse incentives to artificially inflate the price of glasses. We would also encourage the OFT to consider the merits of expanding the voucher scheme for people on low incomes.

As things stand, help for people on low incomes via this scheme is insufficient, with vouchers failing to reflect the real costs of glasses. We support recommendations by NACAB to make the value of vouchers reflect the costs the industry faces (specifically, the marginal cost to the manufacturer). Glasses within the value of NHS vouchers should be available from all optometrists participating in the scheme and NHS Direct should provide information about the availability of glasses within the voucher scheme.

Another option worth exploring is NHS bulk purchase of frames to bring down the cost to the consumer, in the same way that it has with NHS digital hearing aids.

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Hearing aids

The NHS has committed itself to offering tens of thousands of people who are deaf or hard of hearing the 'very latest' digital hearing aids free on the NHS by 2005 (Department of Health 2003).

These cost the NHS up to £75 per aid. Similar products cost people purchasing them privately around £2,000. Moreover, hearing tests are free of charge (albeit dependent on the referral of a doctor) and the NHS hearing aid service is free and includes testing, fitting, servicing and even batteries (Department of Health 2000). The hearing aids are provided on long-term loan to patients and remain the property of the NHS. It is against the law for hospitals to sell NHS hearing aids (Modernising Hearing Aid Services website information).

The aids are available to every patient waiting for their first hearing aid if their hearing tests show that they would benefit from one. People who already bought a hearing aid privately will still be eligible for an NHS digital hearing aid. People will generally not be eligible to get digital aids if they have been fitted with a new hearing aid within the last three years, unless their hearing has got significantly worse since then (Royal National Institute for the Deaf (RNID) factsheet).

NHS patients clearly benefit from the ability of the NHS to bring down the cost of hearing aids by bulk purchasing. However, it does not necessarily follow that hearing aids should be provided free to all NHS patients in need of an aid. Indeed the arrangements seem unfair when considered next to the provision of glasses. Even people who are registered blind or partially sighted must meet the full cost of glasses unless they are entitled to vouchers on the grounds of age (under 16 years of age) or low income.

FREE PROVISION LIMITED TO THOSE ON LOW INCOMES

We are of the view that digital hearing aids should not automatically be provided free to all. People who are able to contribute to the cost of these aids should do so – just as they must pay for spectacles – while still benefiting from the ability of the NHS to bulk purchase.

We therefore recommend that low income consumers and children should receive NHS digital hearing aids at no cost. However, others should pay the cost to the NHS of the hearing aid (£75) or a nominal charge. Under our proposed system for prescription charges, digital hearing aids could be made available under the prescription band that attracts the full cost to the NHS of the item.

References

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Charges for wigs and fabric supports

Charges above the prescription rate can be made for elastic tights, spinal and abdominal supports and wigs. The costs range from £21.90 for a surgical bra and £32.00 for a spinal/abdominal support, to £52.30 for an acrylic wig or £201.70 for a bespoke wig made from human hair.

Certain groups are entitled to free NHS wigs and fabric supports. These include children under 16 and young people in full-time education, hospital in-patients, war pensioners (if the appliance is for the pensionable disability), people receiving Income Support and some other benefits, and those named on an HC2 certificate. People in receipt of an HC3 certificate might get help towards the costs (they will pay the amount on the certificate or the actual cost, whichever is the lesser).

A MORE CONSISTENT APPROACH

Wigs and fabric supports needed because of a medical condition should be provided by the NHS on the same basis as other physical aids and devices, such as wheelchairs, walking sticks and artificial limbs. In these circumstances such items should not carry a charge. Instead the patient could be given a voucher that covers the cost of the less expensive wigs and fabric supports available and which the patient could put towards a higher quality wig, for instance, of their choice. However, given the seriousness of the conditions involved and the importance to morale of appearance, we would advocate a level of aid sufficient to allow the purchase of a wig of human hair, rather than an acrylic wig.

People on low incomes and children would probably require a voucher of greater value, in order to ensure that they were not worse off under this proposed system.

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Travel to and from hospital for NHS treatment

The costs of travel to NHS services represent the indirect costs of care. Everyone must pay these unless they qualify for help under the Hospital Travel Costs Scheme (HTCS).

People entitled to reimbursement under the HTCS include: those attending a genito-urinary medicine clinic over 15 miles from home, war pensioners if the reason for travel is for the pensionable disability, people and their dependants getting Income Support and some other benefits, also those named on an HC2 certificate and Isles of Scilly residents. People named on an HC3 certificate will normally receive a partial refund. Those who would not normally fall into the low income category might become eligible because they have to travel long distances frequently.

Eligible patients are also entitled to claim for the travelling expenses of escorts where their GP or consultant considers this medically necessary. Claims for help with travel costs must be made up to three months after the date of travelling.

The amount reimbursed depends on the cost of travel. Reimbursement is calculated on the basis of the cheapest form of public transport or, for people using a private car, the estimated cost of fuel or the equivalent public transport costs (whichever is the lesser). Car parking charges will be reimbursed where unavoidable and in exceptional cases the cost of a taxi for all or part of the journey will be refunded. For people who live in the Isles of Scilly the maximum amount they pay for travel to and from hospital is £5.00.

The Social Exclusion Unit (2003) reported that over 1.4 million people each year miss, turn down or choose not to seek healthcare because of transport problems. In the wake of this, the Department of Health has established a working party to review Patient Transport Services and the HTCS. This is due to report to Ministers during the summer of 2003. In the meantime, the Department of Health has updated guidance about the HTCS to address some of the shortfalls that have been identified (Department of Health 2003).

Limited scope

The rationale behind the limited remit of the scheme is unclear. Assistance with travel costs is restricted to travel to and from units managed by NHS Trusts or PCTs or private units used by the NHS (such as diagnostic and treatment centres). There is no reimbursement mechanism for the costs of travel to a dentist, GP surgery or other primary care services. However, here the complexities of the scheme become evident. Patients treated in a primary care setting under a consultant are eligible for reimbursement while patients treated by a primary care practitioner, such as a GP, are not (R Wallis, Department of Health, personal communication, 2003).

Problems with travel in rural areas are well recognised but Age Concern London (2001) found that the health of older people can suffer because of difficulties travelling to health services within London. There are many costs to older people in getting to health services – in terms of stress, time and effort and money. Indeed, for people of all ages, the cost of travel to services is just one of many costs patients face when accessing NHS services. For instance, there is no provision to help with loss of earnings as a result of attending NHS services.

The HTCS does not provide assistance with overnight costs for people who must travel long distances for hospital care. However, hospitals are encouraged as a matter of good practice to arrange accommodation within the hospital for someone who cannot reasonably travel home the next day. Where

accommodation within the hospital cannot be arranged, the costs of other types of accommodation should be met by the hospital or from non-Exchequer funds.

The way the HTCS is administered

NACAB (2001) has criticised a lack of information about the scheme. It has reported that people often miss out on the help they are entitled to because there is little or no information given to patients about the help available. There can also be difficulties obtaining the relevant claim forms. A lack of knowledge by health professionals often results in misinformation to patients.

Updated guidance about the HTCS (Department of Health 2003) makes clear that provider units should have arrangements for informing NHS patients of their entitlement and making refunds at any time of the day or night. Information about the scheme should be displayed in all patient areas and details should be provided to patients with admission and appointment letters so that they can apply for an assessment of their eligibility in advance.

Paying the cost of travel up front and then claiming a refund later can pose a barrier to care for the very people the scheme is designed to help. However, the updated guidance states that there should be arrangements for dealing with requests for payments in advance.

NHS patients undergoing treatment in a private hospital are entitled to help under the scheme just as they would in an NHS hospital. But the process of claiming reimbursement is complicated and depends on whether or not the patient is receiving treatment as a result of a tertiary referral.

TARGETING HELP WHERE IT IS NEEDED

We recommend that help with the costs of travel is provided on the basis of low income only. This reflects our approach to charges generally, although we acknowledge that there may be exceptions and anomalies (such as provision for those attending genito-urinary medicine clinics) that may require further consideration.

There would appear to be no reason why people who receive help with the costs of travel to hospital on the grounds of low income should not also receive help with the costs of travel to other NHS services, such as GP and dental surgeries. At the same time, we believe that there is a case in logic for giving consideration to other costs, such as loss of earnings (a particular problem for the working poor), that could prevent patients from accessing clinical services.

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Locally determined charges for non-clinical services

Charges for televisions, telephones, car parking and amenity beds come under this banner. Often the objective is to increase patient choice of hotel-type services while bringing additional revenue into the system and enabling the NHS to preserve its resources for clinical services. It is unclear exactly how much the NHS benefits from charges for non-clinical services.

No formal financial assistance is available to help with the cost of these charges as they are above and beyond core NHS provision and are largely a matter for individual choice. Of course choice is limited to those who can afford it, although some services combine free and paid-for services and in doing so bring some element of choice to those who cannot afford to pay. For example, Guy's hospital has launched a new bedside entertainment system, consisting of a bedside TV, telephone and radio. All patients can watch up to an hour of breakfast television daily and listen to unlimited radio free of charge. Special cards can be purchased to get access to 20 television channels and the telephone. Children under 16 can watch daytime television free of charge and there are half price deals for patients over 60 and those who have to stay in hospital for more than two weeks.

Discretionary assistance may be available where charges are not simply a matter of choice – for instance, concessions on car parking charges for visitors who need to attend hospital on a regular basis.

A MORE TRANSPARENT SYSTEM

There is a need to make the system of charges for non-clinical services more transparent so that patients can, as far as possible, plan ahead and consider all the options available to them.

It follows that hospitals should be explicit about charges for non-clinical services before patients attend hospital. Hospital appointment letters should warn patients about car parking charges and detail where concessions exist, as well as charges for other non-clinical services (such as for television sets). This would at least enable patients to plan ahead and possibly set aside money to cover some of these costs.

References

Guy's and St Thomas' Hospital NHS Trust (2003). *Bedside entertainment gives Guy's patients something to smile about.*

Charges levied at the discretion of health service staff

A number of charges operate outside of a national framework, are imposed at the discretion of individual health professionals and do not take account of an individual's ability to pay. Some are specifically designed to alter consumer behaviour (e.g. cancellation charges by dentists for missed appointments) or to encourage careful consumption of health resources (e.g. asking GPs to countersign passport applications). Some represent private fees to health professionals for services that fall outside of the NHS (e.g. certain travel vaccinations and writing medical reports for insurance companies). Others are designed to cover the costs incurred and inconvenience of providing certain services (e.g. fees to GPs for providing access to medical records).

Demands on GPs

Most of these types of fee are levied by GPs. The BMA points out that GPs are not employed by the NHS and must cover their costs in the same way as any small business. It maintains that in recent years more and more doctors have become involved in a wider range of non-medical work. Sometimes the only reason GPs are approached by patients is because they are in a position of trust in the community or because an insurance company or employer wants to be sure that information provided is true and accurate.

The BMA recommends GPs tell patients in advance if they will be charged and by how much and produces a list of suggested fees, which it claims surgeries often display on the waiting room wall. One surgery advertises charges for non-NHS work on its website. Prices range from £20 to countersign a passport application or insurance claim form to £65 for a fitness to drive or employment medical. In practice there are wide variations in charging policies and the fees imposed.

In 2001 the Regulatory Impact Unit at the Cabinet Office (2001) published a report aimed at reducing GP paperwork. A follow-up report claimed that guidance outlining the limit of GPs' responsibilities in appeals against benefit decisions had resulted in savings of 15,000 hours (Cabinet Office 2002). GPs no longer need to countersign applications for shotgun applications. However the report neglected to mention the many other areas where GPs play a key role in validating identity.

The new GP contract (BMA/NHS Confederation 2003) reiterates the Government's commitment not to introduce new NHS charges for patients and there are no plans to change existing arrangements concerning non-NHS work. However, the new contract seeks to make clear that GPs can accept fees in various circumstances. These include providing medical supplies for patients going abroad, examining a patient at the request of an organisation for the purpose of creating a medical report or in connection with a claim for compensation or to assess whether a patient is fit to travel by air. No mention is made of medical reports to support benefits and insurance claims (see below). However, the contract outlines an objective to reduce certification work within general practice.

Access to benefits and insurance claims

NACAB (2001a) has concerns that the drive to reduce GP paperwork is making it difficult for people to claim benefits to which they are entitled. Specifically, it prevents people from getting the evidence they need to appeal against decisions to refuse social security benefits (mainly Incapacity Benefit and Disability Living Allowance).

Medical reports requested by the Department for Social Security (DSS) are covered in the GP contract but the cost of reports requested by patients seeking to appeal against benefit decisions is not included. GPs often impose a charge for this and people can be excluded from obtaining medical evidence on the

ground of cost. Additional evidence from the GP is important as neither the Benefits Agency nor the tribunal is under any obligation to obtain further medical evidence when reconsidering a case, even where the reason for refusal relates directly to the initial medical report.

Another area of concern relates to charges for completing insurance claim forms. NACAB points out that, by helping patients claim, GPs can play a role in protecting people from severe debt during illness and minimise the risk of anxiety and depression associated with debt. It argues that even relatively small charges can present an overwhelming obstacle to people on low incomes. The problem is made worse by the fact that insurance claims usually need repeat evidence every few weeks. Many people will have a number of loans covered by separate insurance policies, which each attract a charge even though the same information is required. No attempts are made to link the charges to what the patient can afford.

Barrier to accessing medical records

The Secretary of State prescribes the maximum fees patients can be charged for accessing their medical records. A maximum of £10 may be charged for providing access to records held on computer, even where no copy of the records is required. Where all or part of the information is held manually, up to £50 may be charged for providing access and supplying copies. There is no guidance on scales of charges up to £50, leaving doctors to assess what charge is reasonable.

Doctors' representatives have deplored the maximum fee levels as 'unrealistic' and 'inadequate' to cover the costs involved in retrieving and copying notes (BMA 2001a). However, these charges can effectively deny individuals on low incomes their right to access their medical records and could make it difficult for them to pursue a complaint or case of clinical negligence. The charges also penalise patients who belong to practices without automated systems for storing medical records.

The Department of Health is conducting a review of access to medical records which will consider the need for fair and equitable guidance on the charges that apply here (Cabinet Office 2002).

Arbitrary charges for missed appointments

There is no schedule of charges for broken dental appointments and dentists are likely to base the charge on their private rates – with the result that cancellation charges can cost as much as £60 or £70 (NACAB 2002). Often dentists take no account of the reasons for which an individual has to cancel, which may sometimes reflect administrative problems on the part of the service – such as a constantly engaged telephone or appointment letters failing to reach the recipient. Patients often are not aware in advance that a charge may be made.

CHARGES THAT WORK FOR PATIENTS AND PROFESSIONALS

GPs have heavy workloads and it is right that efforts are made to minimise the amount of time they spend on non-NHS work in order to maximise the time they have for patient care. The role expected of GPs in terms of validating identity is particularly outdated, given that few people these days have one GP from cradle to grave.

Other charges impact unfairly on patients, particularly those least able to afford them. Charges for medical evidence to support insurance claims should where appropriate be picked up by insurance companies.

Addressing charges for evidence to support benefit appeals is more complex. On the one hand these charges hit patients least able to afford them and their ability to launch an effective appeal comes down to whether they can afford the costs of collating the necessary evidence. However, to push the cost onto

the DSS could give everyone an incentive to appeal. We recommend that the Government works with the profession to find a solution to this, perhaps considering cost-sharing between the government and the person appealing.

Finally, while we do not oppose cancellation charges in principle, we are of the view that the health service is not yet ready for them. Not until a system of booked appointments is fully operational, together with efficient mechanisms to enable patients to cancel unwanted appointments, can a system of cancellation charges be fairly introduced. The health service also needs to be clear about the impact missing an appointment has. Many GP surgeries deliberately over-book which means that the impact of a patient failing to attend is minimal. These issues need to be addressed before cancellation charges can be properly considered.

References

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Conclusions

Our analysis of the existing user charges reveals a system lacking all logic. Taking each area of charging in turn, we have tried to find ways to bring greater coherence to the system, to help people on low incomes more effectively, to link charges to the value or benefit of the treatment or service, to encourage a preventive approach wherever possible, to better protect people with chronic conditions and to simplify the system of exemptions.

Overall, the package is intended to be revenue-neutral. However, it will clearly mean that some people have to pay for things that are at present free. For example, we propose:

- Removing automatic exemption from prescription charges for the over 60s and pregnant women
- Making a greater number of dental treatments subject to private provision and to full-cost pricing
- Making people pay the cost to the NHS of a digital hearing aid unless they are children or on low incomes
- Limiting help with the cost of travel to and from hospital to people on the basis of low income only.

Based on the numbers of pensioners who are eligible for the minimum income guarantee, we expect that just over a quarter of people over 60 years old living in Great Britain would continue to get free prescriptions.

But there are gainers too. Many people, usually the sickest or the poorest, will gain from:

- Using some of the revenues gained by removing automatic exemptions for older people to reduce prescription charge levels
- Our proposed limit on the amount anyone has to pay for prescriptions each year
- Free dental check-ups and lower charges for preventive and medically essential dental treatments
- Free sight tests for everyone
- Better access to glasses within optical voucher values
- Free wigs and fabric supports needed because of a medical condition
- Extending help with the cost of travel to other NHS services such as GP and dental surgeries
- Providing help with other costs that could prevent people on low incomes from accessing clinical services such as loss of earnings.

The sceptics will brand what we propose ‘politically impossible’. There is a rule of politics that goes back to Machiavelli which states that those from whom benefits are withdrawn protest vehemently while those to whom new benefits are given are ungrateful, thinking them no more than their due.

But, if accepted, that is a rule that prevents all progress. Here we have a cluster of systems that perpetuate injustice. They do little for the poor and too much for the rich. They distort medical priorities and hinder access to vital treatment. They owe everything to history and chance and nothing to reason and logic. ‘At our best when we are at our boldest’; if ever there was a policy area where boldness was required, this is it. We ask our politicians, on behalf of the people, to have the courage to do the right thing.

Summary of recommendations

PRESCRIPTION CHARGES

- We recommend that prescriptions are provided free to children and to others on the basis of low income only. Automatic exemption for pregnant women or older people will no longer apply. Criteria for exemption on the ground of low income should be determined, as far as possible, using existing measures such as Income Support.

- An annual ceiling on the amount an individual should pay on prescription charges should be introduced to protect against excessive prescription bills, particularly for the chronically ill. The ceiling should be set at around £90. This is the level of the existing prescription pre-payment certificate scheme which should be abolished.

- There is a strong case for a variable ceiling on the basis of individual income. However, the potential of this to undermine the principle that redistribution of wealth should operate through a tax mechanism, and potentially high administrative costs, rule this out for the immediate future.

- Patient-held smartcards could be used to hold information about exemption status, where applicable, as well as indicating when the ceiling has been reached.

- The introduction of a ceiling on the total outlay on prescriptions mitigates the problems of those just above exemption income levels, so new mechanisms of tapered support, which are invariably costly to administer, are not needed.

- The arbitrary flat rate national prescription charge should be abolished. Linking prescription charges with drug efficacy, with a nominal charge assigned to each different band of treatments, has many attractions. Medicines that are vital to life or for chronic conditions would be provided cheaply or free of charge. Many medicines would carry a lower charge than at present but medicines defined as low priority to the NHS would cost more. There are difficult issues to address here. However these need not impede introduction of simpler exemptions and an annual ceiling.

DENTAL CHARGES

- We recommend that the NHS pays for check-ups at reasonable intervals (as decided by NICE) for everyone.

- Ideally, preventive and medically essential treatments (i.e. those to treat serious medical problems) should also be free to patients. If this is not practical, we recommend that consideration be given to lowering the cost-sharing percentage that patients pay for these types of treatments.

- All other dental services should be subject to private pricing. As all dentistry would be provided privately, the need for this sector to become more customer-oriented and provide clearer information about treatment options and costs would be all the greater.

- Greater use could be made of dental capitation schemes. Government endorsement of these schemes and better consumer information about this market could encourage membership. There could be some mileage in considering arrangements whereby the state pays some or all of the costs of enrolment in a capitation scheme for people on low incomes.

OPTICAL CHARGES

- We recommend that the Government consider making sight tests available to everyone, paid for by the NHS, at reasonable intervals. The cost of doing so should be offset against the health and social care savings from preventing advanced eye disease.

- We have not been able to get to the bottom of the peculiarities of the spectacles market. We recommend that the OFT considers conducting a review of this market. Such a review should consider the system of reimbursement to opticians for carrying out NHS sight tests and, specifically, any perverse incentives to artificially inflate the price of glasses. Other possible lines of inquiry include the merits of expanding the voucher scheme for people on low incomes and for the NHS to bulk purchase frames in the way that it has with digital hearing aids.

- We support recommendations by NACAB to make the value of optical vouchers reflect the costs the industry faces. Glasses within the value of NHS vouchers should be available from all opticians participating in the scheme.

HEARING AIDS

- Hearing aids should not automatically be provided free to all. People who are able to contribute to the cost of these aids should do so – just as they must pay for spectacles – while still benefiting from the ability of the NHS to bulk purchase.

- We recommend that low income consumers and children should receive NHS digital hearing aids at no cost. However, others should pay the cost to the NHS of the hearing aid (£75) or a nominal charge.

WIGS AND FABRIC SUPPORTS

- Wigs and fabric supports needed because of a medical condition should be provided free by the NHS on the same basis as other physical aids and devices such as wheelchairs, walking sticks and artificial limbs.

- Patients should be given a voucher that covers the cost of wigs and fabric supports of decent standards which they can put towards a higher quality wig, for instance, of their choice.

- People on low incomes and children would probably require a voucher of greater value.

TRAVEL TO AND FROM HOSPITAL

- We recommend that help with the costs of travel is provided on the basis of low income only.

- There would appear to be no reason why people who receive help with the costs of travel to hospital on the grounds of low income should not also receive help with the costs of travel to other NHS services such as GP and dental surgeries.

- There is a case in logic for giving consideration to other costs, such as loss of earnings, that could prevent low income patients from accessing clinical services.

LOCALLY DETERMINED CHARGES FOR NON-CLINICAL SERVICES

- There is a need to make the system of charges for non-clinical services more transparent so that patients can, as far as possible, plan ahead and consider all the options available to them.

- Hospitals should be explicit about charges for non-clinical services before patients attend hospital. Hospital appointment letters should warn patients about car parking charges and detail where concessions exist, as well as charges for other non-clinical services (such as for television sets).

CHARGES LEVIED AT THE DISCRETION OF HEALTH SERVICE STAFF

- It is right that efforts are made to minimise the amount of time GPs spend on non-NHS work. The role expected of GPs in terms of validating identity is particularly outdated.

- Charges for medical evidence to support insurance claims should where appropriate be picked up by insurance companies.

- We recommend that the government works with the profession to find a solution to the problems caused by patient charges for evidence to support benefit appeals, perhaps considering cost-sharing between the government and the person appealing.

- We do not oppose cancellation charges in principle. However, not until a system of booked appointments is fully operational, together with efficient mechanisms to enable patients to cancel unwanted appointments, can a system of cancellation charges be fairly introduced into the NHS.