user charges for health care

THE SOCIAL MARKET FOUNDATION
HEALTH COMMISSION – REPORT 2D

The Commission would like to thank Niall Maclean for his hard work in preparing this report.

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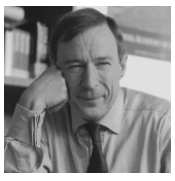

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User Charges For Health Care

KEY POINTS:

– The main advantages of user charges for medical services are that they can generate extra income, promote a more efficient use of services, make providers more accountable for the quality of their services, and promote various forms of patient choice.

– The disadvantages are that charges (if badly designed) can create inefficiencies (such as high downstream costs due to deterred use of preventative services), be unfair, and be costly to administrate.

– Viable changes to the existing system of charges in the UK include charges for convenient GP appointments, charges for non-clinical services or for 'supplementary' clinical services, and various rational reforms of the current set of exemptions and subsidies.

– Ultimately, the case for reform of the existing charges system might seem weak in an era when the NHS is enjoying unprecedented levels of increased funding. However, we can expect the arguments for reform we present here to take on greater salience when this increased funding levels off, as at some point it inevitably will.

User charges, where patients pay directly for all or part of the cost of a particular treatment or service, have a long history in the UK health care system. Yet their purpose is rarely stated. Charges are seldom explicitly used to ration care, although their presence often reflects demand for services and attempts to control public expenditure. There is no tax relief on out-of-pocket payments and no specific insurance policies exist to cover co-payments in the NHS.

User charges tend to be much more extensive in other EU countries, although the extent to which they are used and the services to which they are applied does vary significantly from country to country. Nevertheless, there are some commonalities. Charges to see a GP or specialist, and for inpatient hospital care and prescription medicines, are found in many EU countries. All such countries charge for dental services. Most countries offer exemption schemes to protect people on low incomes, those with certain medical conditions, or members of vulnerable groups. Exemptions are also sometimes used to encourage the take-up of particular services or products (such as contraceptives). Some countries set an annual limit on the level of payments an individual is expected to meet, above which nothing further is paid. In some countries (such as France) the public can purchase voluntary health insurance to cover some or all of the costs of charges.

In our first report (A Fairer Prescription for NHS Charges [SMF 2003]), we argued on grounds of equity for a rationalisation of the existing charging system in the NHS. While this report is again concerned with NHS charges, its remit is quite different – we aim to examine the case for changing the existing system of NHS charges in order to generate extra revenue. Changes to the system can take four broad forms:

– we could introduce new charges;

– we could raise the level of an existing charge;

– we could extend the number of people liable to pay an existing charge;

– we could rationalise the existing charging system in such a way as to generate extra revenue.

Our approach is pragmatic, and we shall consider all four of these sorts of changes. We will begin on a more general note, by examining the advantages of user charges. In the second section, we will consider the drawbacks. Our third section will be given over to discussing the specific options for change that might be feasible in the UK context.

THE ADVANTAGES OF CHARGES

Advocates of user charges highlight a number of advantages:

Income generation

The contribution made to NHS revenue by the existing set of user charges is difficult to pin down precisely, since there are numerous different revenue streams and some payments are generated by informal and ad hoc charging arrangements. Nevertheless, we do have some estimates. The King's Fund (2001) has estimated that user charges generate some £800 million in England, accounting for 2-4 per cent of NHS revenue. Elsewhere, the figure is put at 4 per cent of NHS revenue (European Observatory on Health Care Systems 2002).[1] Many believe that extending existing charges (either by putting the charge up, or by widening the set of individuals liable to pay the charge), or introducing additional charges, would be a useful way to inject more funds into the NHS without increasing public spending. Research by the BMA (2001) has suggested that 'hotel charges' of £40 or £80 per day in hospital would raise £1.25bn or £2.5bn per year respectively, though this income would be halved if all under 16s and over 65s were automatically exempt. A £10 fee for GP consultations could raise £3.3bn, although the same exemptions would reduce this to about £2bn. The issue of exemptions from charges is one to which we return towards the end of this report.

Efficiency

Charges give users at least some sense of the value of the services they are consuming (although charges will rarely, of course, reflect the true cost of services). This can encourage a more responsible usage of resources, and thus generate cost savings.

Accountability

The Audit Commission (2000) highlighted some support from users of social care for charges on certain services, on the grounds that they act as a way to hold managers to account for the quality and value of services – if the user pays at least something for the service, they feel more entitled to complain when the quality of provision falls below a certain level.

Patient choice

User charges can provide patients with greater opportunities to exercise choice of GP or hospital facility, and to buy services that meet their particular requirements. Wanless (2002) pointed out that charges can help to extend services and tailor them to the needs of different consumer groups, while state subsidies are more specifically targeted at priority areas and users.

[1] The figures are much higher if we include the fact that individuals are expected to pay for many aspects of long-term social care – were the state to provide these services, it would cost between £800m – £1.2bn at 1995 prices (*With Respect to Old Age: Long Term Care – Rights and Responsibilities. A Report by The Royal Commission on Long Term Care*. London: The Stationary Office; 1999). Although charges for these services do not go directly to the state, the fact that the state does not provide them constitutes a significant saving.

THE DISADVANTAGES OF CHARGES

These include the following:

Inefficiencies

Badly designed charges can deter use of necessary services, particularly among the less well off. Deterring demand for services amongst those in need creates inefficiencies in the system by discouraging early diagnosis and treatment, thus generating unnecessary downstream costs that are often greater than the costs of early diagnosis and treatment. The NHS Plan (2000) cites evidence from the RAND Health Insurance Experiment, which found that charges led to less use of preventive care. A study conducted by Mori for the National Association of Citizens Advice Bureaux (2001) estimated that around 750,000 people in England and Wales had failed to get their prescription dispensed because of the cost. In France, one in four declared that they had been put off seeking care for financial reasons. In Sweden, the proportion was one in five people. In both countries, women, older people and the unemployed form a large proportion of those not seeking care (Dixon & Mossialos 2001). Wanless (2002) remarked that in countries like France, the majority of patients take out supplementary insurance to cover charges, thereby negating any potential efficiency gains.

Inequities

By their nature, user charges are levied on those who are sick and who turn to the health care system. Charges that aren't means-tested and involve paying a flat rate fee are regressive and affect lower income groups disproportionately. Even where charges are means-tested, people on low incomes just above the threshold for help can find themselves caught in a poverty trap – not wealthy enough to be able to afford user charges but not poor enough to qualify for assistance with them. Lower income groups, together with older people and those with chronic diseases, also tend to be heaviest users of health services and therefore carry the burden of user charges disproportionately. Ultimately, the extent to which charges are inequitable depends on the safety net of exemptions and means-testing, as well as on the service carrying the charge.

Administrative burden

The experience of cost sharing schemes in the EU is that they can be complex and expensive to administer (Mossialos *et al* 2002), and cost more to administer than taxation or social health insurance (Mossialos & Dixon 2001). Systems of exemptions reduce the revenues generated and increase collection and administration costs. The NHS Plan (2000) cites New Zealand's experience of introducing user charges for the use of hospital beds in 1992. These were abolished just a year later due to difficulties in collecting the charges from patients. The large number of exemptions and high administration costs meant that the scheme raised less than 0.5 per cent of total health services costs in extra revenue (Brown 2002).

OPTIONS FOR THE UK

User charges attract little support from the public. Pollard & Raymond (1999) revealed that 14 per cent supported a charge for visiting a doctor, 13 per cent a higher prescription charge, and 6 per cent supported a charge for visiting hospital. Bryson & New (2000) reported that twice as many people supported charging for home visits as for GP consultations, although the percentages were still low (17 per cent and 8 per cent respectively). However, a quarter supported the idea of charging for the cost of hospital meals.

The Chancellor has ruled out any significant expansion of user charges for GP and hospital care (Brown 2002). The Wanless Review (2002) concluded that it would be inappropriate to extend out-of-pocket payments for clinical services because of equity concerns. However, Wanless was of the view that there may be scope for extending charges for non-clinical services (such as the provision of IT facilities in patients' rooms), in order to provide more choice for patients while preserving resources for clinical services. He believed there was also a case for charging for missed appointments.

Conservative Party policy is to introduce charges 'for those who abuse the system' (Conservative Party 2002) – specifically, those who use emergency services inappropriately (e.g. using ambulances as a taxi service), and those who fail to turn up to appointments (Fox 2002). The Conservatives have decided against increased charges for medical care on the grounds that they present a further barrier to access.

One area often regarded as having potential for greater charges is primary care. GPs are currently prevented from imposing more user charges on patients. The new GP contract reiterates the Government's commitment not to introduce new NHS charges and there are no plans to change existing arrangements concerning non-NHS work. NHS GPs can accept fees in certain circumstances, such as providing medical services and supplies for patients going abroad, or examining a patient at the request of a third party for the purpose of creating a medical report. They can also provide private primary care services (including private consultations and clinics), but not to patients on their lists.

We have considered four areas where the existing charges system could be changed: charges for GP appointments; charges for 'convenience' GP appointments; charging for missed appointments; charging for non-clinical and supplementary clinical services. In the final section, we consider an interesting alternative – the rationalisation of the existing charging system.

Charging for GP appointments

Calls for charging patients for GP appointments often originate from concerns about inappropriate use of GP services, including unnecessary request for home visits.

Research suggests that the majority of GPs oppose the idea of charging patients to see their GP. According to the BMA (2001), 59 per cent of doctors oppose this, although a slight shift away from this view in recent years is reported. A recent study of GPs' attitudes to charges, jointly undertaken by Norwich Union Healthcare and Dr Foster (2003), backed this up. Again, 59 per cent of GPs were opposed to charging for GP appointments; 62 per cent believed it would represent privatisation by stealth. Even so, 41 per cent of GPs were in favour of such charges – for an average fee of £16.

There are significantly higher levels of support from GPs for charging for home visits. The same study found that 58 per cent of GPs supported the idea of charging for this service; the average fee suggested was £37. Other research by Norwich Union Healthcare (2003) uncovered the same findings.

Doctors' preferences aside, there is good evidence to suggest that those most in need of care would be deterred from seeing their GP because of the cost. It is likely either that they would approach other frontline services instead (such as accident & emergency), or would simply go without care. Either alternative would create inefficiencies in the health system. Moreover, we take the view that problems such as inappropriate requests for home visits are better dealt with using measures that do not run the risk of deterring usage from some of those who really need the services, e.g. by better triaging of patients, and by providing good quality patient information about what constitutes appropriate use of services.

Charging for convenient appointments

The 1998 National Survey of NHS Patients (NHS Executive 1999) found that 15 per cent of people put off going to the surgery because of inconvenient surgery hours. Students and people in work reported the most difficulties – 20 per cent of people in paid work said that in the last 12 months they had put off going to see a doctor because of inconvenient opening times.

Some of these people, if given the option, may be willing to pay a fee in order to be guaranteed an appointment with a GP at a convenient time, perhaps in the evening or first thing in the morning. Other options might include paying for improved out of hours services, more screening services, internet and telephone based primary care services (personal communication, T Baker, Norwich Union Healthcare, 2003).

Charging for convenient appointments could have a positive knock-on effect on services for non-fee payers. Offering additional services to paying customers could free up appointments during the other parts of the day, or lead to longer consultation slots at these 'less popular' times. Convenient appointments for working people could have wider economic benefits – if these individuals can book GP appointments before the working day begins (or at its end), absences from work would decline and productivity would rise.

The most important thing would be to ensure that patients receiving free services did not suffer poorer access as a result of improved access for those able to pay. Were this to happen, a two-tier service would be clearly visible and could undermine the principle that NHS care be given according to need and not ability to pay. Almost three-quarters of GPs surveyed for Norwich Union Healthcare and Dr Foster (2003) believed that allowing patients to pay a fee to see a GP sooner would create a two-tier system, and over half said they would not feel comfortable accepting fees from patients if that meant they could jump the queue. However, these worries could be ameliorated by careful design – by ensuring that the charged 'convenience' slots do not fill up so much of the day that the numbers of uncharged slots fall to such a level as to deny speedy access to non-paying patients.

Charging for missed appointments

Charging is often mooted as a means of tackling the problem of wastage caused by patients failing to turn up for appointments. A survey by Norwich Union Healthcare (2003) revealed that 58 per cent of GPs would like to 'fine' patients who fail to turn up for an appointment, with the average fine being £11.

However, we need to be clear about the impact of missed appointments. Many GP surgeries deliberately over-book, which means that the impact of a patient failing to attend is minimal. There are also issues about the ease with which patients can cancel appointments – it wouldn't be fair to introduce charges where canceling unwanted appointments is made difficult by constantly engaged or unanswered telephones, for example. Again on the issue of fairness (assuming reciprocity is an aspect of fairness), charges for patients missing GP appointments could lead to calls from patient groups for some form of reimbursement to be made to patients when they have their appointments cancelled. The increased costs this would levy upon the NHS could be substantially greater than any revenue raised via charging patients for missed appointments.

As with charges to deter inappropriate use of GP services, imposing charges for missed appointments is likely to penalise vulnerable groups unfairly. The problem of missed appointments is better tackled in other ways. The National Booked Admissions Programme, whereby patients can leave their GP surgery with a letter showing the time and date of a hospital appointment booked by their GP, is having an

impact on attendance levels. It means patients can choose an appointment that is convenient to them instead of having to wait to be sent an appointment that may not be suitable. Since introducing electronic booking for x-rays in Northampton there has been a zero 'did not attend' rate (Department of Health 2002a). A similar pattern has been identified in other sectors of the NHS that have introduced electronic booking (Department of Health 2002b).

Charging for non-clinical and supplementary clinical services

One of the main objections to charging for NHS services is that it could lead to two tiers of provision – those able to afford charges would receive significantly better services than those not capable of paying. However, this argument only has bite with regard to those services we think ought to be open to all, regardless of ability to pay – such as many clinical services. However, there are good reasons for allowing certain *non*-clinical services to be available within NHS facilities to those patients who are willing to spend some of their own money on such services. Examples of such services might include a bedside telephone, better food (although we believe that standards of food ought to rise for all NHS patients, since adequate nutrition in hospital has important medical consequences), internet access, and better car parking facilities.

In addition to charging for non-clinical services, another option is for GPs to charge for providing clinical services that are not of fundamental importance – what might be called supplementary clinical services. A cardinal example of such a service (for which there would, in all likelihood, be a great deal of demand) would be sports injuries clinics. This would bring arrangements for GPs more into line with those for consultants, who are able to offer a wide range of private services to patients whom they would otherwise see under the NHS. This is an area that attracts high levels of support from GPs – 91 per cent of those surveyed by Norwich Union Healthcare and Dr Foster (2003) believed that GPs should be allowed to run clinics for non-essential treatments, such as treatments for sports injuries, outside the NHS.

Demand for these sorts of services could be stimulated were individuals encouraged to participate in co-payment schemes operated by groups such as the Hospital Savings Association. Another way of stimulating demand might be for groups of GPs to come together in cooperatives (as many currently do to manage their out-of-hours workloads) to offer these supplementary clinical services on a 'monthly plan' basis – individuals would pay a regular fee up front in order to avoid paying for each instance of service usage.

RATIONALISING THE EXISTING CHARGES SYSTEM

There are good reasons for thinking that the amount of revenue raised by charges could be increased were the NHS to operate a more rational system of exemption from charges. In our first report, *A Fairer Prescription for NHS Charges* (SMF 2003), we argued that the existing system of exemptions does not withstand rational scrutiny. At present, all over 60s are exempted from prescription charges, as are all pregnant women. If the operative logic in any system of exemptions is to excuse those too poor to pay, this makes little sense. Old age and pregnancy are poor proxies for income. We ought to be measuring ability to pay using standard measures, such as the receipt of Income Support.

Shifting to an income-based system of exemptions from prescription charges would mean that only about 25% of over 60's would be exempted. Since the remaining 75% are wealthy enough to pay, there is no equity problem here. Similarly, removing exemptions from those pregnant women deemed wealthy enough to pay would introduce large numbers of new payers into the system. Since these women are capable of paying for prescription charges, there is again no cause for complaint on grounds of equity.

Aside from exemptions from prescription charges, our first report suggests further rational amendments to the existing system of NHS charges that could have the effect of increasing NHS revenue. An example would be to remove the state-funded subsidy on certain forms of dentistry, currently provided on the NHS, that are not medically essential. Individuals could manage the sorts of increased charges that would be levied on non-medically essential forms of dentistry by joining a dental co-payment plan.

Another rationalisation would be to review the current practice of providing hearing aids free of charge to all NHS patients who could benefit from them. If patients capable of paying for such aids were to be asked to do so, we could expect the NHS to make a considerable saving. Similarly, savings could be made if help with the cost of travel to hospital were to be restricted to those patients on low incomes.

Admittedly, rationalising the existing charging system would not result solely in cost-savings or income generation. There is reason to think that a fully rational system would also generate some new costs. For example, if we subsidise travel to hospital for those on low incomes, rationality would seem to demand we subsidise their travel costs to other NHS facilities. However, given the large numbers of patients who would be excluded from a rational system of charge exemptions (e.g. 75% of over 60's, many pregnant women, and many of those currently receiving free hearing aids and subsidised non-medically essential forms of dentistry) it is likely that, in financial terms, the NHS would be a net gainer from a rationalisation of the existing charges system.

THE COMMISSION'S VIEW

The fiscal case for new charges, increased charges, or extensions of existing charges is weak at a time when the NHS is receiving increased levels of revenue, but might become stronger during crisis periods when demand for services outstrips investment levels.

Over time, as demand on the health service grows and the population becomes wealthier and more able to shoulder the costs of health care (particularly the hotel-type aspects), the case for extending user charges is likely to become stronger. Scotland's recent experience of trying to offer free personal care in residential homes illustrates how quickly public funding can become swamped where users are not required to share the costs.

We take the view that charges are generally not appropriate for areas of healthcare where take up of services should be encouraged, such as most clinical and preventive services. We therefore do not believe that NHS patients should be charged for GP appointments or for home visits. We also believe that charging for missed appointments is not appropriate, and we advocate instead the introduction of more rational booking systems that could better deal with the costs of missed appointments.

We do not, however, oppose the idea of extending charges for non-clinical services. We also believe there is a case for introducing charges in order that GPs may provide certain supplementary services, giving consumers far greater choice in primary care than they have at present. We are also not opposed in principle to the idea of GPs charging for convenient appointments, provided that any charging system for convenient appointments does not restrict access for those patients who prefer to use uncharged appointments.

Finally, we believe that rationalising aspects of the existing system of charges could result not only in a gain in equity (as we argued in our in our first report, *A Fairer Prescription for NHS Charges* [SMF 2003]), but could also generate extra revenue.

References

Audit Commission (2000). *Charging with care: how councils charge for home care*.
British Medical Association (2001). *Healthcare Funding Review*.
Brown G (2002). *Speech given by Gordon Brown on Economic Stability and Strong Public Services*, at the Social Market Foundation (20 March).
Bryson & New (2000). *Health care rationing: a cut too far?* in Jowell et al, British Social Attitudes: the 17th report – focusing on diversity. National Centre for Social Research. Sage Publications.
Conservative Party (2002). *We will expand choice for all NHS patients says Fox*. Press release (7 October).
Department of Health (2002a). *More NHS patients to benefit from faster and more convenient appointments*. (19th November).
Department of Health (2002b). *5 million patients now get booked appointments: real progress made on reducing the chance of patients not turning up for appointments*. (27th March).
Department of Health (2000). *The NHS Plan*.
Dixon A & Mossialos E (2001). *Funding health care in Europe: recent experiences*. Health care UK 2001.
European Observatory on Health Care Systems (2002). *Health care systems in eight countries: trends and challenges*.
Fox L (2002). Speech to Conservative Party Conference 2002.
Imai Y, Jacobsone S, Lenain P (2000). *The changing health system in France*. Economics Department Working Papers No. 269. OECD.
King's Fund (2001). *General Election 2001 briefing: Funding health care*.
Liberal Democrats. *A clean bill of health*. Policy Briefing 10.
Mossialos E, Dixon A, Figueras J, Kutzin J (2002). *Funding health care: options for Europe*. European Observatory on Health Care Systems. Policy brief No.4.
Mossialos E & Dixon A (2001). *Funding health care in Europe: weighing up the options*, in Mossialos et al (eds), Funding health care: options for Europe, Open University Press, 2001.
National Association of Citizens Advice Bureaux (2001). *Unhealthy charges: CAB evidence on the impact of health charges*.
NHS Executive (1999). *National surveys of NHS patients: general practice 1998*.
Norwich Union Healthcare (2003). *Doctors' orders: the Health of the Nation Index from Norwich Union Healthcare*.
Norwich Union Healthcare & Dr Foster (2003). *Health of the Nation Index 2, National Results*.
Pollard S & Raymond K (1999). *A question of choice*. Social Market Foundation.
Social Market Foundation (2003). *A Fairer prescription for NHS charges*.
Wanless D (2002). *Securing our future health: taking a long-term view*.
With Respect to Old Age: Long Term Care – Rights and Responsibilities. A Report by The Royal Commission on Long Term Care. London: The Stationary Office; 1999.