



House of Commons  
Health Committee

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**NHS Charges**

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**Third Report of Session 2005–06**

***Volume I***

*Report, together with formal minutes*

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## The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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### Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, which can be found in Volume III (HC 815-III). Written evidence is cited by reference in the form 'Ev' followed by the page number and the Volume Number, either Volume II (HC 815-II) or Volume III (HC 815-III).

# Contents

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<b>Report</b>	<i>Page</i>
<b>Summary</b>	<b>3</b>
<b>1 Introduction</b>	<b>7</b>
<b>2 History and principles of health charges</b>	<b>10</b>
History	10
Principles	11
<b>3 Clinical charges: levels and consequences</b>	<b>15</b>
Prescriptions	15
Dentistry	18
Sight tests	19
Additional charges for clinical services	24
<b>4 Exemptions</b>	<b>28</b>
Categories of exemption	28
Age	28
Income	28
Benefit-related exemptions and other forms of assistance	29
Treatment setting	31
Medical exemptions	32
Exemptions policy: the Government's justification	33
<b>5 Non-clinical services</b>	<b>35</b>
Transport	35
Car parking	35
Assistance with transport costs	37
Bedside telecommunications	38
<b>6 Alternative charging systems</b>	<b>41</b>
Improvements to the current regime with no major changes	41
The Prescription Prepayment Certificate	41
Dentistry	42
Sight tests	43
Benefits	44
Transport	45
Bedside telephones	47
Modernisation of the medical exemption list	47
A major reform of the prescription charge	48
A lower charge with fewer exemptions	48
Reference pricing	49
Abolition of charges	50
Introduction of a different set of charges	51

<b>7 Conclusions</b>	<b>55</b>
Prescription Pre-payment Certificate	55
Dentistry	56
Sight tests	56
Benefits and information to patients	56
Transport	57
Bedside telephone charges	57
Longer-term changes	58
<b>Conclusions and recommendations</b>	<b>60</b>
<b>Annex 1: Health Committee visit to Wales</b>	<b>64</b>
<b>Annex 2: Health Committee visit to Sweden</b>	<b>68</b>
<b>Formal minutes</b>	<b>73</b>
<b>Witnesses</b>	<b>74</b>
<b>List of written evidence in Volume III</b>	<b>76</b>
<b>List of written evidence in Volume II</b>	<b>76</b>
<b>Reports from the Health Committee</b>	<b>78</b>

## Summary

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The system of health charges in England is a mess. Charges for prescriptions and dentistry have been in place for over 50 years and sight tests for almost 20 years. They have not been introduced following detailed analysis of their likely consequences; rather they have come about piecemeal, often in response to the need to raise money. There are no comprehensible underlying principles. The charges remain largely for 'historical' reasons. In recent years, hospital patients and their visitors have also had to pay increasing sums for non-clinical services, such as car parking and bedside telecommunications.

International research has shown that health charges have a negative effect on health, and that patients with long-term illnesses suffer particularly when charges are in place. There is also some survey-based and anecdotal evidence which suggests that patients are less likely to visit their dentist or have prescriptions dispensed in full because of the costs.

There are exemptions, which aim to mitigate the negative effects of charges on health. Patients are exempt from paying for prescriptions, dental services and sight tests on the basis of age, income and where they are treated. In addition, patients with specific conditions are exempt from the prescription charge (eg. if they have insulin-controlled diabetes) or sight test fee (eg. if they have glaucoma); pregnant women and those who have recently given birth also receive free dentistry and medicines. Financial assistance towards the cost of charges, and vouchers for spectacles, are available to specified groups.

The system of exemptions is full of anomalies. Age and income exempt some people, but this does not apply across the board. Pensioners are exempt from prescription and sight test charges, regardless of their income, but must pay for dentistry unless they receive help through the NHS Low Income Scheme (LIS). Those in receipt of certain benefits are automatically exempt, others must apply for financial assistance or exemption through the LIS.

The system of medical exemptions to the prescription charge is particularly confusing. People with diabetes who require insulin receive free medicines for all conditions while people with diabetes controlled by diet must pay for all their medication. The list of exemptions was compiled in 1968 and has not changed. Given the vast improvements in medical science since that time, this is unacceptable. People with cystic fibrosis who would have died of their illness during childhood in the 1960s now reach adulthood. Diseases such as HIV/AIDS did not exist in 1968. The original list could not have taken these conditions into account.

The current system of charges must change. However, even after over 50 years of operation, there is a woeful absence of evidence about the effects of charges in this country. It is known that harmful effects occur but they are largely unquantified. The English evidence is limited and one of our key recommendations is that more research on the effects of charges be carried out here. We need to know the extent to which charges deter patients from seeking medical, dental or ophthalmologic help when they need it and how this affects their health status. Similarly, we do not know what the consequences would be of making large-scale changes to the charging system. It is therefore difficult at this stage to

decide what should be done. Accordingly, we recommend that evidence is gathered on:

- public attitudes to health charges;
- the extent to which charges affect the use of health services and, in the long term, health;
- the extent to which charges reduce 'frivolous' demand.

There are a number of short-term changes that should be implemented immediately to improve the situation.

Take up of the Prescription Pre-payment Certificate (PPC) is low. We recommend that a monthly PPC be introduced to help those on low incomes who cannot, or prefer not to, buy a yearly PPC. The cost of the yearly PPC should be pegged at 12 times the cost of a single prescription. The cost of a monthly PPC should be pegged at the cost of one prescription. There should also be a reduced price PPC for those receiving help through the Low Income Scheme.

The dental contract, which includes a new, banded system of charges, was introduced in April 2006; it is therefore too early to know how patient care will be affected. Criticisms of the contract include the lack of consideration given to preventative care and the risk that fewer NHS patients will be treated. We therefore recommend a review to report the effects of the new contract on patient access and care, including prevention, and on NHS dentist numbers, recruitment, salaries and workload.

It is unclear whether the sight test fee deters patients from visiting their optician. Sight test numbers, and consequent referrals to hospital for specialist treatment, certainly fell after the free sight test was abolished. However, the Department reported that numbers of over 60s seeking sight tests did not rise significantly after the charge was removed once more for this group. Many opticians practices do not sell spectacles within the value of vouchers provided by the NHS to those eligible for help. We recommend that all practices carry stock within the value of these vouchers. It is also clear that many of those at risk of eye disease are not being targeted effectively. We recommend that greater efforts be made to improve attendance among these groups, and that sight tests for all children be reintroduced.

The setting of treatments has changed significantly in recent years. Patients who would previously have stayed in hospital now often receive treatment on an outpatient basis. This has led to problems with the cost of attending hospital. While car parking charges must remain a matter for hospital trusts, we recommend that they provide reduced rates for patients and their visitors who attend hospital regularly and free parking for those who must attend on a daily basis. Those unable to visit friends and family in hospital now usually have the possibility of telephoning loved ones' bedside telephones. Unfortunately, they have often paid a high price to do so. We recommend that this problem be addressed immediately.

The minor recommendations detailed above will lead to small improvements for patients, but will not address the fundamental problems in the current system of health charges. We heard several other options for major improvements to the system of charges. Inevitably

they each have positive and negative consequences and the evidence is not sufficient to reach a conclusion as to which of these options would be best. Little work has been done in this country on the costs or benefits of the different possible systems. This work needs to be done urgently so that an alternative charging system, with consistent underlying principles, can be developed. The Government should undertake a major review to assess the costs and benefits of the following:

- abolishing all the existing health charges;
- abolishing only the prescription charge;
- abolishing only charges for initial consultation and diagnosis, such as dental check-ups and eye tests;
- establishing a system of reference pricing for medicines;
- completely revising the medical exemptions to the prescription charge;
- introducing a flat-rate prescription charge with no exemptions; and
- basing exemption to charges solely on income so that those who can afford to pay for their prescriptions, dental care and sight tests do so.

The terms of reference and results of the review should be published.

The use of a limited NHS formulary of medicines, possibly linked to reference pricing, could reduce the drugs bill and improve prescribing practice. We recommend that the Government look at this and respond to us specifically on this matter.

The review should also consider a system of charges appropriate for future challenges. In the future, the NHS may not be able to pay for every possible medical treatment in a country with an ageing population, demographic pressures, rising public expectations and increased possibilities of medical treatment and long-term therapies. Some treatments or procedures may have to be charged for. The Government should consider this possibility sooner rather than later to ensure that a set of consistent criteria apply to those areas for which a fee is charged, to avoid the development of charges in an ad hoc way, as has been the case until now. With the introduction of such a system, it may be possible to abolish health charges which currently have a negative effect on health outcomes. The key principles that should be considered in this review are:

- services that are clinically necessary should be free;
- fees should not deter patients visiting their doctor or accessing healthcare; and
- any system chosen should be adaptable (to changing medical practice, treatments etc) and consistent.

The review should include:

- the possibility of establishing a package of core services which would be free (these might include prescriptions and dental care); and

- a set of treatments for which the NHS could charge.

Treatments/interventions that are not cost-effective, such as branded drugs where an effective generic exists, could be subject to a charge. The use of charges to promote more responsible use of services could also be considered, including:

- the introduction of a small charge for non-emergency patients presenting to A&E. This would encourage people to register with a GP, and make better use of out-of-hours services; and
- a fee for patients who do not attend or fail to cancel GP or hospital appointments.

# 1 Introduction

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1. It is often said that the NHS is paid for by taxation and therefore free at the point of use. There are various ways in which the NHS is not free. Personal nursing care (defined by the NHS as ‘social care’) is a massive financial burden on the elderly.<sup>1</sup> Some clinical interventions such as cosmetic surgery are undertaken in the NHS only in limited circumstances. Some patients must pay for their prescriptions, regardless of whether the medicine is for a life-threatening illness or mild pain relief. Similarly, some may also pay for dental care and sight tests. Some charges were first introduced over 50 years ago.

2. Charges have been criticised for many years. Studies have shown that charges reduce the uptake of prescribed medicines, which can have an adverse effect on health outcomes.<sup>2</sup> The Government’s own *NHS Plan* states that, “charges are inequitable in two respects: they increase the proportion of funding from the unhealthy, old and poor compared with the healthy, young and wealthy, ... [they] risk worsening access to health care by the poor”.<sup>3</sup>

3. The current system of charges may also undermine important health and social care policies. The Government wants to reduce social exclusion, yet charges may deter people from returning to work.<sup>4</sup> The Government also wants to improve preventative healthcare, yet charging for a dental check-up means people are less likely to attend.<sup>5</sup> As Professors Donald Light and Joel Lexchin stated:

Every study we know of done in Europe or North America documents again and again over the past 15 years that co-payments and other charges contradict the goals of a good health care system, harm patients, save little money, and generate little revenue.<sup>6</sup>

4. The consequences of charges are mitigated by exemptions, which cover children and patients over 60, patients with specific medical conditions, hospital patients (for the prescription charge) and groups that are in receipt of certain benefits. However, the medical exemptions to the prescription charge have not changed for 40 years and do not take changed practice and treatments into account. Income-related exemption can involve a complex application process and must be renewed annually. Charges also create a harsh poverty trap for those just above the threshold. More fundamentally, no easily understood principle underlies the complex set of exemptions.

5. In view of these concerns, we decided to look at healthcare charges to determine whether they have a place within an NHS which claims to be free at its point of use, or whether the resources could be better raised elsewhere. In October 2005, we announced the following inquiry:

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1 Health Committee, Sixth Report of Session 2004–05, *NHS Continuing Care*, HC 399–I

2 See Chapter 3 for details

3 NHS Plan. July 2000: <http://www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf>

4 Q 282 (Mind)

5 See Chapter 3 for details

6 Ev 94 Volume II

*The NHS makes charges for certain treatments, for example prescriptions, dentistry and optical services and for certain amenities, for example for television and telephone use and for car parking at some hospitals. These charges (sometimes known as co-payments) have not been systematically or thoroughly examined for many years. Their rationale is unclear. Patients are often unaware of the rules surrounding charges and of exemptions. Accordingly the Health Committee has decided to undertake an inquiry into the subject with the following terms of reference:*

*Whether charges for:*

- *Treatments, including prescriptions, dentistry and optical services; and*
- *Hospital services (such as telephone and TV use and car parking) are equitable and appropriate.*
- *What is the optimal level of charges?*
- *Whether the system of charges is sufficiently transparent*
- *What criteria should determine who should pay and who should be exempt?*
- *How should relevant patients be made more aware of their eligibility for exemption from charges?*
- *Whether charges should be abolished.*

6. The Health Committee last examined charges in 1994, in its report *Priority setting in the NHS: the NHS drugs budget*. It recommended lower prescription charges and fewer exemptions.<sup>7</sup> Here we consider this recommendation again, as well as other options including the abolition of the prescription charge, which will soon take effect in Wales.

7. We also consider the issue of fees from first principles. What is the purpose of charges? Are medicines and dental and ophthalmic services the most suitable areas of healthcare for which to levy a charge? What else could the NHS charge for which would minimise the adverse effects on health?

8. As part of the inquiry, we made two visits. In February, we went to the National Assembly for Wales in Cardiff, where we had the opportunity to discuss the effects of phasing out the prescription charge, as well as different policies in dental services. We had useful meetings with the Welsh Minister for Health, Dr Brian Gibbons; with the current and previous Chairs of our counterpart Committee, Rhodri Glyn Thomas, David Melding, and Kirsty Williams; and with officials from the Department for Health and Social Services.<sup>8</sup> Our visit to Sweden in March gave us the chance to study a health system where patients make a larger financial contribution through a range of fees, including hotel charges for staying in hospital and a charge for visiting a clinician.<sup>9</sup>

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7 Health Committee, Second Report of Session 1993–1994, *Priority Setting in the NHS: The NHS Drugs Budget*, HC 80–I

8 See Annex 1

9 See Annex 2

9. We held four oral evidence sessions. We heard from Ministers and officials from the Department of Health, professional associations, Royal Colleges, health professionals, think-tanks, academics, medical charities and private companies working in the healthcare sector. We were particularly impressed by the evidence given by Ms Lynsey Beswick, an “Expert Patient Adviser” with the Cystic Fibrosis Trust which vividly highlighted the problems that charges might cause patients.

10. We are very grateful to our Specialist Advisers, Professor John Mohan of Southampton University and Professor Nick Bosanquet of Imperial College London, for their expert guidance and help throughout the inquiry.

## 2 History and principles of health charges

### History

11. Health charges for prescriptions, dental care and visual aids have been in place for almost as long as the NHS itself. The legislation needed for the introduction of health charges was passed in 1949 for prescriptions and 1951 for dental and ophthalmic services. Charging for prescriptions, dental services and spectacles began in 1952.<sup>10</sup> Prescription charges were abolished in 1965, but re-introduced in 1968, when there was also Treasury support for a GP consultation fee.<sup>11</sup> In 1968, a list of medical exemptions to the prescription charge was drawn up.<sup>12</sup> No systematic review of this list has taken place since its compilation. Box 1 contains a brief history of NHS Charges.

12. Several reviews have examined health charges, including the 1953 Guillebaud Committee of Enquiry into the cost of the NHS, our predecessor Committee's 1994 report on *Priority setting in the NHS: the NHS drugs budget* and the Comprehensive Spending Review of 1998. There have also been studies by think tanks and other organisations.<sup>13</sup> The Comprehensive Spending Review of 1998 examined alternatives to the current system of health charges, and the savings/costs they would entail. The alternatives considered included a reduced prescription fee with fewer exemptions,<sup>14</sup> charges for pensioners with income above a certain level, free dental checks for the over-60s and free sight tests for all.<sup>15</sup> It was decided to leave the system unchanged, although the reasons for this were not clarified in the written evidence we received. The Minister stated:

We were not the first government to have done that: since [charges] were introduced, they have been looked at many times, and on each occasion it has been concluded that, whilst there are anomalies in the system—and we accept that—the system we have is probably best left as it is.<sup>16</sup>

10 A prescription charge of 1 shilling per form was first introduced. Four years later, a charge per item contained on the form was introduced

11 Eversley 2001. *Contemporary British History*; 15: 53–75

12 See Chapter 4 for the list of medical exemptions

13 Eg. Social Market Foundation, 2003, *A fairer prescription for NHS charges*. National Consumer Council, 2003, *Creeping charges: NHS prescription, dental and optical charges—an urgent case for treatment*. Citizens Advice, 2001, *Unhealthy charges*.

14 With no exemptions, a flat rate of £1 per item with no exemptions would save £120 million; a £2 charge per item would produce income of £410 million. A flat rate charge of £4 with exemptions for all children up to age 18 and low income groups, but without automatic exemptions for other groups would produce additional income for the NHS of around £250 million a year. See Ev 106 Volume III

15 Free dental checks for the over-60s and eye tests for all would entail costs of £20 million and £120 million each year, respectively. See Ev 107 Volume III for more details

16 Q 562 [Jane Kennedy]

### A Brief History of NHS Charges

1948	Launch of NHS with free prescriptions, dentistry, sight tests and spectacles
1949	Legislation passed giving power to charge for prescriptions
1951	Similar powers put in place for dentistry and spectacles
1952	Charges introduced for prescriptions, dental treatment and spectacles
1956	Prescription charge doubles
1965	Prescription charge abolished
1968	Prescription charge re-introduced with exemptions for some medical conditions
1976 onwards	Health charges rise (“pressure from IMF”)
1976-85	Charges for spectacles double until replaced by voucher system
1979-99	Prescription charge rises from 20p to £5.80 (more than 5 times in real terms)
1988	Free eye tests abolished
1998	Comprehensive Spending Review leaves charges unchanged
1999	Abolition of sight test charge for the over-60s
1999	NHS Plan states that charges are “inefficient and inequitable”
2003	Comprehensive Spending Review leaves charges unchanged
2004	Chargeable bedside televisions and telephones introduced
2006	Prescription charge rises to £6.65 per item
2006	Introduction of new dental contract with revised system of charges

### Principles

13. What should be provided free within healthcare and what should be available for a fee has been continuously debated since the introduction of charges in the early 1950s. There has been extensive discussion of the services that the NHS should provide. Rationing is already common: many Primary Care Trusts (PCTs) meet the cost of only one cycle of in-vitro fertilisation (IVF) treatment, for example, and eligibility criteria vary.<sup>17</sup> The provision

17 See the Human Fertilisation and Embryology Association, <http://www.hfea.gov.uk>

of Herceptin, the newly licensed, expensive medicine for early stage breast cancer, by individual PCTs has been a recent topic of debate. Whether the NHS should extend its screening programme to include other diseases has also been discussed.<sup>18</sup> Underpinning such rationing are considerations of the types of care designated as 'essential'. As people's expectations of life in general, and healthcare in particular, rise, it is perhaps increasingly difficult to differentiate between essential care and non-essential treatments.

14. The purpose of charges is twofold. They were introduced in the late 1940s and 50s both to raise money and to reduce demand. The then Prime Minister, Mr Attlee, justified the legislation on prescription charges in 1949 as a means of reducing unnecessary use of doctors' and pharmacists' time, "as a deterrence against extravagance, rather than as an economy".<sup>19</sup> The introduction of dental and sight test charges had less to do with health policy than with the need to pay for rearmament prior to the Korean War.<sup>20</sup> Professor Peter Smith of York University stated:

User charges in health care have two broad roles: to raise finance for the health system, and to send signals to patients who would otherwise face a zero price for access to health care.<sup>21</sup>

15. Although one of the purposes of charges is to raise funds, Governments have never set a target to obtain a particular proportion of the health budget from them. At present charges for prescriptions and dentistry amount to just over 1% of the total NHS budget.<sup>22</sup>

16. The signals sent by charges indicate to patients that the goods or services they receive are not without value and therefore should not be over-used. They could be used to discourage the wrong sort of behaviour; for example, patients could be charged for non-attendance for appointments. As we have seen, Attlee believed that prescription charges would reduce unnecessary demand for drugs.

17. The need to raise funds can send signals which discourage best practice, however. The charges for prescriptions for hospital day-case patients but not for inpatients are inconsistent with the desirable switch from inpatient to community based care.

18. It is desirable both that fees should be set at a level which does not deter patients from seeking or obtaining essential care and that exemption systems are in place to protect those on low incomes. Therefore the level of fees and the exemptions should ensure that medicines and services can be used by everyone when necessary but not used when other courses of action are more appropriate.

19. The subject of exemptions raises many questions. If the purpose of exemptions is to ensure that everyone gets the treatment they need, should exemptions policy be designed specifically to achieve this? For example, should there continue to be exemptions based on age alone rather than income?

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18 Eg. to include certain types of cancer. See *Population screening and genetic testing*, BMA August 2005

19 Webster 1996. Cited in Eversley 2001, *Contemporary British History*; 15: 53–75

20 Ibid

21 Ev 155 Volume III

22 See Chapter 3 for amounts raised by charges

20. The charges currently levied by the NHS may lower demand in that they reduce the numbers of patients obtaining their medicines and visiting a dentist; unfortunately, on the other hand, they may also stop patients from visiting their doctor, pharmacist or dentist whenever they need care. If this occurs, patients' health may suffer.

21. The evidence of the effects of reduced demand associated with charges is of two main kinds: the first consists of studies in which a population was observed before and after the imposition of a charging regime. Much of this controlled research was performed overseas. An experiment carried out in the US in the 1970s by the RAND group, in which over 2,000 patients were assigned to one of four types of charging regime, showed that increasing charges resulted in consistently reduced use of healthcare services, with associated cost savings and minimal health effects on most of the socio-economic groups included. However, the study also showed a seriously adverse effect on the health outcomes of those with low-incomes who had chronic illnesses. The annual risk of death related to hypertension, for example, was 10% greater in this group.<sup>23</sup>

22. The English evidence is largely of the second type which consists of surveys and focus group work. A telephone survey of patients from five countries including the UK concluded that of individuals on "low incomes" in the UK 6% did not obtain medicines after being issued with a prescription, or complete courses of prescribed drugs due to cost, and 24% did not consult a dentist for financial reasons.<sup>24</sup> There is also the testimony of organisations which work with individuals who have problems paying charges, such as Citizens Advice. They told us that they had seen, "people driven to below poverty level"<sup>25</sup> by health charges. Difficulties increase when such individuals are the victims of long-term illness:

From our point of view it is a combination of people's chronic health problems and low income. It is when those two things butt up against each other, that is the client group that we find most often has problems with prescription charges.<sup>26</sup>

23. Such evidence, like the evidence of surveys, does not provide a firm basis for conclusions that can be generalised to a large population. The English evidence base is very small and the effects of charges in this country have not been systematically assessed. Nevertheless, the general gist of the evidence is clear. As Professor Donald Light informed us, charges have adverse effects on the use of services, and this conclusion is supported by all the available international evidence.<sup>27</sup> This is also the conclusion of the WHO, which has stressed that charges deter use of services by the poorest and sickest in a population.<sup>28</sup>

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23 RAND's Health Insurance Experiment started in 1971 and lasted 15 years. It is the largest health policy study ever conducted. Details can be found in Keeler EB, Effects of Cost Sharing on Use of Medical Services and Health. *Journal of Medical Practice Management*, 1992, 8: 317-321

24 Commonwealth International Health Policy Survey 2004 (covering Australia, Canada, New Zealand, United Kingdom and United States) [http://www.cmwf.org/surveys/surveys\\_show.htm?doc\\_id=245240](http://www.cmwf.org/surveys/surveys_show.htm?doc_id=245240). This was a telephone survey of between 1,400 and over 3,000 patients from each country. Cited in Ev 86 Volume II

25 Q 253

26 Q 218

27 Ev 94 Volume II

28 Cited in Eversley 2001, *Contemporary British History*; 15: 53-75 (p 54)

24. It appears difficult to protect vulnerable groups that need effective and accessible healthcare but are less likely to seek it, while limiting “unnecessary” demand among other, usually wealthier and healthier groups, which might overuse services. Charges do not readily differentiate between frivolous, necessary and unnecessary use of services—as a result, they are a blunt instrument and are likely to have negative effects on access to and use of services. Professor Peter Smith told us:

Unless carefully designed, user charges designed to curb excessive demand amongst the bulk of the population could have ruinous financial or health consequences for a relatively small number of poor people with health problems.<sup>29</sup>

25. Much of the debate about charges has focussed on prescription medicines and dental and optical services, but there are other costs involved in accessing healthcare, notably car parking, and the introduction of new services to hospitals such as bedside telephones.<sup>30</sup> We are considering them here because there is growing evidence that these are of concern to many patients. Car parking charges have become more important as changing medical practice means that many patients have to attend hospital more often as day cases, while bedside telephones are a recent development.

26. Below we discuss the charges for elements of clinical care, namely medicines, dentistry and sight tests. This is followed by an examination of charges for services provided by hospitals that do not form part of clinical patient care, including charges for bedside telecommunication and car parking.

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29 Ev 157 Volume III

30 Parking charges have been in place for many years at some hospitals. Chargeable bedside entertainment services have been available in some hospitals since 2004

## 3 Clinical charges: levels and consequences

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27. Compared to other Organisation for Economic Co-operation and Development (OECD) countries, health charges in the UK are low.<sup>31</sup> However, the money raised by charges—approximately £1 billion per annum—is one of the principal reasons for maintaining the regime. The former Health Minister Jane Kennedy MP stated that, “the contribution that prescription charges makes to the health service is a valuable one”.<sup>32</sup> In this chapter, we outline the level of the charges that are in place and their effect on patient behaviour, health and access to care.

### Prescriptions

28. Patients pay £6.65 for each item on a prescription. Prescriptions are often written for one month of treatment only to reduce wastage of potentially expensive drugs. 50% of individuals must pay the prescription charge but only 13% of prescriptions dispensed actually incur a payment.<sup>33</sup> Prescription charges account for approximately 6% of the NHS drugs bill, raising £427 million each year.<sup>34</sup> Although there are many exemptions to charges, levels of prescribing are low in the UK compared to other developed countries.<sup>35</sup> Administration of the prescription charge system is also fairly inexpensive, costing approximately £7 million each year in England.<sup>36</sup>

29. Prescription charges, like charges in general, reduce demand. When the prescription charge was abolished in Italy in January 2001, overall spending on medicines rose by one third.<sup>37</sup> The Welsh Health Minister, Dr Brian Gibbons, told us that he expected demand to rise in Wales as the prescription charge was phased out.<sup>38</sup> The reduction in demand has both positive and negative effects. The Royal Pharmaceutical Society of Great Britain (RPSGB) pointed out that the increase in demand seen with free prescriptions may represent inappropriate use but it may also indicate that people had not previously been getting the medicines they needed because of the cost.<sup>39</sup>

30. There is international evidence that this is the case. US research into the effects of limiting state payment for schizophrenic patients’ medicines showed that the use of antipsychotic drugs and antidepressants fell immediately after the cap was imposed. Visits to community mental health centres increased by one or two visits each month and visits to A&E rose sharply. Removal of the spending cap after 3 months restored the use of medication and mental health services to previous levels. The authors estimated that the

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31 OECD 2001

32 Q 564

33 Ev 1 Volume II

34 Q 3

35 Those with lower prescribing rates include Australia, Greece and the Scandinavian countries. OECD 2001

36 This includes administration of the Prescription Pre-payment Certificate and the NHS Low Income Scheme (described later)

37 Ev 77 Volume II

38 See Annex 1

39 Q 139

increase in costs per patient was £1,530, the outlay being 17 times greater than the savings made in the cost of medication.<sup>40</sup> A Canadian study, which looked at the effect of requiring the elderly or those receiving benefits to contribute more to the cost of medicines, found that there had been detrimental effects on health.<sup>41</sup>

31. There is no UK equivalent of such studies, but there are other smaller scale surveys that indicate problems with health charges. A survey of Citizens Advice clients conducted in 2001 showed that 28% of those liable for the prescription charge did not have their medicines dispensed in full.<sup>42</sup> Of this group, 38% were single parent households and 37% had long-term conditions; for these patients the price of prescriptions is obviously a serious problem.<sup>43</sup> A MORI survey of people in England and Wales estimated that 750,000 people did not have their prescriptions dispensed each year because of cost.<sup>44</sup> Dr Hamish Meldrum, from the BMA, stated:

There is plenty of evidence...that people for whom it would be appropriate to attend the doctor are dissuaded from doing so because of the thought of charges.<sup>45</sup>

32. The mechanisms people use to cope with the cost of prescriptions may affect health. We were told that patients often ask which of the items on a prescription is most critical to their health.<sup>46</sup> Those unable to pay the prescription charge may substitute their prescribed item for a cheaper over-the-counter (OTC) medicine. This may be adequate in some cases, but Dr Ellen Schafheutle from the Drug Usage and Pharmacy Practice group (DUPP) at the University of Manchester pointed out that, as a result, patients sometimes do not receive “clinically important” medicines or may not choose the item that is of most benefit. For example when asthmatics were given the choice between a long-term preventative inhaler and one that gave immediate relief, patients were more likely to choose the latter even though it did not treat the cause of the condition.<sup>47</sup> Mind,<sup>48</sup> Professors Light and Lexchin<sup>49</sup> and the Kings Fund argued that patients who did not receive pharmaceutical treatment early on were more likely to have more severe health problems later and that there were likely to be increased costs to the NHS. Dr Anthony Harrison stated:

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40 Soumerai et al. *New England Journal of Medicine* 1994; 331:650–655

41 Reduced use of essential drugs occurred (15% among the elderly group, 23% among those on benefits), alongside a higher rate of serious adverse events (mortality, hospitalisation, nursing home admission) and an increased rate of admission to A&E. Tamblin et al. *Journal of the American Medical Association* 2001; 285, 421–429

42 The survey included 1602 people who had paid prescription or dental charges in the last year. Citizens Advice reported that 28% of these people did not have their prescription dispensed due to the cost. See *Unhealthy Charges*, published by Citizens Advice 2001. <http://www.citizensadvice.org.uk/unhealthy-charges.pdf>

43 Ev 143 Volume III [cited in evidence from the All Party Group on Primary Care and Public Health]

44 Ev 137 Volume III 1,052 adults were interviewed by MORI in 150 sampling points in Great Britain from 6–10 April 2001. The results were extrapolated

45 Q 172; see also Q 216, Martin Rathfelder from the Socialist Health Association (SHA), who told us: “If you make a charge on something...then the consumption of those items is likely to reduce amongst the population least able to afford them. If we are serious about encouraging people less able to pay to use the Health Service, then forcing them to come up with [£6.65] every time they have a prescription seems counterproductive”

46 Qq 148, 149, 151. According to the BMA, this is a “very frequent occurrence...[happening] once or twice a week”. Dr Schafheutle said that GPs and pharmacists probably underestimate how often this occurs

47 Q 159

48 Q 281

49 Ev 94 Volume II

Studies have confirmed that hospital admissions may rise as a result of people not taking up prescriptions because of costs and they may find themselves going to their GP or doctor more frequently.<sup>50</sup>

33. Though this is valuable evidence, and enough to reinforce concerns about the negative health effects of charges, we have little idea of the scale of the problems associated with prescription charges. The evidence that exists on attitudes to charges, or their effect on patient behaviour and decisions to seek and obtain medical treatment, is also limited.<sup>51</sup> Ministers did not seem to be aware of the studies that have been done to date, and stated that they did not intend to request that work be undertaken in the future.<sup>52</sup> Jane Kennedy said:

We have no plans at the moment to commission any further evidence, but we want to consider that in the light of what the Committee might say.<sup>53</sup>

34. There is also little evidence about the extent of frivolous or inappropriate prescribing related to free prescriptions. We were told of GPs being badgered to prescribe OTC medicines to save patients paying the prescription charge. The DUPP told us that patients who routinely received prescribed medicines were more likely to request products for the relief of minor ailments on prescription than those who are not exempt.<sup>54</sup> Researchers also found that when medicines were deregulated from prescription-only status to pharmacy status, as is increasingly common, exempt patients were more likely than others to seek a prescription for these products than to buy them. According to the BMA, it is common for parents to request a free prescription for Calpol, or its generic equivalent, from their GP when their child has a cold, rather than buying it directly from their chemist.<sup>55</sup>

35. One of the fundamental difficulties of this inquiry is that there is little hard evidence about public attitudes to charges or how charges affect the use of services in the short term or health in the long term. We found remarkably little evidence about the extent to which charges reduce 'frivolous' demand or free prescriptions encourage it. **We recommend that evidence is gathered on**

- **public attitudes to health charges,**
- **the extent to which charges affect the use of health services and, in the long term, health,**
- **the extent to which charges reduce 'frivolous' demand.**

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50 Q 142

51 Eg. the subject has never been included in the British Social Attitudes Survey

52 Q 632

53 Q 634

54 Ev 92 Volume II

55 Q 154

## Dentistry

36. Total public spending on dentistry is around £1.8 billion each year in England.<sup>56</sup> Of this sum, dental charges raise approximately £483.6 million.<sup>57</sup> According to the BDA, between £1.3–2 billion is spent on dentistry in the private sector.<sup>58</sup> The amount raised by the NHS has risen steadily, in real terms and as a percentage of the costs, since 1952.<sup>59</sup> Between 1980 and 1998 the maximum dental charge rose from £30 to £340. The cost of administering dental charges is low, at approximately £0.4 million.<sup>60</sup>

37. There was much criticism of dental charges in the past, mainly because of the complexity of the charging system. Until recently, patients could be charged for over 400 different ‘items’. A new dental contract was introduced on 1 April 2006. One of the main criteria for the new contract was that the same level of income be generated from charges as before.<sup>61</sup> Charges were simplified under the new regulations; now there are only three bands of pricing:

- Band 1 (£15.50) for a preventative course of treatment (which might include an examination, a scale and polish, x-ray and advice);
- Band 2 (£42.40) for dental interventions (fillings or restorative treatment);
- Band 3 (£189.00) for complex treatments including fitting dentures and crowns.

38. Traditionally, a dental check-up was recommended for everyone every six months. Recent guidance from the National Institute of Health and Clinical Excellence (NICE) on recall intervals indicated that it was unnecessary to have check-ups as often as that; rather the dentist should use their clinical judgement to decide when to recall patients.<sup>62</sup> The Department has emphasised this guidance alongside the new charges regulations and expects it to reduce the frequency of visits.<sup>63</sup> The proposed future activity level is 5% less than at present.

39. It is claimed that the new banded system of charges is far simpler for patients to understand, and easier to administer. Nevertheless, there are a number of problems with the new contract. Firstly, it is feared that dentists will treat fewer NHS patients because they

56 Q 328

57 Written evidence to the Health Committee, *Public Expenditure on Health and Personal Social Services 2005*, HC 736. This represented the income from charges collected within the General Dental Service. Charge income collected within Personal Dental Service pilots was not separately identified in NHS accounts before 2005–06. The Department of Health gave a figure of £630 million. This was a projection of the expected income in the current financial year, 2006–07, under the new dental charge system, to be collected within all primary care dental practices that had previously worked either within the GDS or Personal Dental Service pilots

58 Source: British Dental Association. Not printed

59 In 1988 the percentage of treatment costs paid by patients was 75%. Now it is 80%, and will remain at this level under the new contract. Eversley, 2001, *The history of NHS Charges* and Q 247

60 According to the Department, administration of dental charges is inextricably tied to the main process of paying dentists and the separate marginal cost of dealing with patients is minimal. The cost of salaries and overheads of the department that deals with exemption checking and patient refunds is £0.3 million per annum; the Department estimates that direct exemption checking costs less than £0.1 million per annum

61 Q 247

62 Clinical Guideline 19. Dental recall: recall interval between routine dental examinations. NICE, October 2004

63 Ev 4 Volume II

consider re-imburement inadequate. Secondly, although the maximum charge for NHS dentistry has fallen, the price of some individual ‘items’ has increased; for example the BDA said that a partial denture was more expensive now than previously.<sup>64</sup>

40. Thirdly, according to the British Dental Association (BDA), a vital area is missing from the contract, namely “the drive towards prevention”.<sup>65</sup> The BDA was concerned that preventative care did not receive any major focus during the contract renegotiations. The old dental contract was often criticised for encouraging ‘drill and fill’ rather than prevention and we were told that the new contract did nothing to allay this criticism. Preventative care does not attract Units of Dental Activity (the reference for how activity and payment are determined), meaning that there is no incentive for dentists to spend time with patients providing, for instance, oral health advice (eg. how to floss and use a toothbrush properly). Dentists are therefore more likely to continue to ‘drill and fill’.<sup>66</sup> Other preventative measures, such as sealants cost more now than under the old contract. There are also concerns that patients will delay check-ups, or ‘store up’ fillings to save money.<sup>67</sup> The Minister responsible for dentistry, Ms Rosie Winterton MP, was doubtful:

I find it very difficult to think that people would say, “If I hang on six months to get another filling, I can get that one in the same band.”... I do think that if people were in that bad a position there would be assistance given through the various schemes.<sup>68</sup>

41. Under the new contract, the cost of replacing dentures that are lost or damaged will be 30% of the highest of the three bands of payment (approximately £57). Previously this charge was around £100.<sup>69</sup> However, dentures that need to be replaced due to wear and tear will be subject to the highest charge (£189). Age Concern were worried that the high cost would mean people would hang on to dentures longer than they should.<sup>70</sup> It could be argued that the renegotiation of the dental contract was an opportunity to address the situation that has been missed. On the other hand, the Minister observed that the replacement of dentures due to wear and tear had always been charged at a higher level than those that were lost or damaged.

## Sight tests

42. Over 17 million sight tests were carried out in 2003–04 in the UK.<sup>71,72</sup> These include both NHS tests which conform to a protocol agreed with the Department and private tests which may be more or less extensive than the NHS test. A high percentage of tests are provided free: around 11.7 million (all NHS tests) are paid for by PCTs and their

64 Ev 24 Volume II

65 Q 330

66 Source: British Dental Association. Not printed

67 Q 328

68 Q 595

69 Q 247

70 Ev 11 Volume II

71 Department of Health, *Sight test volume and workforce survey, 2003–04*

72 In 2004–05, 11.7 million NHS sight tests were performed in England alone, Q 318

equivalents;<sup>73</sup> the rest are either private or NHS tests which people who are not eligible for a free test pay for directly. The NHS sight test currently costs £18.39, but the General Ophthalmic Services contract will be renegotiated this year and the price of the test is likely to rise.<sup>74</sup> A survey carried out by the Federation of Ophthalmic and Dispensing Opticians (FODO) found that the average cost of a private sight test was £17.68.<sup>75</sup> The amount spent annually by the Government on free tests in England was £178 million in 2003-04; spending by patients was approximately £106.08 million. According to the Department, the cost of administration of the NHS sight test is low, at around £1 million a year.<sup>76</sup>

43. Free universal eye tests were abolished in 1988.<sup>77</sup> Full screening of school age pupils does not now take place everywhere in the country. However, free tests for the over 60s were reintroduced in 1999. There has been a 68% real terms increase in Departmental expenditure on NHS sight tests between 1994-95 and 2004-05 (see table below).

### **General Ophthalmic Services Expenditure, England, at 2004-05 prices (£million)**

Financial Year	Total gross expenditure <sup>1, 2, 3</sup>	Cost of sight test provision <sup>4</sup>	Cost of glasses provision <sup>5</sup>
1994-95	275.0	112.6	162.1
1995-96	279.7	113.4	166.0
1996-97	286.7	117.4	169.0
1997-98	285.5	121.3	163.9
1998-99	277.4	119.5	157.5
1999-2000	321.1	166.9	153.5
2000-01	321.3	171.5	149.3
2001-02	327.0	176.0	150.3
2002-03	318.6	171.4	146.5
2003-04	328.5	178.0	149.4
2004-05	340.0	189.1	149.7

Health and Social Care Information Centre

1. Expenditure is on a resource or accruals basis
2. Revalued to 2004-05 prices using GDP deflators (December 2005)
3. Includes; cost of grants to supervisors of ophthalmic optical graduate trainees, not counted in the cost of sight tests or the cost of glasses provision.
4. An estimated proportion of total expenditure based on more detailed breakdown of costs available in same year's cash monitoring data. Comprises fees paid to ophthalmic opticians and ophthalmic medical practitioners, including payments for domiciliary visits, help given towards private sight tests and employers' superannuation contributions.
5. An estimated proportion of total expenditure based on more detailed breakdown of costs available in same year's cash monitoring data. Comprises the cost of vouchers and repairs and replacements.
6. The consistency of data may have been affected by the changeover in accounting responsibilities from Strategic Health Authorities to Primary Care Trusts from 1 October 2002. Cost of sight tests and glasses estimated, assuming same proportions as in 2001-02.

73 General Ophthalmic Services: Consultation tables, NHS sight tests, vouchers, workforce, premises 2004/2005. <http://www.ic.nhs.uk/pubs/genophth2005>

74 Opticians groups estimated that the actual price of providing the test is approximately £37

75 Optics at a Glance, FODO 2005. Survey based on a 25% sample of providers. The average figure is taken from a range of prices (£15 to £50). The average price also includes free sight tests for particular promotions or groups of patients. This inevitably reduces the average significantly

76 This comprises 0.5% on top of the cost of the sight test to compensate optometrists for requesting evidence of entitlement from patients, and recording and reporting the results to PCTs. In addition, a small supplementary fee is paid for similar checks on patients who claim NHS vouchers towards the cost of spectacles. PCTs oversee the General Ophthalmic Service and conduct sample checks on patients who claim entitlement to NHS services

77 The Health and Medicines Act of 1988 abolished free universal sight tests. [http://www.opsi.gov.uk/ACTS/acts1988/Ukpga\\_19880049\\_en\\_2.htm#mdiv14](http://www.opsi.gov.uk/ACTS/acts1988/Ukpga_19880049_en_2.htm#mdiv14)

44. The opticians' groups that appeared before the Committee did not consider that there needed to be changes to the charging system.<sup>78</sup> Rather they stressed the need for greater awareness of the importance of eye health and preventative eye care. Their main concern was the consequence of failing to undergo a sight test, which increased the risk of serious eye disease, particularly in vulnerable groups. Failure to screen children at the appropriate age can also have serious consequences.<sup>79</sup> The International Glaucoma Association (IGA) stated that some racial groups were particularly at risk of certain eye conditions, and that these groups often do not use chargeable NHS services:

A prime example of this are people of African Caribbean origin who are more prone to developing glaucoma than the Caucasian population...such glaucomas tend to be more difficult to control effectively, making early detection even more of a priority if vision is to be preserved for life.<sup>80</sup>

Dr David Cartwright, of the College of Optometrists, pointed out the importance of diagnosing eye disease early as a means of preventing sight loss later in life, and of saving the NHS money. A patient with glaucoma, for example:

...is not immediately aware that their vision or the visual fields might be getting worse until it is often too late to treat. So it is essential to diagnose that early and treat it early and that would lead to savings later on in the ongoing care of that patient.<sup>81</sup>

45. It is unclear whether charges have much effect on whether those at risk undertake eye tests. Abolition of the free sight test in 1988 was followed by a decrease in the number of tests performed<sup>82</sup> and levels of referrals from opticians to hospital ophthalmologists fell significantly after the sight test fee was introduced.<sup>83</sup> On the other hand, the overall number of sight-tests received by the over 60s did not increase significantly when free tests were reintroduced in 1999, suggesting that older adults were not deterred from undergoing a test by the charge.<sup>84</sup> Opticians' groups also doubted whether cost was a major reason why people did not have tests. The Minister agreed that people were unlikely to be deterred from visiting their opticians by cost:

There is no evidence that people, frankly, just do not go because they could not afford it.<sup>85</sup>

78 Q 404

79 The Child Health Sub-Group Report on Vision screening, of the National Screening Committee, recommended that all children should be screened between ages 4 and 5. Vision defects include amblyopia (3% of children), refractive error (hypermetropia, astigmatism, rarely myopia), and strabismus (3-6%). NSC May 2005

80 Ev 148 Volume III

81 Q 308

82 Office of Health Economics, *Compendium of health statistics* 1997. Cited in Eversley 2001

83 Laidlaw and Bloom. The sight test fee: effect on ophthalmology referrals and rate of glaucoma detection. *BMJ* 1994;309:634-636. Referrals to the Bristol Eye Hospital were 13.7-19.0% lower than expected after the introduction of the sight test fee

84 Q 636

85 Q 624

She also agreed that identifying groups particularly at risk for eye disease was more important than encouraging more people overall to seek a sight test.

46. Age Concern, Citizens Advice and others were concerned that the value of the vouchers provided by the NHS to cover, or contribute to, the cost of spectacles was too low. There is a gap between the value of the voucher and the cost of spectacles and contact lenses at some opticians. According to Citizens Advice:

If you are living in a rural area where you cannot shop around so easily, you could well find that your local optician just does not provide them within [the value limit] and you have got to find the difference, which then immediately brings you below the Income Support level. You may then decide maybe, “I can’t afford to go to the optician’s at all”<sup>86</sup>

47. In written evidence opticians groups agreed that patients could not afford to buy expensive glasses with the vouchers:

The allowances [for spectacles vouchers]...are insignificant against the actual retail cost of these expensive lenses.<sup>87</sup>

However, in oral evidence the Association of Optometrists (AOP) stressed that, “there is plenty of opportunity to buy spectacles within the voucher value”.<sup>88</sup>

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86 Q 240

87 Ev 138 Volume III

88 Q 356

### Health charges elsewhere in the UK

Some aspects of the charging systems in Scotland and Wales differ significantly from that in place in England.

#### *Prescriptions*

The National Assembly for Wales has decided to introduce free prescriptions for all by April 2007. Prescriptions are already free to the under-25s and the prescription charge to others fell from £4 to £3 in April 2006. Prescription Pre-payment Certificate (PPC) prices are falling in accordance with the per-item charge.

The NHS in Scotland charges the same price per prescribed item as in England, and the PPC price is identical. However, a draft proposal on the Abolition of NHS Prescription Charges (Scotland) Bill was introduced to the Scottish Parliament on 19 January 2005. The Scottish Health Committee was asked to scrutinise the bill, and its underlying principles and feasibility, and published a report on 11 January 2006. The report found that the existing prescription charging system was inequitable:

[The system] exempts individuals suffering from some chronic illnesses, but not others, and it exempts some people on low incomes, but not others.<sup>89</sup>

The Scottish Health Committee concluded that the only way of ensuring true equity was to abolish charges altogether, although it acknowledged the financial implications of such a move. The Scottish Executive voted against the abolition of the charge on 25 January 2006<sup>90</sup> but Ministers promised to reform the charges system and introduce more exemptions for long-term conditions, students and those on low incomes.

#### *Dentistry*

In Wales, a similar dental contract has been introduced to that in England but Welsh dentists will be expected to carry out 10% less treatment after the implementation of the contract compared to 5% less in England. The dental charges levied are banded in a similar way, but the bands are lower (English equivalent in brackets):

- Band 1 – £12.00 (£15.50)
- Band 2 – £39.00 (£42.40)
- Band 3 – £177.00 (£189.00)

In Wales, the over-60s already have free dental examinations and the under-25s are eligible for free dental check-ups.

89 Health Committee 1st Report, 2006, SP Paper 482

90 The motion was supported by the Scottish National Party and the Greens, but defeated by 77 votes to 44 by Labour, the Liberal Democrats and Tories

The Scottish Executive has made a commitment to introduce free dental check-ups for older people. In March 2005, the Scottish Executive announced its new *Action Plan for Improving NHS Dentistry*, with £150 million new investment over the next three years. The plan provides for 200 extra dentists by 2008 and reform of the payment and charges structure.

### **Sight tests**

An expanded eye test is in place in Wales and Scotland. The new Scottish examination reportedly removes the necessity of a test for the provision of glasses alone and allows practitioners to provide a more appropriate and individual service. This test...

...will consist of a primary and a supplementary examination, both of which will attract funding more appropriate to the actual time spent with patients...<sup>91</sup>

According to AOP, it would cost £90 million to introduce a similar scheme to England.

In Wales, the Welsh Eye Care Initiative (which involves screening of at-risk groups, such as those with sight in only one eye, retinitis pigmentosa or of Black African, Black Caribbean, Indian, Pakistani or Bangladeshi origin) and the Primary Eye Acute Referral Scheme (which allows rapid referral of specific patients by GPs) are provided by over 80% of the optometric workforce. The Wales Low Vision Examination, which provides patients referred to optometrists by their GP with a range of visual aids and appliances, has been operational for 17 months, moving the provision of low vision services into primary care. The opticians groups stated:

Waiting time and appliance provision has dropped from 18 months to 8 weeks. ...Significant savings in secondary care have accrued as a result.<sup>92</sup>

No figures on the level of these savings were given.

## **Additional charges for clinical services**

48. During the inquiry we heard about the increasing number of charges for clinical services which may have an effect on health outcomes and patient wellbeing. We looked at evidence in respect of two: the Gentle Midwifery scheme at Hammersmith Hospitals Trust and the dermatology clinic run by Harrogate and District NHS Foundation Trust (see boxes below).

49. The Gentle Midwifery scheme was introduced in 2004 to give one-to-one midwife care to women throughout the course of their pregnancy and after delivery. The National Service Framework (NSF) for Maternity Services states that such care should be the

91 Ev 16 Volume II

92 Ev 17 Volume II

national standard.<sup>93</sup> Few hospitals at present meet the NSF; the Jentle scheme attempts to do this but only for those who can pay £4,000, plus a number of other women with particular needs.

50. The advantages of the scheme are that a small number of women, both those who pay and those with special needs who are subsidised by the women who pay, get a high class service that otherwise they would not receive. It is argued that there are not the funds to provide the service in any other way.

51. Several witnesses, however, objected to the scheme. The main objections are first that better NHS care which affects health outcomes is being made available to those who pay. Secondly, the scheme provides private care on the cheap; it would be more acceptable if the scheme were clearly in the private sector and the women who used it paid the full cost.<sup>94</sup> The money raised in this way could be used to fund NSF services for those who need it. Dame Gill Morgan of the NHS Confederation said the scheme made her “slightly uneasy” and described it as an “uncomfortable situation”:

The challenge for schemes like this is that they are right on the cusp between the private sector and the NHS which makes it, I think as you have been exploring, really quite difficult to know how far people will take them.<sup>95</sup>

Jane Kennedy agreed that the situation at Queen Charlotte’s and Chelsea Hospital made her “uncomfortable”, as women pay for a service that should be available as standard from the NHS.<sup>96</sup> She said that she had asked for an investigation to be carried out following evidence received by the Committee on the scheme.

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93 National Service Framework for Children, Young People and Maternity Services. Department of Health 2004. <http://www.dh.gov.uk/assetRoot/04/09/05/23/04090523.pdf>; Research has shown that women are less likely to need a C-section when they receive one-to-one care from a single midwife

94 More exclusive private hospitals may charge over £10,000

95 Q 417

96 Qq 685–687

### The Gentle Midwifery scheme

The Gentle Midwifery scheme at Queen Charlotte's and Chelsea Hospital (Hammersmith Hospitals Trust) in London was first established in 2004. It provides NHS patients with support from a single, named midwife throughout their pregnancy for a charge. The midwife is available 24 hours a day throughout the pregnancy. Ante-natal support is more flexible in terms of time and location than the service normally provided by the NHS. According to Queen Charlotte's, it already provides this service free of charge in the case of "clinical necessity", which it defines as a traumatic first birth, domestic violence, or when it is likely that a woman will experience complications during childbirth. Maggie Elliot, director of midwifery at the hospital and President of the Royal College of Midwives said:

The scheme has allowed us to provide this service for women with a clinical need ... so, as well as...providing that service for the women who pay for it, we actually now can provide it for women with severe clinical need, and [the midwife] takes on women free of charge which we would not have been able to have done if we had not actually started this scheme.<sup>97</sup>

The provision of information, equipment, scans and other tests under the scheme is no different to the service provided to all NHS patients. The main difference is that women not taking part in the scheme cannot be guaranteed the same midwife while they are pregnant, when they give birth, or afterwards. Ms Elliot stated:

The women who are in our one-to-one midwifery service actually receive a very similar service [to that available on the NHS], but these women pay for extra things which are not clinical need. They are things that they want, not things that they need.<sup>98</sup>

The scheme costs £4,000, and no additional charge is made if the baby requires treatment. In comparison, it costs at least £7,000 to have a baby at a private hospital, and more exclusive hospitals may charge over £10,000. To date, over £160,000 has been generated by the Gentle scheme, which has been reinvested in the trust's NHS maternity services. 74 women have used the scheme. Ms Elliot stressed women who pay and those who do not receive the same quality of care:

It is not a two-tier system because all women at Queen Charlotte's, I hope, have a high quality of care. These women do not actually receive a better quality of care, but they simply pay for the reassurance of one midwife and nobody else will get that.<sup>99</sup>

52. The dermatology clinic run by Harrogate and District NHS Foundation Trust (see box below) caused less concern than the Gentle Midwifery Scheme, because it provides treatment that is no longer available on the NHS in that area and because patients pay the

97 Q 410

98 Q 432

99 Q 415

full cost of treatment. Nonetheless, the clinic operates from the main hospital and is run by NHS employees. There may be questions about the use of management and other staff time.

#### Harrogate dermatology clinic

NHS patients can pay the Foundation Skin clinic in Harrogate for the cosmetic removal of moles and warts, to screen moles and to have Botox injections to reduce heavy sweating. Some of the services available at the clinic were offered free by the hospital trust until 2003, when the funding for all cosmetic procedures was stopped.<sup>100</sup> None of the cosmetic services are available in the area on the NHS now, although they may be provided by trusts elsewhere in the country.

Prices range from £85 for the removal of a single lesion using curettage (scraping) and cautery (hot wire treatment) to £450 for Botox injections for excessive underarm sweating (£50 consultation plus £200 per area treated). It costs £250 for a mole consultation, scanning session and discussion about removal.<sup>101</sup> Actual removal costs £125 for large and £95 for smaller moles. All patients must undergo a preliminary consultation with a dermatologist, costing £90. NHS doctors and nurses perform the procedures. The clinic is located on the first floor of the main hospital.

**53. The dermatology clinic in Harrogate and the Jentle Midwifery scheme in London differ significantly. The former involves charging for purely cosmetic procedures while the latter charges a fee for services that should be available, according to the National Service Framework on maternity services, as standard. The Jentle Midwifery scheme provides cut-rate private care within an NHS hospital. This is unacceptable. Essential care of this type should be given to all or paid for privately at full cost.**

<sup>100</sup> Craven, Harrogate and Rural District PCT stopped all funding for cosmetic procedures in 2003

<sup>101</sup> Patients complete a screening questionnaire before attending the clinic. If there are any indications that a mole may be malignant, the patient is redirected to NHS services. The expectation is that patients will have no 'indicators of concern' but want their moles checked, possibly with a view to cosmetic removal

## 4 Exemptions

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54. Approximately 50% of the population are exempt from prescription charges, and around 87% of prescription items are dispensed free of charge.<sup>102</sup> A slightly lower percentage of the population is eligible for free sight tests, and approximately 25% of the population is eligible for financial help with dental costs. Exemptions are based on age, income, treatment setting and medical condition.

### Categories of exemption

#### Age

55. Children and young people are largely exempt from charges. All under 16s are exempt from the prescription charge and are eligible for free sight tests, and under 18s are exempt from dental charges. Those under 19 in full-time education are exempt from the prescription charge and are eligible for free dental care and sight tests. The over 60s are exempt from prescription charges and are eligible for free sight tests, but must pay dental fees.

#### Income

56. People between 16 and 60 are entitled to exemptions according to their circumstances. Patients in receipt of Income Support, Income-based Jobseeker's Allowance or Pension Credit (guarantee credit) are exempt from health charges, but those receiving Incapacity Benefit or Disability Living Allowance are not automatically exempt. Individuals who hold a valid exemption certificate for a War Disablement Pension do not have to pay prescription charges (but only in respect of medication for the accepted disablement).

57. Those most affected by charges are working adults on incomes just above the level of Income Support. Professors Light and Lexchin argued:

Co-payments and other charges discriminate sharply by income, constituting a burdensome expense for lower- and working-class patients. The greater the share of a household budget that a disincentive represents, the more effectively will user fees reduce consumption of medicines needed by patients.<sup>103</sup>

Dr Maureen Baker from the Royal College of GPs said that patients just above this threshold experience “quite a hit” if they are not expecting to be charged.<sup>104</sup> The mutual organisation Simplyhealth stressed:

There are a number of people in society who do presently find themselves hugely impacted by charges because they are not on certain benefits but they are not top

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102 Ev 1 Volume II

103 Ev 94 Volume II

104 Q 301

earners... £189 for dentistry, for instance, can make a tremendous impact on them come the end of the month.<sup>105</sup>

There are schemes in place to help some people in this position, in particular the NHS Low Income Scheme (LIS) and the Prescription Pre-payment Certificate (PPC).

### ***Benefit-related exemptions and other forms of assistance***

#### ***The NHS Low Income Scheme***

58. The NHS Low Income Scheme (LIS) provides financial assistance for those who are not eligible for exemption from charges through other means. It covers prescriptions, dental and optical services, travel expenses, wigs and fabric supports. Under the LIS some patients receive services completely free of charge, while partial support is available for those with slightly higher incomes. The capital threshold for the LIS is £21,000 for those permanently in a care home and £16,000 for all other patients.<sup>106</sup>

59. To apply to the scheme, patients must complete a lengthy HC1 form which is sent to the Prescription Pricing Authority (PPA).<sup>107</sup> Patients are then sent an HC2 certificate, an HC3 certificate or an explanation of why they are not eligible for help through the scheme.

60. The HC2 certificate entitles the patient to help with the full costs of their medicines, NHS dental treatment, maximum value vouchers towards the cost of glasses and reasonable costs incurred when travelling to hospital while under the care of an NHS hospital consultant. The HC3 certificate entitles the person named to limited help with the above. The certificate shows the maximum amount patients are expected to pay for prescriptions, NHS dental treatment, towards the cost of glasses or towards transport to hospital.<sup>108</sup> The certificates usually lasts for 12 months and must be renewed each year.

61. Witnesses thought the LIS had many failings. The application process, in particular, was highlighted as lengthy and complicated. Ministers argued that the form was brief, comprehensible and easy to complete, but the BDA told us:

That is a big, complex document, as you rightly say. We would like that simplified because it makes it very difficult for patients to deal with and some, I am sure, are deterred by the fact that it is a big jargony form.<sup>109</sup>

The nature of the form means that many patients do not apply for the scheme, and aid agencies spend considerable amounts of time helping patients to complete it.<sup>110</sup> One Member of the Committee put the situation as follows:

105 Q 505

106 See [www.ppa.org.uk](http://www.ppa.org.uk)

107 From 1 April 2006 the PPA is a division of the NHS Business Services Authority

108 Vouchers are available for eligible patients to pay for glasses. There are eight bands of voucher value, ranging from £32.90 to £181.40. Otherwise, financial assistance for dental charges and the cost of glasses is absolute and no tapered help is available. The voucher is redeemed by the optician from the local PCT. The allowances for complex lenses include a supplement of £12.40 for single vision and £31.30 for bifocal lenses. In March 2006, regulations were laid before Parliament to increase the value of these vouchers by 2.5%. HC Deb, 10 Mar 2006, Col 83WS

109 Q 390

I am absolutely horrified. It is the most impossible form anybody could ever have to fill in even if they were 50 with an IQ of 150.<sup>111</sup>

62. In 2001/02 the PPA received 879,000 claims for the LIS. Of these, 496,000 patients received HC2 certificates (allowing full help with costs) and 305,000 received HC3 certificates (allowing limited help).<sup>112</sup> Numbers of claims have been reportedly falling steadily, and between March 2005 and March 2006, 542,549 claims were received.<sup>113</sup> There is no assessment of take-up; the Department of Health does not collect information about those who might be entitled to help through the scheme but choose not to claim.

### *Prescription Prepayment Certificate*

63. Those who are not entitled to a free prescription and do not qualify for the LIS can take advantage of the Prescription Prepayment Certificate (PPC), which was introduced as a means of reducing costs for individuals who require several prescribed items on an ongoing basis. A PPC requires an up-front payment of £34.65 for four months or £95.30 for 12 months, after which no further payment is required for an unlimited number of prescribed items.<sup>114</sup> According to the Department of Health, 4.7% of prescriptions are paid for using a PPC.

64. There are two significant problems with the PPC. Firstly, £34.65 can be a relatively large sum for poorer patients to find. Secondly, people do not always know that they will require a long course of treatment and so may have already spent money on prescriptions before they consider whether to purchase a PPC.

### *Information to patients*

65. While they said that there was a good deal of information about the benefits available to assist patients to pay charges, Ministers admitted that patients often do not claim the benefits to which they are entitled.<sup>115</sup> Many do not know about the assistance that is open to them. The Prescription Pricing Authority encourages, but does not oblige, GP surgeries, chemists, opticians and dentists to hold copies of relevant information leaflets.<sup>116</sup> Citizens Advice, which now operates from some GP surgeries and clinics, highlighted the lack of information to patients about exemptions. This point was also made by Macmillan, the Socialist Health Association (SHA) and Age Concern.<sup>117</sup> Professional groups agreed. The BDA and the opticians groups said that most of their members accepted that it was their role to give information to patients regarding exemptions. Despite this, the BDA stated that patients were still often not sure whether they were eligible for free dental care:

110 Ev 34 Volume II, Qq 235, 242

111 Q 708

112 See SK Sihota, *Creeping Charges*, National Consumer Council, July 2003

113 Source: Department of Health. Not printed. The Department could not explain the fall in the number of claims submitted

114 Ev 1 Volume II On average, 46 items were dispensed to each PPC-holder in 2004–05. According to the Department, 4.7% of prescriptions dispensed were charged at PPC rates

115 Q 622

116 The PPA spends £416,000 every year on material to promote the help that is available and also runs a help line

117 Ev 55, Ev 80, Ev 13 Volume II

There needs to be a more coordinated approach, firstly, between Government departments and, secondly, with patient and professional organisations...on the most appropriate way for making people aware of their eligibility for exemption from charges.<sup>118</sup>

Mr Darracott of the RPSGB demonstrated a card, produced by pharmacists, which is found at the dispensing counter, but added:

I think, in short, more publicity would be helpful because at the moment the profession itself is producing this card to tell patients about what the charges are.<sup>119</sup>

### **Treatment setting**

66. The setting in which patients are treated dictates whether or not they are charged: hospital inpatients do not pay for prescriptions or dental charges, but outpatients are charged. Some patients admitted for day surgery must pay the prescription charge for the painkillers they take home. The British Association of Day Surgery argued that this would soon be standard practice throughout the NHS.<sup>120</sup>

67. Changing medical practice and technology have overtaken the charging system. Far fewer patients need to stay in hospital now compared to 40 years ago. This means that more people have to pay for prescriptions because they are treated as outpatients rather than inpatients. A breast cancer sufferer said:

Dealing with a terminal disease is difficult enough without worrying about the cost of life-saving prescriptions.<sup>121</sup>

68. Outpatient treatment means that those who might need persuasion to take medication do not receive it. Charges add to this problem. Mental health patients must pay prescription charges, even though their liberty may depend on compliance with the drug regime.<sup>122</sup> The requirement to prescribe some types of treatment on a weekly basis, to guard against overdose, increases patient costs dramatically. Moira Fraser from Mind pointed out that the mentally unwell are a vulnerable group who need all encouragement possible to take their medicines. Dr Geoff Searle, a consultant psychiatrist in charge of a Crisis Response Team, echoed this view:

They never have enough cash in hand to buy pre-payment certificates. For those on three or four medications long term the prescription charges are a considerable burden and expense, and for those with doubts about the need for medication the charges are a great excuse not to comply with needed treatment.<sup>123</sup>

118 Ev 25 Volume II

119 Q 201

120 Short stay hospital patients face charge for painkillers, *The Guardian*, 13 December 2005

121 Pat Montgomery, Leicestershire, Ev 21 Volume II [evidence from Breast Cancer Care]

122 Ev 60 Volume II. Section 25a of the 1983 Mental Health Act requires patients previously held under section in hospital to take their medication in the community or risk being taken back into hospital

123 Ev 154 Volume III

### Medical exemptions

69. Patients are also exempted because of their specific medical conditions (see box below). The treatment and vaccination of sexually transmissible infections is free, as are contraceptives for women. Pregnant women and those who have given birth in the last 12 months are exempt from the prescription charge and dental costs. Those with diabetes, glaucoma, or aged over 40 with a first degree relative with the disease, are eligible for free sight tests.

#### Conditions for which medicines are free of charge

- Permanent Fistula (including caecostomy, colostomy, laryngostomy, or ileostomy) which requires continuous surgical dressing or requires an appliance;
- Forms of hypoadrenalism (including Addison's disease) for which specific substitution therapy is essential;
- Diabetes insipidus or other forms of hypopituitarism;
- Diabetes mellitus (except where treatment is by diet alone);
- Hypoparathyroidism;
- Myasthenia gravis;
- Myxoedema;
- Epilepsy requiring continuous anti-convulsive therapy;
- Continuing physical disability which prevents the patient from leaving his residence without the help of another person.

70. The criteria that distinguish between patients exempt from health charges and those who pay are inconsistent and anomalous. In particular, witnesses thought it absurd that the list had not been updated since 1968. Representatives from Macmillan, the Cystic Fibrosis Trust, Parkinson's Disease Society and others were frustrated by the exclusion of some long-term conditions from the list of exemptions.<sup>124</sup> Dr Meldrum of the BMA pointed out the illogicality of the system:

If you happen to have an under-active thyroid at any time in your life and you are required to take thyroxine you are prescription exempt for everything. Somebody who happened to have an under-active thyroid at 20 and who turns out to be hypertensive in their 30s or 40s gets free medication. Somebody else who just

becomes hypertensive and did not have the fortune to have an under-active thyroid does not, they pay.<sup>125</sup>

This criticism is not new. In 1994, the Health Committee stated:

The current system of exemption on medical grounds contains elements of illogicality. The Government has stated that exemption is granted for patients with “specified readily identifiable chronic illnesses calling for lifelong medication”. What is not clear is why some conditions which are judged to satisfy this criterion are exempt, whereas others—for instance, pernicious anaemia, cystic fibrosis, chronic asthma, hypertension and a variety of dermatological conditions including eczema—are not. One reason may be that the medical understanding of some of these conditions has developed since the list of current categories was drawn up.<sup>126</sup>

71. Diseases such as HIV/AIDS did not exist in 1968 when the original list was compiled. The ways in which many diseases are treated has also changed; more and better medicines are available and the possibilities for intervention have increased. In 1968, most babies born with cystic fibrosis, for example, did not live beyond childhood, and so the issue of prescription charges was not relevant: patients were automatically eligible due to their young age. Thanks to improved treatments, many patients now reach adulthood, the average life expectancy exceeding 30. Such patients take a myriad of different medicines a day. A cystic fibrosis patient, Ms Lynsey Beswick, told the Committee:

There are about 85 tablets, plus nebulisers three times a day. 85 tablets are what I have to take daily. I am surprised I do not rattle really.<sup>127</sup>

### Exemptions policy: the Government’s justification

72. It is not easy to determine the underlying principles of the Government’s policy on exemptions. It stated that its policy is that financial assistance is based on the principle that:

...those who can afford to contribute should do so, while those who are likely to have difficulty in paying should be protected.<sup>128</sup>

73. But it is evident that this principle does not apply. Many wealthy older adults in England could afford to pay for their prescriptions, but do not. Wealthy people with certain medical conditions are exempt as are the children of wealthy parents. We questioned the Minister about this:

**Dr Taylor:** ...you have said that one of the principles is that those who can afford should pay. Are you not now contradicting that?

**Jane Kennedy:** No, because we have exempted those who are in retirement and are not working.

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125 Q 161

126 Health Committee, Second Report of Session 1993–1994, *Priority Setting in the NHS: The NHS Drugs Budget*, HC 80–I

127 Q 274

128 Ev 1 Volume II

**Dr Taylor:** But you have also exempted a lot who could afford to pay?

**Jane Kennedy:** That is true.

**Dr Taylor:** Which goes against your principle?

**Jane Kennedy:** If you like, we have refined the principle.<sup>129</sup>

74. Ministers were clearly concerned about taking benefits away from currently eligible individuals<sup>130</sup> and were reluctant to consider a move towards requiring rich pensioners and others in receipt of free prescriptions to pay for their medicines,<sup>131</sup> regardless of the equity of the system:

Wherever we have made those changes, the intention has been to preserve an existing entitlement; it has never been to take one away.<sup>132</sup>

**The Government claims that its exemptions policy is based on income: those who can afford to pay, those who cannot do not. However, this is not the case: many wealthy people are exempt, but many poor working people are not. The exempt medical conditions have not been revised for almost 30 years, creating many anomalies. It is evident that Government policy is to maintain the status quo and not to upset any existing beneficiaries.**

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129 Qq 609–611

130 Q 608

131 Qq 607–608

132 Q 586

## 5 Non-clinical services

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### Transport

75. Increased car use, the concentration of specialist services in fewer areas, the treatment of ever more people as outpatients and the construction of new out-of-town hospitals with poor public transport access mean that car parking and transport costs have become matters of serious concern. Giving more choice to patients is likely to exacerbate the problem. Witnesses' main complaint was about car parking charges, but we also received evidence about the cost of public transport and taxis. These are not charges made by the NHS but we include them in the inquiry because they add to the sums patients have to pay.

### Car parking

76. According to Macmillan, cancer patients make an average of 20–30 round trips to hospital for radiotherapy alone, and an average of 60 visits overall.<sup>133</sup> Chief Executive Peter Cardy told us:

If we take a typical cancer career of perhaps nine months or so...they will be paying travel costs which because of the concentration of specialities in cancer centres...means that people are often travelling long distances... and they will be paying car parking charges. When discharged from hospital they will be paying prescription charges. So costs, each of which is modest in itself, will be piling up very considerably for people who have this quite typical trajectory.<sup>134</sup>

Patients with other conditions, such as renal failure, suffer similar, often longer-term, problems.

77. NHS facilities are not obliged to provide parking. Where they do so, individual trusts decide on the level of the charge. According to the Department, charges are necessary to meet the costs incurred by the provision of car park spaces, including the provision of security. Charges may also be used as a means of raising revenue for the hospital.<sup>135</sup>

78. Guidance is in place on the range of factors that should be considered if a trust wishes to introduce parking charges, such as local user needs and management of the scheme.<sup>136</sup>

79. A survey by Macmillan of car parking charges in 285 of the 292 UK hospitals with cancer units found that 92% of English hospitals charged patients for car parking, compared to 53% of hospitals in Wales, 20% in Northern Ireland and 6% in Scotland. The survey showed that hourly rates varied from 30p to £4.00 an hour in England (average £1.22) and that 24-hour stays cost up to £30.

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133 Ev 52 Volume II

134 Q 261

135 Ev 51 Volume II

136 Income Generation: Car Parking Charges—A Guide to Implementation. Department of Health. Further information is contained in NHS Standard Service Level Specifications, <http://www.dh.gov.uk/assetRoot/04/02/10/06/04021006.doc>

80. The total number of parking spaces available and the overall income provided from car parks is shown below.<sup>137</sup>

Hospital parking spaces and income		
Total Parking Spaces	Income from Staff Parking (£)	Income from Visitor Parking (£)
378,720	15,130,961	62,755,934

*Figures provided on a voluntary basis. 80% of NHS hospital trusts responded.*

*Source: Estates Return Information Collection 2004/05*

81. The sums raised from parking charges represent a very small proportion of the NHS budget—less than 0.1%. The figures suggest that the average income per parking space is around £200, but there is wide variation. For some trusts the income generated can be much greater, from about £2,000 per space for some provincial general hospitals (eg. Southend, Good Hope in Sutton Coldfield, Luton, Frimley Park in Surrey, and Epsom). In contrast, other hospitals generate less than a quarter of this (for example East and North Hertfordshire, North Hampshire and Queen Mary's Sidcup). For individual trusts, income from car parking generally equates to less than 0.25% of their total budget but there are a number of cases where the proportion exceeds 1%.

82. It is not altogether clear why such variation exists. The provision of parking spaces generally reflects site constraints. Charges are usually higher in London and the South East. Variations in the level of charges or the income raised from parking, however, cannot be fully explained in this way or by demand for spaces. There is some evidence that car park charges in PFI hospitals are higher but the differences are not statistically significant because the comparison is based on a small sample. A more detailed analysis of the information is available in the written evidence.<sup>138</sup>

83. Some hospitals exempt, or offer concessions to, patients and visitors who drive to hospital regularly,<sup>139</sup> but they do not always advertise the fact clearly nor do they make it easy to obtain the concession.<sup>140</sup> Some hospitals make special arrangements for specific types of patients. Contact a Family cited a survey of 67 hospital trusts, of which seven offered free parking and 25 offered concessions to families with sick children.<sup>141</sup> Macmillan's survey showed that 41% of hospitals that charged for parking made exceptions for cancer sufferers.<sup>142</sup>

84. Ministers believe that costs and car parking facilities in English hospitals are acceptable:

137 A full breakdown of this data, from the trusts that responded, is shown in Ev 108–Ev 110 Volume III

138 Ev 159 Volume III (Professor John Mohan)

139 Eg. Gloucestershire Foundation Trust exempts parents staying overnight with children in the children's wards or feeding babies in the Special Care Baby Unit as well as patients having dialysis, radio- or chemotherapy. Addenbrookes in Cambridge has a weekly concession rate for Oncology and Rehabilitation patients of £2.20 and South Tees issues permits for regular patients and visitors at a cost of £13.20 for 3 months. See hospital websites for details

140 Ev 80 Volume II

141 Ev 36 Volume II

142 59% versus 41%, respectively. Ev 51 Volume II

Obviously nothing is ever perfect but I think they are getting it broadly right.<sup>143</sup>

## Assistance with transport costs

### Patients

85. In 2003, the Social Exclusion Unit (SEU) estimated that 1.4 million people each year miss, turn down or choose not to seek healthcare because of transport problems.<sup>144</sup> The report suggested that a poor supply of public and specialist transport, lack of financial support for those on low incomes and the location of healthcare facilities were to blame.

86. Patients with a clear medical need (as authorised by a doctor, nurse or midwife) can use the non-emergency Patient Transport Service (PTS) to get to hospital. Patients on low incomes can get some help with the cost of travelling to hospital to receive consultant-led care from the Hospital Travel Costs Scheme (HTCS).

87. The recent White Paper, *Our health, our care, our say*, announced that the HTCS was to be extended to certain non-hospital settings. However, some witnesses pointed out that there were still shortcomings: for example, initial GP visits are not included and the Patient Transport Service (PTS) is not available for patients seeking healthcare from primary care facilities. Dentistry is also not included under either scheme. Citizens Advice stated:

If the PCTs cannot deliver dentistry in the local community, then at least there should be help through the [HTCS] for people on low incomes who actually have to make journeys of 30 or 50 miles...one of the main reasons people have not been taking up any dentistry that they can get hold of from the NHS [is] that they cannot afford to get there<sup>145</sup>

While the NHS Confederation considers that the HTCS is “widely advertised in the majority of hospitals”, the Socialist Health Association argued that information about the scheme was hard to find.<sup>146</sup> The SEU seemed to agree: it recommended that the Department “develop options” for information and advice on accessing healthcare facilities.<sup>147</sup>

### Hospital visitors

88. There is no financial help for hospital visitors, unlike, for example, prison visitors. Relatives or friends can receive help towards transport costs to visit hospital only through a Social Care Grant, and this is open to those receiving Income Support only, not other types of benefit.<sup>148</sup> According to Citizens Advice:

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143 Q 675 [Jane Kennedy]

144 Chapter 11, Access to Healthcare. *Making the Connections: Final Report on Transport and Social Exclusion*. Office of the Deputy Prime Minister. February 2003

145 Q 222 [Ms Phelps, Citizens Advice]

146 Ev 80 Volume II

147 Chapter 11, Access to Healthcare. *Making the Connections: Final Report on Transport and Social Exclusion*. Office of the Deputy Prime Minister. February 2003

148 Ev 36 Volume II

If you compare that with the Assisted Visitors Scheme for prisoners...they can get help every two weeks for a visit, yet you might have an elderly person who is long-term in hospital and her health is very much affected by the fact that she cannot get visits from her spouse because he cannot afford it. Those are exactly the kind of cases we are getting in bureaux which are really heart-rending.<sup>149</sup>

## Bedside telecommunications

89. A recent chargeable service in the NHS is the provision of bedside television and telephone units. The *NHS Plan* set a target to increase the availability of bedside televisions and telephones in all major hospitals in England by the end of 2004 as part of the Patient Power programme.<sup>150</sup>

90. Several private companies were contracted to supply the telecommunications services<sup>151</sup>; most signed 15-year contracts with the NHS and were given exclusive rights to install, maintain and operate the systems. Under the agreement there was to be no subsidy from the NHS; the system had to be installed for free by providers and paid for by users. The companies were required by the NHS to provide several free services such as radio for all and television for children. The systems were also required to provide internet access and to be capable of calling up the electronic patient record, and sending and receiving information both for patients and professionals. Ten licences were granted after 2000. Private sector investment was approximately £150 million and, by the end of 2004, over 75,000 bedside television/telephone units had been installed in 122 major hospitals and 33 smaller hospitals in England.<sup>152</sup>

91. The range of services and prices differ from provider to provider. Television use costs up to £3.50 per day. Outgoing telephone calls are capped at around 10p per minute. Some companies offer discounts to older patients and long-stay patients; some allow unused credits to be distributed to patients who cannot afford the service.

92. Bedside telephones and televisions are popular with patients. Patientline stated that 10–15 million patients, relatives and friends use the systems each year, with 70% of terminals usually registered as in use by a patient. Half of these terminals incur a charge at any given time (other terminals may be being used by children or adults listening to the radio). We were told by the NHS Confederation that:

The surveys that have been done show that 88% of patients really love these things, and certainly have found the availability of a bedside personal phone of great benefit to them. There is very high patient satisfaction...[high charges are] a problem outside the hospital and for relatives rather than for patients. The patients like it and value it.<sup>153</sup>

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149 Q 222 [Ms Phelps, Citizens Advice]

150 Ev 67 Volume II

151 This is in contrast to other countries. In the US, for instance, hospitals bear the full cost of installation

152 Ev 67 Volume II

153 Q 487

### Ofcom investigation into cost of calls to bedside telephones

An investigation by Ofcom into the cost of inbound telephone calls to hospital patients started in July 2005, following numerous complaints from consumers. It looked at whether the cost of inbound calls was contrary to the Competition Act 1998, as there was no alternative service to the licensed provider. The terms of the investigation were:

- a) whether the agreements that are in place between certain NHS trusts and both Patientline and Premier each infringe the Chapter I prohibition of the Competition Act 1998 (“the Act”) and/or Article 81 of the EC Treaty (anti-competitive agreements); and
- b) whether the prices that Patientline and Premier each charge consumers for making calls to hospital patients each infringe the Chapter II prohibition of the Act and/or Article 82 of the EC Treaty (abuse of a dominant position).

The investigation was completed in January 2006.<sup>154</sup> It revealed that the high prices were a result of “a complex web of Government policy and agreements between the providers and the NHS... and not as a result of unilateral conduct by the providers themselves”. The costs were particularly due to:

- The requirement to install a system at every bedside;
- The requirement to use a combined unit, with the capability of a PC (to bring up the electronic patient record etc);
- The cap on outgoing calls;
- The need to offer free radio and one hour of television to all patients, and to children.

The conclusion of the investigation was:

Ofcom continues to have significant concerns about the level of charges for incoming calls to hospital patients. However, for the reasons set out above, Ofcom has concluded that it would not be appropriate at this stage to continue with the Competition Act investigation....

Concession agreements entered into by the companies with NHS trusts included that mobile telephones would continue to be prohibited within the premises in circumstances “where it is lawful and there is proper reason to do so”. This meant that patients would have little choice but to use the bedside telephone. The investigation noted, however, that in some cases there was evidence that a provider had applied pressure to maintain a total ban on the use of mobile telephones in hospitals, “in an apparent attempt to extend and widen the provision contained in the written agreement”. Ofcom has not yet decided whether an outright ban on mobile telephones would be legal under competition law. David Stewart, Ofcom’s Director of Investigations, commented on the reasons for

<sup>154</sup> Ofcom, *Ofcom Own-initiative investigation into the price of making telephone calls to hospital patients*, A case closure document issued by the Office of Communications, CW/00844/06/05, 18 January 2006

maintaining such a ban:

There are clearly some very important clinical reasons related not only to the need to give patients time undisturbed during their care but also, more recently, with the development of camera phones, some issues around patient privacy.<sup>155</sup>

Ofcom referred the matter back to the Department for an “in-depth review” to examine the “extent to which NHS trusts have made use of the added functionality” of the bedside units installed, the requirement to cap incoming calls at 10p a minute and install units at every bedside, whether “cross-subsidisation across the various services is appropriate or desirable” and why the introductory message cannot be skipped. A Patient Power Review Group has been set up to look at issues relating to the use of telephone and television units in hospitals. The membership and terms of reference of the group were announced on 28 March 2006.<sup>156</sup> It will report later this year.

93. However, incoming calls are a source of anger and distress. They are charged at a very high rate—up to 49p per minute. A recorded message, which cannot be skipped, makes incoming calls even more expensive. This has been the subject of an Ofcom investigation, described in the box above. At the same time restrictions have been placed on the use of mobile phones which may or may not have acceptable clinical or privacy rationales.<sup>157</sup>

94. The cause of these very high charges is the Government’s decision to install bedside units which can be used by health professionals to access the new electronic patient record, allow electronic prescribing, ordering of X-rays, investigations and the patient’s choice of food, patient surveys and provision of information and email services to patients. The private companies believed that they would be able to charge the NHS for additional services the Government insisted on. However, most hospitals have not yet taken up these services, so the company’s means of recouping costs is limited to charges for telephone and television usage. As a result, overall revenues have been lower than expected and charges to users have been very high. Patientline has incurred losses each year of operation, totalling £50 million.<sup>158</sup> Ofcom’s investigation noted the extensive requirements set by the Department, highlighted the initial capital expenditure required of the provider and concluded that the providers were not wholly to blame for the high costs imposed on callers.

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155 Q 534

156 HC Deb, 28 Mar 2006, Col WS71

157 Q 534. David Stewart, from Ofcom, stated, “There are clearly some very important clinical reasons related not only to the need to give patients time undisturbed during their care but also, more recently, with the development of camera phones... There are some good reasons why hospitals should have and do have the right to restrict the use of mobile technology”

158 Ev 67 Volume II

## 6 Alternative charging systems

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95. It is evident that charges cause problems, particularly for those patients on low income who are not exempt. The system of charges and exemptions, particularly as it applies to prescriptions, is full of anomalies. Here we consider the options for change, including:

- Improvements to the current charging system for prescriptions, dentistry and sight tests and non-clinical charges, such as car parking and telephone charges, but with no major changes;
- Modernisation of the list of medical exemptions to prescription charges;
- A major reform of the prescription charge;
- Abolition of charges; and
- Introduction of a different set of charges.

### Improvements to the current regime with no major changes

96. Patients do suffer under the existing system, but there is a case for maintaining it while making a number of relatively minor improvements that would alleviate some of the difficulties and could be implemented quickly. Any major change in the charging system would bring resistance from losers: both those who would have to pay new charges and those who would lose their exemption status. We were informed that improvements could be made in respect of:

- the Prescription Prepayment Certificate;
- dentistry;
- sight tests;
- benefits (for all charges);
- car parking;
- bedside telephones.

Some of these changes, for example to car parking and bedside telephones, could also be made in connection with more substantial reforms discussed later in the chapter.

### *The Prescription Prepayment Certificate*

97. A monthly Prescription Prepayment Certificate (PPC) was proposed at a level of about £10 a month. This change would assist poorer patients who cannot afford the upfront payments for quarterly and annual PPC certificates. In addition, Citizens Advice suggested that patients receiving limited financial help through the NHS Low Income Scheme (LIS)

should be able to buy a reduced price PPC.<sup>159</sup> This would allow those with an HC3 certificate to have reductions in the price of prescriptions. There would be some additional administrative costs associated with introducing a monthly or reduced price PPC and a small loss of revenue in providing a reduced price PPC.

98. An annual cap on prescriptions was proposed by the RPSGB and Dr Harrison from the Kings Fund.<sup>160</sup> Such a system is in place in Sweden, Ireland and Denmark. This proposal would mean that patients need not make the relatively high up-front payment for a PPC. It would also benefit patients who unexpectedly require large numbers of prescribed items. Dr Schafheutle of the DUPP suggested that those with a chronic disease that is normally well-controlled would gain from such a scheme:

For [asthma patients] who are feeling generally well and who pick up their inhalers every six weeks getting a [PPC] is just not worth their while. They do not know when they are going to have an infection that may require antibiotics and when... they may need another course of antibiotics or they may need a course of steroids. These individual charges add up very quickly. There is no way for them to go back and say, "Over the last four months I have paid out far more than this £30".<sup>161</sup>

99. If the annual cap were set at the same level as the annual PPC the cost in terms of lost payments would be small. However, the cap could be difficult to administer. It may require a sophisticated IT system to keep track of payments made, but the NHS IT system is years away from completion. The Swedish system appears to be well-accepted and efficient, but part of the reason it runs so smoothly is because all medicines are dispensed by the same company—the state-owned pharmacy, Apoteket. Pharmacies in this country are owned by many different companies and standardising the systems to accommodate an annual cap could be complicated and costly.

100. In the absence of sophisticated IT, it would be necessary for patients to use the same pharmacist. This would be consistent with the Government's policy of increasing the role of pharmacists in healthcare, laid down in the new pharmacy contract. According to Mr Darracott:

It would seem to be entirely consistent with that policy that people are encouraged to use the same pharmacy over and over again because that is the way the relationship builds up...<sup>162</sup>

Others may not view this possibility so favourably, particularly in a country where people are so mobile.

## **Dentistry**

101. We received little evidence about the level of dental charges for specific treatments. The main exception was the cost of dentures that need to be replaced due to 'wear and

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159 Q 238

160 Qq 165, 204

161 Q 159

162 Q 204

tear'. The cost has fallen since the introduction of the new contract but is still £189 (dentures that are broken are charged at a lower price) which, according to Age Concern, might lead people to hang on to old dentures longer than they should.<sup>163</sup>

102. The main concerns raised about the new contract during our inquiry related to its effect on the amount of NHS work dentists would be willing to undertake and whether there were sufficient incentives in the contract for dentists to undertake preventative work. The two concerns are related: dentists had hoped the new contract would allow them to escape the 'drill and fill treadmill' but claim that it has not; as a result they claim to be disillusioned and inclined to reduce their NHS work. Dentists also note that the price of some preventative treatments, such as applying sealants to rear molars, has increased.

103. To address these concerns dentists want the contract to provide incentives to undertake preventative work such as advice to patients (for example about flossing). Preventative care of this kind should attract specific 'units of dental activity' (the reference for how activity and payment are determined). Preventative work is important and so is a motivated workforce that wants to work for the NHS. It seems only sensible to reward behaviour we want to encourage.

104. However, since the contract only came into force in April 2006, it is difficult as yet to judge its effect. There must be also some scepticism about some of the dentists' claims: is there no time to talk to patients about flossing and even other aspects of oral hygiene during a consultation?

### **Sight tests**

105. Information collected before and after the sight test fee was introduced in 1988 shows that numbers of sight tests carried out fell after the charge was introduced. Moreover, a high percentage of the population do not have regular tests; however, we received little evidence that the cost of such tests deter people from seeking them.

106. Opticians' groups and the Minister thought there were more important priorities, in particular better tests with more emphasis on detecting eye disease and the need to encourage groups at risk of eye disease to undergo sight tests. The new Scottish NHS eye examination is, according to the opticians groups who gave evidence to the Committee, more flexible to the needs of the individual patient and does not necessarily involve refraction tests for spectacles/lenses. The Welsh Eye Care Initiative and Primary Eye Acute Referral Scheme target groups at risk of eye disease and allow rapid referral of specific patients by GPs, respectively.

107. The Committee did not receive information from patient groups or others about these schemes and it is therefore difficult to gauge the benefits (and difficulties) of introducing them to England. The opticians' groups estimated that it would cost £90 million to introduce the Scottish sight test to England. We do not yet know how successful the Scottish test has been in reducing eye disease.

108. While we did not receive many complaints about the cost of sight tests, Citizens Advice was concerned about the cost of glasses, particularly those with complex lenses.<sup>164</sup> The NHS provides vouchers to people on Income Support and the Low Income Scheme, but one-third of opticians do not sell glasses within the voucher value. In rural areas with few opticians, this may present a problem.

109. The Department of Health could encourage or compel opticians to carry a range of spectacles within the maximum NHS voucher value. There would be a number of objections to compulsion, both practical and in principle, not least that some opticians find there is no demand for cheaper glasses.

### **Benefits**

110. Patients not in receipt of Income Support, Income-based Jobseeker's Allowance or Pension Credit but on low incomes may apply for financial assistance with health charges and other costs through the NHS Low Income Scheme (LIS). The application form (the HC1) for the LIS is poorly written and very complicated. A simpler form written in clear English which is easier to fill in would be of great benefit.

111. Citizens Advice argued that there was no need for most patients to complete the HC1 form. It pointed out that those eligible for the LIS could be identified during application for other benefits, such as Incapacity Benefit. Jobcentre Plus increasingly identifies applicants' circumstances and establishes entitlement to benefits through a single telephone call. The LIS could be included:

This would provide an excellent opportunity to identify claimants entitled to help under LIS, as on the one hand much of the information required for the HCI is common to that required for [Income Support or Jobseeker's Allowance], and on the other hand a key group to target is people claiming Incapacity Benefit but not entitled to IS/JSA.<sup>165</sup>

112. This approach would require the Department of Work and Pensions (DWP) to have a key role and the Department of Health and the DWP to work closely together.

113. The Prescription Pricing Authority runs a helpline and encourages doctors' surgeries to carry leaflets containing information on help with health charges. The BDA and RPSGB said their members felt it was their job to ensure patients knew about possible financial assistance. The RPSGB produces a card available at pharmacies to promote knowledge of benefits.

114. Nevertheless, several witnesses, including the Socialist Health Association, Age Concern and professional groups stressed that patients often did not know about their entitlement to assistance with health charges. Ministers agreed that this was the case.

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<sup>164</sup> Q 240, Ev 31 Volume II

<sup>165</sup> Ev 137 Volume III

115. Witnesses suggested that information about assistance with health charges, and exemption from charges, should be better advertised within GP and dental surgeries, pharmacies, opticians and hospitals.<sup>166</sup>

## Transport

### Car Parking

116. There were many complaints about the cost of car-parking. Witnesses made a number of proposals, including nationally imposed limits on charges and concessions to particular groups, such as cancer patients.<sup>167</sup> Some hospitals offer exemption or ‘season tickets’ for frequent attendees to park at a reduced rate; it was suggested that all should be instructed to do so, and to inform patients better of such concessions.

117. Limits to charges would obviously benefit patients. They would also reduce a potential deterrent to increasing use of day treatment and patient choice. On the other hand, revenue forgone by lower charges would have to be found from other sources, either from NHS funds or, if concessions are made for some patients, by increasing charges for others. If NHS funds are spent, other services will have to suffer. To what extent should money spent on care be reduced to lower parking charges?

118. There is also an objection in principle to nationally imposed rules about the cost of car parking. While national guidance on car parking is issued, the Government argues that:

...it is neither practical nor helpful to issue national blanket guidelines on car parking charges on NHS premises setting, for example, maximum levels or requiring free parking to be available for certain categories of user.<sup>168</sup>

The provision of parking spaces and the level of charges is the decision of individual NHS trusts. It is difficult to see how the same regime might apply in Central London and rural Shropshire.

119. Dame Gill Morgan of the NHS Confederation implied that the problem of the high cost of car parking might be eased because trusts would start to build new car parks (for which they would not charge) as a means of attracting patients to particular hospitals just as supermarkets attract shoppers:

If you want to market your hospital the things that patients will go on is accessibility, car parking and availability, and then one or two clinical indicators, but it is the car parking which is the biggest drive....<sup>169</sup>

Knowing they have got guaranteed car parking when they come...is going to be a massive competitive advantage for organisations, much more direct and understandable than any other clinical indicators that hospitals will present.<sup>170</sup>

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166 Q 235

167 Ev 50–59 Volume II [Macmillan]

168 Ev 9 Volume II

169 Q 490

We questioned the Minister, Jane Kennedy, about this possibility. She replied that car parking was, “a service for patients” rather than, “a draw”.<sup>171</sup>

### *Assistance with transport costs*

120. As a result of the poor location of many medical facilities and lack of public transport many patients without access to a car face severe transport problems. Patient choice will require more travel and its transport implications are being examined by the Department. Hospital mergers will also increase the need to travel but the impact of more care in the community may reduce this need for patients.

121. The non-emergency Patient Transport Service (PTS) provides transport to patients unable to reach hospital by other means. It is a slow method of travelling. Macmillan criticised the PTS; it was “unreliable and involves long waits and lengthy ambulance journeys as other patients are picked up or dropped off along the way”.<sup>172</sup>

122. The Hospital Travel Costs Scheme (HTCS) provides financial assistance for patients who do not have a medical need for ambulance transport but who cannot meet the cost of travel to hospital.

123. The recent white paper *Our health, our care, our say*, indicated that the HTCS would be extended to include some primary care facilities, but would exclude dental surgeries and initial appointments with GPs. Witnesses pressed for the speedy implementation of the policy and for extension to a wide range of primary facilities; for example, the scheme should cover eligible patients receiving minor surgery in primary care facilities or those undergoing complex dental work. However, such proposals have financial implications which would be significant if a large range of primary care facilities were included in the HTCS.

124. The NHS Confederation thought more could be done to inform patients about the HTCS.<sup>173</sup> In 2003 the Social Exclusion Unit recommended that the Department “develop options” for information and advice on accessing healthcare facilities, such as a “one-stop shop” for patients (and healthcare staff, welfare organisations etc), to review transport options, and book transport if patients are eligible for help,<sup>174</sup> but its recommendations have not yet been acted upon.

125. Several organisations, including the Disability Alliance, Mind and Citizens Advice, thought it unfair that prison visitors received help with transport costs while those wishing to visit sick relatives did not.<sup>175</sup> Patient escorts may be covered by the existing HTCS, but hospital visitors are not. Money is available through discretionary payments from a Social Fund for certain categories of people such as those visiting their children, or relatives

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170 Q 492

171 Q 677

172 Ev 52 Volume III

173 Q 489

174 Chapter 11, Access to Healthcare, in Office of the Deputy Prime Minister Social Exclusion Unit, *Making the Connections: Final Report on Transport and Social Exclusion*. February 2003

175 Ev 43, Ev 61, Ev 32 all Volume III

receiving long-term care. However, while the costs are a difficulty for some low-income patients, extension of the scheme to cover a large number of visitors would be expensive and might not be the best use of funds.

### **Bedside telephones**

126. The high cost of incoming calls to patients' bedside units was blamed by an Ofcom investigation on a "complex web of Government policy and agreements between the providers and the NHS".<sup>176</sup> Since the providers were not found to be entirely at fault by Ofcom, there is a case for the Department to provide public funds to reduce the costs of calls.

127. Another solution is to make use of the extensive facilities the bedside units can provide. Some hospitals have used the units for more than the provision of telephony, television and radio; this begs the question why others are not following their lead. Patientline told us:

The great opportunity, we believe... is to extend the use of these systems for the purposes for which they were originally designed and selected so that the benefits extend well beyond those of patient entertainment and communication.<sup>177</sup>

This is a desirable solution but the need to generate more revenues should not be the main determinant of whether the additional available facilities are used.

128. It has been suggested that providers had encouraged hospitals to maintain the ban on mobile telephones so that bedside telephones would be used. Ofcom raised the question, but did not draw any conclusions. It is claimed that mobile phones disturb other patients and staff and because of their cameras can breach patients' privacy. On the other hand, in many circumstances the sensible and sensitive use of a mobile phone would inconvenience no one. Should all patients and their friends and relatives suffer because a minority were inconsiderate? We did not receive any evidence that mobile telephones interfere with the operation of medical equipment.

### **Modernisation of the medical exemption list**

129. Many witnesses called for the medical exemption list to be changed to include their particular condition. The many anomalies in the medical exemption list, for example the fact that some individuals with long-term debilitating conditions are exempt while others with equally serious illnesses are not, makes the modernisation of the list an eminently sensible suggestion in principle.

130. There are, however, problems arising from the proposal. The first is, as Department of Health officials told us, "where would you draw the line?".<sup>178</sup> Modernisation of the list of

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<sup>176</sup> Ofcom, *Ofcom Own-initiative investigation into the price of making telephone calls to hospital patients*, A case closure document issued by the Office of Communications, CW/00844/06/05, 18 January 2006

<sup>177</sup> Q 455

<sup>178</sup> Q 35

medical exemptions, while pleasing groups newly included, would doubtless result in a some groups who thought they should be exempt continuing to pay the charge.

131. If most groups with a claim to exemption were included in the list of exemptions, the increase in the number of free prescriptions would lead to a considerable loss of income. Ministers saw this as a powerful reason for leaving well alone. In Wales the likelihood that modernisation would lead to so many exemptions was one of the reasons for the abolition of prescription charges.<sup>179</sup>

132. We tried unsuccessfully to find out what the cost of modernising the list might be. We were told by officials that no large-scale review of the list of conditions exempt from the prescription charge had ever taken place. We asked the Department to estimate the cost of modernisation but we were told that when this had been considered during the 1998 CSR the costs had been difficult to establish.

133. It would be possible to reduce the amount of revenue lost by requiring exempt patients to pay for prescriptions that are not related to the exempted condition. At present, some patients with long term conditions are exempt from paying for any prescription, however unrelated to their long term condition. War disablement pensioners, however, are only exempt for prescriptions related to their disability. It should be possible to extend this to other patient groups although it would be complicated in some cases (for instance, diabetics are more likely to suffer other conditions such as hypertension and it would be difficult to distinguish between medicines that treat the main condition and those for unrelated illnesses).

## A major reform of the prescription charge

### *A lower charge with fewer exemptions*

134. Another option would be to make more radical changes to the prescription charge. One possibility, recommended by our predecessor Committee in 1994, is “a lower charge and fewer categories of exemption”.<sup>180</sup> A lower charge would be of particular help to those poorer working people who currently pay for their prescriptions. The amount of revenue raised would depend on the level of the charge and the extent of exemptions. Sweden, for example, has virtually no exemptions to charges for prescriptions.<sup>181</sup>

135. The Social Market Foundation proposed ending exemptions for expectant and nursing mothers and older adults who are not on low incomes. It stated:

Older people who can afford it are expected to pay a proportion towards the costs of their social care, so it seems illogical that prescription costs are excluded.<sup>182</sup>

This principle could be extended so that the only exemptions were income-related.

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179 See Annex 1

180 Health Committee, Second Report of Session 1993-1994, *Priority Setting in the NHS: The NHS Drugs Budget*, HC 80-I

181 See Annex 2

182 Ev 83 Volume II

136. In its written evidence the BMA suggested the removal of all exemptions and the introduction of a low flat-rate fee. It argued that such a low fee was unlikely to prevent anyone from seeking healthcare or obtaining prescription items:

... for example a £1 payment that every patient would pay per prescription or item, with no exceptions. This might mitigate against inappropriate use of the exemption status (ie: for over the counter medicines) but be low enough to ensure that those on low incomes or on multiple medication could still afford it.<sup>183</sup>

137. Such a system would also increase the revenue to the Exchequer. As part of the 1998 Comprehensive Spending Review, the Department investigated a flat-rate charge of £1 with no exemptions. It found that this would produce an extra £120 million in revenue. In 2004, 686 million prescribed items were dispensed<sup>184</sup>; a charge of £1 per item would therefore raise £686 million (currently £427 million is raised), if no exemptions were made. If children were exempted, income would drop by around £42 million since 6% of prescribed items are for children.

138. There is likely to be opposition to these proposals from groups that are currently exempt. Witnesses raised other concerns. Dr Harrison of the Kings Fund thought they would be complicated and expensive to administer, although this seems unlikely given that the system would in principle be the same as that currently in use. It is possible that even a low charge of £1 might deter some people and be a hardship for those on low incomes.

### Reference pricing

139. The Social Market Foundation proposed a new system for prescription charges, “which would link the charge to the therapeutic value of the medicine”.<sup>185</sup> One way of doing this would be to introduce reference pricing, whereby patients are charged different fees according to which medicine they choose to use within a specific drug class.

140. Under such a system, one medicine within a given class is designated as the most suitable—using both clinical and cost-effectiveness measures—and is used as a reference. The cost of this drug is automatically covered by any co-payment scheme. If patients decide to use a different, more expensive, medicine, they pay the difference in cost. If a clinician judges that the reference drug is unsuitable, the patient may receive a more costly alternative at no extra charge.

141. Such schemes are in place in Denmark, Finland and parts of Canada and have been shown to reduce costs without any negative effect on health.<sup>186</sup> According to Profs Light and Lexchin, reference pricing,

...encourage[s] patients to use the most cost-effective drug available for their condition... Thus co-pays serve to keep overall costs down, yet support clinically appropriate prescribing.<sup>187</sup>

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183 Ev 28 Volume II

184 Department of Health 2004. *Prescription Cost Analysis*, England

185 Ev 83 Volume II

186 Ev 95 Volume II

142. We received little evidence on the subject of reference-pricing but it seems likely that it would be complicated to administer and would require work to determine which drug should be the reference and on what basis, and at what level, alternative medicines should be charged.

### Abolition of charges

143. A simpler proposal, which was the preferred option of several witnesses, is the abolition of health charges. Abolition would ensure that no one was deterred from seeking treatment. It was, furthermore, argued that it was illogical to charge people for drugs, dental protection and eye tests when other medical procedures are free.<sup>188</sup>

144. Witnesses pointed out that the reasons for charges are historical, as officials from the Department of Health admitted. If we did not have the present system of charges we would not introduce it now. Age Concern told us:

...the only rationale [for the fact that older people pay for dentistry] offered in the recent Department of Health consultation on dental fees was that there have been dental charges in place since 1951—that is usually the argument made for change and modernisation.<sup>189</sup>

145. The arguments put against abolition were as follows. First, the abolition of all health charges should not be seen as a cure-all for the current problems; more people might go to the dentist and the optician, but it is far from clear that charges are the main reason why large numbers of people do not regularly visit them now. Secondly, it is likely that demand would rise following abolition and some of the increased demand might be “extravagant”, in the words of Attlee. If all charges were abolished, it might be necessary to introduce some other way of restricting demand, particularly for prescriptions. Finally and most importantly, if all charges were abolished, an extra £1 billion would be required for the NHS budget; if demand rose following abolition, as might be expected given the experience in Italy, the cost could be significantly greater. Even if £1 billion could be afforded, should it be a priority?

146. Could there be a way of off-setting the lost revenue? There is, as we have seen, anecdotal evidence that doctors too readily prescribe OTC medicines to patients who get free prescriptions and do not always prescribe the cheapest, most effective drug.<sup>190</sup> The introduction of a limited formulary listing which medicines can be prescribed routinely for which conditions could address this problem. Formularies are used effectively in hospitals and a formulary for general practitioners is being developed in Wales. Such a system would curtail the prescription of drugs that are available cheaply from pharmacists. Ministers were interested in this possibility; Jane Kennedy said she wanted to consider the idea:

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187 Ev 94 Volume II

188 Qq 213, 255

189 Ev 11 Volume II

190 But we do not know how extensive this problem is

I want to give some thought to what you are saying. It would be quite a major step...It would be interesting to see if the Welsh Assembly finally does take that step.<sup>191</sup>

147. A limited NHS formulary could also be combined with a system of reference pricing, as described in the previous section. Such a scheme is in place in Australia, where the state pays the cost of medicines listed on an agreed formulary minus a contribution from patients.<sup>192</sup> Medicines included in this formulary have been considered according to effectiveness and cost and have been compared to other available therapies. Patients who want, for example, branded rather than generic drugs can obtain them, but must pay the difference in price.<sup>193</sup> Local examples of formularies exist in England; a good example is in place at University College London Hospitals trust, where medicines are included on the list only after information on drug efficacy, safety and cost are considered by a dedicated committee.<sup>194</sup> If well organised and regularly revised, such a formulary would encourage prescription of the best medicines, in terms of both clinical and cost-effectiveness. Ensuring that the list remain current would be a challenge, however.

### Introduction of a different set of charges

148. A further option is to abolish some or all existing charges but replace them with a new set of charges. Ideally such charges would encourage desirable behaviour and not deter people from seeking treatment as the present system does. Professor Smith, of York University, sent us a memorandum arguing for a major reform. His proposals were:

- The establishment of a set of core NHS treatments to be provided for free;
- A number of additional treatments which are not considered clinically necessary which patients would pay for in whole or in part;
- Levying small ‘user’ charges on a range of services which the NHS provides which would reduce excessive demand for health services; the aim would be to choose charges which did not deter patients from seeking treatment when it was appropriate.

149. Professor Smith argued that some degree of healthcare rationing was inevitable. He proposed the provision of a “core package” of essential care free of charge to everyone. ‘Extra’ services would then be defined and charges levied for these procedures or treatments:

The central policy problem is to decide which health care technologies should be subsidized from public funds. User charges policy then flows naturally from the

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191 Qq 575–576

192 Most people pay a charge of up to £11.90 and ‘concession card’ holders (mainly those on low incomes) pay approximately £1.90. See [www.health.gov.au](http://www.health.gov.au) for details

193 See [www.health.gov.au](http://www.health.gov.au) for details

194 See page 42. Health Committee, Fourth Report of Session 2004–05, *The Influence of the Pharmaceutical Industry*, HC 42–I

choice of the subsidized treatments. Once the ‘public’ package of care is chosen, patients would still be free to purchase the remaining unsubsidized interventions.<sup>195</sup>

The private sector, as well as the NHS, could provide services that are additional to core clinical treatment for a fee. This already happens for treatment no longer available on the NHS, such as the cosmetic procedures performed by the Foundation Skin Clinic in Harrogate. Simplyhealth stated:

...there are no markets or services of any kind in any area of our lives where we can all have the very best of everything all the time, how and where we want it. This is not the case with food or shelter or education. It is unreasonable therefore to expect it of healthcare, it is not possible.<sup>196</sup>

150. Ministers may be considering something similar. At a meeting of the Liaison Committee last year, the Prime Minister suggested that co-payments in certain non-core areas of public services should be looked at.<sup>197</sup> Jane Kennedy told us that although she was opposed to healthcare rationing:

What we have been discussing this morning is where on the edge of that definition it might be possible for NHS organisations and others, and indeed the state, to raise resources by charging. That is the debate that we are having today and we will continue to have, I am sure.<sup>198</sup>

151. A range of charges are employed in other European countries to promote the better use of services. In Sweden, patients are charged for each outpatient visit (to a nurse, GP or specialist, and for each visit to A&E), and pay a ‘hotel’ charge for inpatient stays. Patients are encouraged to visit the appropriate healthcare professional by different levels of charges; thus, it costs less to see a nurse than a consultant and therefore patients are less likely to use the services of a specialist in the first instance. Patients pay around £6 to see a nurse, £9–10 to see a GP and £17–20 to see a specialist. It costs about £10 to go to A&E. Swedish patients also pay for dentistry and medication.

152. There are few exemptions to charges. Instead, expense is mitigated by the use of an annual cap on payment for outpatient care, and pharmaceuticals. The annual cost ceiling is £66 for outpatient care. Inpatient care is capped at £6 per day, but there is no annual limit. For medicines, each patient (or all the children in a family together) does not pay more than £134 per year. Co-payments have been in place in Sweden since the 1970s and generate approximately 3% of total healthcare resources.

195 Ev 157 Volume III

196 Ev 139 Volume III

197 Oral Evidence taken before the Liaison Committee on Tuesday 3 February 2004, Q 140

Mr McFall: ...Could I ask you the general question: are higher user fees going to have to make a major contribution to increasing funding for public services from now on?

Mr Blair: ...No, in the sense that those that are funded by general taxation, the schools and the National Health Service, will continue to be so. However, on the other hand, our tuition fee policy is an example. Congestion charging is another example. I think there is an issue for the long term about how—not for those, as I say, core public services that have traditionally been funded under general taxation but for other issues, like skills—we look at issues to do with co-payment

198 Q 702

153. There are similar charges in the rest of Europe. In Germany, from 2004, there has been a €10 charge for the first appointment with a doctor in each three month period, up to an income-related maximum. In France, from January 2005, patients have been charged €1 for each consultation, intervention and test. French adults not suffering a long term illness are charged a fee for consulting a specialist without the endorsement of a ‘gatekeeper’ physician. Introducing a charge of £1 to see a GP here would raise £200 million, in gross terms, if appointment rates remained stable.<sup>199</sup>

154. Establishing a core package of free NHS services and adopting a “European” system of charges of the type used in Sweden (including access charges and hotel charges) would have advantages. It is better to be clear about what is funded for free and what is not. Otherwise, according to Professor Smith, it is probable that we will have to:

...reduce the scope and quality of the NHS by stealth, and reduce the widespread support for tax funding of the NHS, an outcome that cannot be to the general public good.<sup>200</sup>

155. “European” style charges could persuade patients to use the NHS more appropriately. Every year, 15 million GP and practice nurse appointments are missed and patients do not attend one in 10 hospital appointments.<sup>201</sup> Missed GP appointments cost the NHS over £162 million annually<sup>202</sup> and missed hospital appointments cost £680 million.<sup>203</sup> A survey of 683 GP surgeries by the group Developing Patient Partnerships (DPP) found that two-thirds of respondents would support charging patients who did not attend or cancel their appointment.<sup>204</sup>

156. If charges of this type were introduced it would be possible to abolish existing charges on medicines and dentistry and make sight tests free. Thus charges which discouraged bad behaviour (failing to turn up for appointments) would replace the current charges on medicines, dentistry and sight tests which adversely affect healthcare.

157. On the other hand, the introduction of “European” style charges would also have disadvantages:

- major changes would be made to raise what is in the context of the total NHS budget a relatively small sum;
- they could be complicated and costly to administer; and
- they could put people on low incomes off seeking healthcare.

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199 Source: House of Commons Library. Not printed

200 Ev 158 Volume III

201 Research conducted in 2004 by the Institute of Healthcare Management and the charity Developing Patient Partnerships

202 Institute of Healthcare Management, 2004

203 Source: Grant Shapps MP. Full data not printed. Reported in the *Daily Telegraph*, 8 May 2006

204 DPP survey data from GP practices throughout the UK, August 2005. 683 practices were included in the survey; there was no indication of which staff members responded

158. If the aim of the new charges is to replace all existing charges, they will need to raise £1billion net which is only a little more than 1% of the NHS budget. Is it worth a radical overhaul with all the disruption involved for such a sum? Modest access charges would be unlikely to bring in large sums: Swedish charges raise 3% of the budget but that includes charges for pharmaceuticals.

159. A new system of charges would require hospitals and GPs' practices to collect access and hotel charges. We were told that collection is straightforward and causes few difficulties in Sweden, but is unlikely to be as easy in England. In Sweden, the system is well-established; here it would be new and it is likely that neither hospitals nor GPs would welcome having to collect the charges. We were told that in Sweden patients were sent a bill for their time in hospital and pay it. A similar response could not necessarily be expected in England.

160. Even in Sweden charges create some problems for those on low incomes. Charges to see clinicians discourage some people from seeking health advice or treatment. A recent large-scale study showed that of Swedish people with "financial difficulties", over one-third refrained from seeing a doctor compared to around 10% of the group as a whole.<sup>205</sup> A survey by the Swedish National Board of Health & Welfare in 1999 found that around 3% of the Swedish population avoided using healthcare due to charges. The figure would probably be higher in England since the same survey concluded that 4% of Swedes did not fill prescriptions or buy medicines, and 15% did not seek dental care<sup>206</sup> whereas the comparable English figures are 6% and 24%.

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205 This study included 70,000 participants and was conducted by the Swedish National Institute of Public Health

206 Swedish National Board of Health & Welfare, 1999. These are only lower than in England, where 6% of patients do not fill prescriptions and 24% do not seek dental care for financial reasons

## 7 Conclusions

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161. The current system of NHS charges is a mess. In the words of Lord Lipsey of the Social Market Foundation it is “a dog’s dinner”. There are no comprehensible underlying principles to health charges. Age and income exempt some people, but this does not apply across the board. Pensioners are exempt from prescription and sight test charges, regardless of their income, but must pay for dentistry unless they receive help through the NHS Low Income Scheme. People with diabetes who require insulin receive free medicines for all conditions while people with diabetes controlled by diet must pay for all their medication.

162. Rather than improving health, charges deter some patients from seeking and obtaining care and can have a negative effect on health outcomes. Charges aim to reduce excessive or unnecessary demand for healthcare services, but separating the demand that is necessary from that which is deemed unnecessary is no mean feat. As Dr Harrison of the Kings Fund said:

The general evidence...suggests that both are affected by charges. So charges do not distinguish between frivolous or inappropriate or unnecessary use; they are too blunt an instrument to do that.<sup>207</sup>

163. It is clear that the system needs to be reviewed. However, even after over 50 years of operation, there is a woeful absence of evidence about the effects of charges. It is known that harmful effects occur but they are largely unquantified. Similarly, we do not know what the consequences would be of making the changes to the charging system which we examined in the previous chapter. Accordingly, it is difficult at this stage to decide what should be done. **We recommend that evidence is gathered on:**

- **public attitudes to health charges,**
- **the extent to which charges affect the use of health services and, in the long term, health,**
- **the extent to which charges reduce ‘frivolous’ demand.**

Nevertheless there are a number of short-term changes that should be implemented immediately to improve the situation.

### Prescription Pre-payment Certificate

164. Changes to the Prescription Pre-payment Certificate (PPC) should be made to help patients on low incomes. Take-up of the PPC is low. **We recommend the immediate introduction of a monthly Prescription Pre-payment Certificate (PPC). We also recommend that the annual certificate be pegged at the cost of 12 times the price of a single prescription. The monthly certificate should be pegged at the cost of one prescription.** Those patients on the NHS Low Income Scheme should have access to the

same benefits as all other patients. **We recommend that a reduced price PPC be introduced for those receiving limited help through the NHS Low Income Scheme.**

165. **Once the NHS IT system is in place, we recommend that the Government consider introducing a yearly cap on payment for medicines, as is in place in Sweden.** Such a development would mean that the PPC was no longer necessary. It would allow those who unexpectedly require many prescriptions within a short space of time to benefit in the same way as those who currently purchase a PPC in advance.

## Dentistry

166. There are fears that the new dental contract will discourage preventative care, and that the numbers of people receiving NHS dental care will fall. The contract has not been in place long enough for an assessment of these fears. **Concerns have been raised that the new dental contract may lead to some serious problems for dentists and for patients in the future. We recommend that the Department of Health after one year institutes a review to report on the effects of the new contract:**

- on patient access and care, including prevention; and
- on NHS dentist numbers and recruitment, their salaries, workload and how many signed the new contract ‘in dispute’ and how these disputes were resolved.

## Sight tests

167. It is unacceptable that one-third of opticians do not sell spectacles within the NHS voucher value. **We recommend that, as part of the General Ophthalmic Services contract negotiations, the Department of Health require all opticians practices to carry a range of spectacles within the maximum NHS voucher value.**

168. During the inquiry witnesses expressed concern that too many people at risk of eye disease were not having sight tests. **We recommend that the Department increase efforts to target people at risk of eye disease. All young children should be fully screened for visual impairment. The Department should look at eye examination schemes in place elsewhere in the UK with a view to implementing them in England.**

## Benefits and information to patients

169. Information to patients about health charges is poor and, as the Minister admitted, many people do not claim the benefits to which they are entitled in respect of health charges. It is thought that better information would improve this situation. **We recommend that that all pharmacies, hospitals, and GP and dental surgeries make available to patients information on charges to which they might be liable, eligibility for exemption, and possible assistance with costs associated with attending for treatment.**

170. The form which patients have to fill in to claim help through the NHS Low Income Scheme is lengthy and incomprehensible. **We recommend the HC1 form should immediately be re-written in clear English.** The form is often completed by patients already receiving other benefits. It could be avoided altogether if eligible patients were

identified when applying for these benefits. **We recommend that the Department of Health and the Department of Work and Pensions work together to find ways of automatically extending health charge exemption from means-tested benefits so that the HC1 form can be abolished.**

## Transport

171. For a variety of reasons patients now have to travel further and to less accessible locations than in the past. As a result the cost and inconvenience of travel have become increasingly important to patients and to their families and friends.

172. Many patients are unaware of the transport schemes available, or find it hard to access those schemes. **We recommend that the Hospital Travel Costs Scheme be extended to cover patients attending for treatment at primary care facilities, in accordance with *Our health, our care, our say*. Consideration should be given to including dental surgeries under the scheme where patients have to travel considerable distances to access care. Information provision on the HTCS and the Patient Transport Service should be improved to increase uptake of the schemes.**

173. The friends and families of hospital patients often are unable to visit due to the cost of transport. While it would be impossible to extend the Hospital Travel Costs Scheme to all hospital visitors, there are some groups who would benefit significantly from such an extension. Prisoners' families receive financial assistance to visit those in custody; we suggest that a similar system should be in place for low-income visitors to specific groups of hospital patients. **We recommend that the Government consider extending the Hospital Travel Costs Scheme to some hospital visitors on low incomes (for example, to those visiting long-stay mentally ill patients for whom it may be particularly important to maintain links with family and friends).**

174. The provision of parking spaces and the level of charges should remain a matter for individual NHS trusts to decide upon according to local circumstances. However, allowances should be made for frequent attendees. **We recommend that the guidance on car parking arrangements be reissued by the Department of Health. It should recommend that trusts:**

- **issue all regular patients, or their visitors, with a 'season ticket' that allows them reduced price, or free, parking;**
- **introduce a weekly cap on parking charges for patients;**
- **provide free parking for patients who have to attend on a daily basis for treatment; and**
- **inform patients before their treatment begins of the parking charges, exemptions and reduced rates that will apply.**

## Bedside telephone charges

175. The cost of incoming calls to hospital bedside telephones is unacceptable, but the providers are not wholly responsible for the problem. Ofcom described the high prices of

inbound calls as, “a result of a complex web of Government policy and agreements between the providers and the NHS...and not as a result of unilateral conduct by the providers themselves.”<sup>208</sup> **We recommend that urgent consideration be given to short-term measures that could be taken to reduce the costs, such as shortening the recorded message and making it avoidable. In the longer term, we recommend that hospitals should make greater use of the bedside units as soon as possible, since this would reduce the costs of incoming calls. It is an utter waste for these units, which could contribute significantly to the transfer of information within hospitals, to be used as little more than glorified telephones and televisions. If the NHS cannot make use of the additional services in the near future, the Department should pay the difference in cost between the standard rate and the amount charged by the companies. Patients’ relatives and friends should not be penalised for the Department’s failings.**

176. We are not convinced that the ban on mobile telephones in hospitals is solely a result of possible interference with medical equipment. If used sensitively, mobile telephones will not compromise patient care. **We recommend that, provided they do so sensitively, patients and their visitors should be able to use mobile telephones within certain areas of hospitals.**

### Longer-term changes

177. The minor recommendations detailed above will lead to small improvements for patients, but will not address the fundamental problems in the current system of health charges. We have examined a number of options in Chapter 6 of this report, and have outlined the positive and negative consequences of several alternative charging systems. It is clear and has been a constant theme of our inquiry that the evidence is not sufficient to reach a conclusion regarding a better system. Little work has been done in this country on the costs or benefits of the different possible systems. This work needs to be done urgently so that an alternative charging system, with consistent underlying principles, can be developed. **We recommend that the Government establish a review to examine the costs and benefits of the following:**

- **abolishing all the existing health charges;**
- **abolishing only the prescription charge;**
- **abolishing only charges for initial consultation and diagnosis, such as dental check-ups and eye tests;**
- **establishing a system of reference pricing for medicines;**
- **completely revising the list of medical exemptions to the prescription charge;**
- **introducing a flat-rate prescription charge with no exemptions; and**
- **basing exemption to charges solely on income so that those who can afford to pay for their prescriptions, dental care and sight tests do so.**

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208 Letter from Ofcom to Secretary of State for Health, 17 January 2006

The terms of reference and results of the review should be published.

**178. The use of a limited NHS formulary of medicines, possibly linked to reference pricing, could reduce the drugs bill and improve prescribing practice. We recommend that the Government look at this and respond to us specifically on this matter.**

179. In the future, the NHS may not be able to pay for every possible medical treatment in a country with an ageing population, demographic pressures, rising public expectations and increased possibilities of medical treatment and long-term therapies. Some treatments or procedures may have to be charged for. The Government should consider this possibility sooner rather than later to ensure that a set of consistent criteria apply to those areas for which a fee is charged, to avoid the development of charges in an ad hoc way, as has been the case until now. With the introduction of such a system, it may be possible to abolish health charges which currently have a negative effect on health outcomes. **We need to assess the challenge now and avoid the risk of new charges being introduced in an ad hoc way, as they have in the past. The Government should review the costs and benefits of an alternative system of health charges. The key principles that should be considered in this review are:**

- **services that are clinically necessary should be free;**
- **fees should not deter patients visiting their doctor or accessing healthcare; and**
- **any system chosen should be adaptable (to changing medical practice, treatments etc) and consistent.**

The review should include:

- **the possibility of establishing a package of core services which would be free (these might include prescriptions and dental care); and**
- **a set of treatments for which the NHS could charge.**

Treatments/interventions that are not cost-effective, such as branded drugs where an effective generic exists, could be subject to a charge. The use of charges to promote more responsible use of services could also be considered, including:

- **the introduction of a small charge for non-emergency patients presenting to A&E. This would encourage people to register with a GP, and make better use of out-of-hours services; and**
- **a fee for patients who do not attend or fail to cancel GP or hospital appointments.**

## Conclusions and recommendations

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1. The dermatology clinic in Harrogate and the Jentle Midwifery scheme in London differ significantly. The former involves charging for purely cosmetic procedures while the latter charges a fee for services that should be available, according to the National Service Framework on maternity services, as standard. The Jentle Midwifery scheme provides cut-rate private care within an NHS hospital. This is unacceptable. Essential care of this type should be given to all or paid for privately at full cost. (Paragraph 53)
2. The Government claims that its exemptions policy is based on income: those who can afford to pay, those who cannot do not. However, this is not the case: many wealthy people are exempt, but many poor working people are not. The exempt medical conditions have not been revised for almost 30 years, creating many anomalies. It is evident that Government policy is to maintain the status quo and not to upset any existing beneficiaries. (Paragraph 74)
3. We recommend that evidence is gathered on:
  - public attitudes to health charges,
  - the extent to which charges affect the use of health services and, in the long term, health,
  - the extent to which charges reduce ‘frivolous’ demand. (Paragraph 163)
4. We recommend the immediate introduction of a monthly Prescription Pre-payment Certificate (PPC). We also recommend that the annual certificate be pegged at the cost of 12 times the price of a single prescription. The monthly certificate should be pegged at the cost of one prescription. (Paragraph 164)
5. We recommend that a reduced price PPC be introduced for those receiving limited help through the NHS Low Income Scheme. (Paragraph 164)
6. Once the NHS IT system is in place, we recommend that the Government consider introducing a yearly cap on payment for medicines, as is in place in Sweden. (Paragraph 165)
7. We recommend that the Department of Health after one year institutes a review to report on the effects of the new (dental) contract:
  - on patient access and care, including prevention; and
  - on NHS dentist numbers and recruitment, their salaries, workload and how many signed the new contract ‘in dispute’ and how these disputes were resolved. (Paragraph 166)
8. We recommend that, as part of the General Ophthalmic Services contract negotiations, the Department of Health require all opticians practices to carry a range of spectacles within the maximum NHS voucher value. (Paragraph 167)

9. We recommend that the Department increase efforts to target people at risk of eye disease. All young children should be fully screened for visual impairment. The Department should look at eye examination schemes in place elsewhere in the UK with a view to implementing them in England. (Paragraph 168)
10. We recommend that that all pharmacies, hospitals, and GP and dental surgeries make available to patients information on charges to which they might be liable, eligibility for exemption, and possible assistance with costs associated with attending for treatment. (Paragraph 169)
11. We recommend the HC1 form should immediately be re-written in clear English. (Paragraph 170)
12. We recommend that the Department of Health and the Department of Work and Pensions work together to find ways of automatically extending health charge exemption from means-tested benefits so that the HC1 form can be abolished. (Paragraph 170)
13. We recommend that the Hospital Travel Costs Scheme be extended to cover patients attending for treatment at primary care facilities, in accordance with *Our health, our care, our say*. Consideration should be given to including dental surgeries under the scheme where patients have to travel considerable distances to access care. Information provision on the HTCS and the Patient Transport Service should be improved to increase uptake of the schemes. (Paragraph 172)
14. We recommend that the Government consider extending the Hospital Travel Costs Scheme to some hospital visitors on low incomes (for example, to those visiting long-stay mentally ill patients for whom it may be particularly important to maintain links with family and friends). (Paragraph 173)
15. We recommend that the guidance on car parking arrangements be reissued by the Department of Health. It should recommend that trusts:
  - issue all regular patients, or their visitors, with a ‘season ticket’ that allows them reduced price, or free, parking;
  - introduce a weekly cap on parking charges for patients;
  - provide free parking for patients who have to attend on a daily basis for treatment; and
  - inform patients before their treatment begins of the parking charges, exemptions and reduced rates that will apply. (Paragraph 174)
16. We recommend that urgent consideration be given to short-term measures that could be taken to reduce the costs of calls to bedside telephones, such as shortening the recorded message and making it avoidable. In the longer term, we recommend that hospitals should make greater use of the bedside units as soon as possible, since this would reduce the costs of incoming calls. It is an utter waste for these units, which could contribute significantly to the transfer of information within hospitals, to be used as little more than glorified telephones and televisions. If the NHS cannot

make use of the additional services in the near future, the Department should pay the difference in cost between the standard rate and the amount charged by the companies. Patients' relatives and friends should not be penalised for the Department's failings. (Paragraph 175)

17. We recommend that, provided they do so sensitively, patients and their visitors should be able to use mobile telephones within certain areas of hospitals. (Paragraph 176)
18. We recommend that the Government establish a review to examine the costs and benefits of the following:
  - abolishing all the existing health charges;
  - abolishing only the prescription charge;
  - abolishing only charges for initial consultation and diagnosis, such as dental check-ups and eye tests;
  - establishing a system of reference pricing for medicines;
  - completely revising the list of medical exemptions to the prescription charge;
  - introducing a flat-rate prescription charge with no exemptions; and
  - basing exemption to charges solely on income so that those who can afford to pay for their prescriptions, dental care and sight tests do so. (Paragraph 177)
19. The terms of reference and results of the review should be published. (Paragraph 177)
20. The use of a limited NHS formulary of medicines, possibly linked to reference pricing, could reduce the drugs bill and improve prescribing practice. We recommend that the Government look at this and respond to us specifically on this matter. (Paragraph 178)
21. We need to avoid the risk of new charges being introduced in an ad hoc way, as they have in the past. The Government should review the costs and benefits of an alternative system of health charges. The key principles that should be considered in this review are:
  - services that are clinically necessary should be free;
  - fees should not deter patients visiting their doctor or accessing healthcare; and
  - any system chosen should be adaptable (to changing medical practice, treatments etc) and consistent. (Paragraph 179)

22. The review should include:

- the possibility of establishing a package of core services which would be free (these might include prescriptions and dental care);
- a set of treatments for which the NHS could charge;

Treatments/interventions that are not cost-effective, such as branded drugs where an effective generic exists, could be subject to a charge. The use of charges to promote more responsible use of services could also be considered, including:

- the introduction of a small charge for non-emergency patients presenting to A&E. This would encourage people to register with a GP, and make better use of out-of-hours services; and
- a fee for patients who do not attend or fail to cancel GP or hospital appointments. (Paragraph 179)

## Annex 1: Health Committee visit to Wales

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8 February 2006

### *Meeting with Dr Brian Gibbons, Minister for Health and Social Services*

The Minister discussed the abolition of the prescription charge in Wales and a number of areas of relevance to the NHS Charges inquiry.

#### *Prescriptions*

Abolition of the prescription charge was a manifesto commitment, and was not backed up by a significant body of evidence.

A phased approach was taken to ensure affordability and allow health officials to identify and manage the effects of abolition on patient behaviour. The charge is currently £4 per item but is due to drop to £3 in April 2006. It will be abolished in 2007. No change in patient behaviour has been observed to date, but the Minister reported that modellers expect a change with the upcoming fall in price, such as increased demand for medicines, and patients seeking prescriptions for over-the-counter (OTC) drugs.

Changes to the exemption list had Lib-Dem support but it was decided to “keep it clean and simple” and abolish the charge altogether.

The First Minister was reportedly keen on abolishing the prescription charge in order to remove a disincentive for patients to return to work.

#### *Dentistry*

More people are registered with an NHS dentist in Wales (55-60%) compared to England (48%), with figures approaching 75% in Swansea.

The dental contract in Wales is similar to the English version, but the band levels are lower. A note subsequently provided by the Minister’s office detailed the main differences between the new English and Welsh dental contracts:

The main differences are as follows:

- Over the course of a year dentists will be expected to provide a certain number of courses of treatment weighted by their complexity. However, this will be 10% fewer (5% in England) than the courses of treatment carried out in the test period, while the dentist will still receive 100% value of the contract. There is also a tolerance level of 5% in Wales (4% in England) associated with the level of activity before this triggers a discussion between the dentist and the Local Health Board.
- Additional differences in Wales are the way in which Vocational Training and Clinical Audit and Peer Review will be handled and it is the intention that it will remain centrally funded and administered in Wales and not form part of the new dental contract value as proposed in England. This has the full support of the Welsh Central

Assessment Panel, the Welsh General Practitioner Committee, and the Department of Dental Postgraduate Education.

### *Dental Charges*

The new dental charge band levels in Wales (English levels in brackets) are:

Band 1 – £12.00 (£15.50)

Band 2 – £39.00 (£42.40)

Band 3 – £177.00 (£189.00)

Current differences between Wales and England in the categories of patients' exempt from dental charges will continue as now i.e. those under 25 years of age and 60 and over are entitled to a free check up in Wales but not in England.

### *Eye tests*

Some ophthalmic initiatives have been introduced in Wales:

- Wales Eye Initiative—screening of at-risk groups, such as those with sight in only one eye, those with retinitis pigmentosa and people whose family origins are Black African, Black Caribbean, Indian, Pakistani and Bangladeshi
- Primary Eye Acute Referral Scheme—this scheme allows rapid referral of specific patients by GPs.

Exemptions to the sight test charge are more generous than in England (under-25s are exempt, as for dental charges and the prescription charge), but there are no eye tests in schools.

### *Other considerations—parking, bedside telephones*

A similar situation to that of England is in place for car parking, in that each Trust must make its own arrangements. There is also a similar situation for bedside telephones.

The Minister felt that additional help for people visiting patients in hospital was unlikely.

### *Meeting with ex-chairs of Health and Social Services Committee*

The Chairman and Dr Taylor met with Kirsty Williams (Lib-Dem, Chair 2001–03), David Melding (Conservative, Chair 2003–05) and Rhodri Glyn Thomas (Plaid Cymru, Chair 2005–date)

### *The prescription charge*

Revision of the list of medical exemptions for the prescription charge was suggested in a motion put forward by the Liberal Democrats. Ms Williams admitted that a revised list might significantly increase the number of exemptions. She thought that the Labour party had decided to trump her proposals for a revised list by proposing total abolition.

Mr Morgan said Plaid Cymru supported extension of the list but not total abolition of the charge. Mr Melding stated that those with an adequate income should pay for their prescriptions, and that the exemption list should have been expanded. He did not believe that abolishing the prescription charge was worth the cost.

There was reportedly no debate on the funding needed to cover abolishing the prescription charge. The move was funded by the Welsh Assembly Government (WAG) as a whole. The move will cost £32 million, which represents 10–15% of the total drugs budget. A nominal charge per prescription was not considered.

Mr Morgan stressed that chronic illness impacts on earning ability and that individuals need to be protected from perverse incentives against returning to work after illness. The cost of prescriptions make a big difference to those on low incomes and workers have to pay the charge while the unemployed, or those unable to work due to incapacity, are more likely to receive free prescriptions. He added that levels of illnesses such as asthma and chronic obstructive pulmonary disease are much higher in Wales than elsewhere in the UK.

The current and ex-Chairs agreed that the evidence base for abolition of the prescription charge was very weak, and that little was known about the possible health benefits. Ms Williams, Mr Melding and Mr Morgan all expressed concerns relating to how the situation will be monitored, the possible increase in demand for prescriptions for OTC medicines, and the “hassle” that GPs may face as a result.

“Health tourism”, whereby English patients try to have their prescriptions dispensed in Wales to avoid the prescription charge, is not a major problem yet.

### *Dental and ophthalmic issues*

Both the Tory and Lib-Dem Members said they would rationalise those eligible for NHS dental care, to include older adults as well as children. The Lib-Dems would increase the number of patients exempt from paying dental charges and the fee for the NHS sight test to include greater numbers of at-risk patients.

The current and ex-Chairs reported that many dentists are not happy with the new contract, and some are leaving the NHS to work privately. There are problems of access to NHS dentists, as well as retention of dentists. However, the percentage of the population registered with an NHS dentist has changed very little in recent years.

### *Meeting with Ann Lloyd, Head of Health & Social Services Department, and John Sweeney, Director of Community, Primary Care & Health Services Policy Directorate*

The Welsh health officials made three main points regarding the abolition of the prescription charge:

- The evidence base for the move was not available at the time the decision was taken
- It was too difficult to modernise the exemption list

- Abolition supports the shift towards increased use of primary care.

The officials gave the Committee some background to the decision to abolish the prescription charge. The WAG agreed that unless they attacked ill-health, inequality and lack of access to care they would never “climb the mountain” of health problems in Wales. There was a feeling that unless something was done, health inequalities would never improve, and abolishing the prescription charge was seen as one way of addressing this problem. Previously, it was very common for patients not to fill their prescriptions.

The Health and Social Services Department expects the fall in the prescription charge to £3 in April 2006 to increase demand for medicines. There is to be a public education campaign to limit this demand, to appeal to individuals’ better nature and encourage them not to abuse the system. The officials stated that abolishing the prescription charge was not at the top of their list of priorities at the time.

No studies were commissioned to look at the problem before the bill to abolish the prescription charge was passed, however, the policy on prescriptions and charging is to be examined over the next 5 years by the All Wales Strategy Group. This research was commissioned by the Welsh Health and Social Services Department to evaluate any change in prescribing patterns and changes in uptake of medicines. The officials hope that this work will yield evidence that, in an ideal world, should have been available before it was decided to abolish the prescription charge.

The research described above will inform work on a reduced formulary that is also under way in Gwent. If doctors are only able to prescribe free of charge from a set list of medicines, this will limit expenditure on some (possibly expensive or OTC) medicines.

Ms Lloyd pointed out the connection between abolishing the prescription charge and the push towards increasing the availability of health services within primary care. Providing free prescriptions removes a barrier to patients being treated outside hospitals (where prescriptions are free already).

## Annex 2: Health Committee visit to Sweden

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28–30 March 2006

### *Meeting with officials from the Ministry of Health and Social Affairs*

Officials gave a brief overview of healthcare in Sweden, followed by a more detailed presentation on pharmaceutical costs and financing.

Healthcare in Sweden is based on the Health and Medical Services Act of 1982. The Ministry does not provide healthcare directly, but oversees the work of Government agencies, monitors and analyses health and medical care and drafts legislation.

Responsibility for the provision of care is decentralised to the 21 county councils and 290 municipalities, which have the right to levy their own taxes. The County Councils provide medical care to all and are responsible for public health; the municipalities are responsible for the personal care of the elderly, disabled and people with long-term mental illness.

9.2% of GDP is spent on health. Charges comprise around 3% of overall resources, with the bulk of the remainder met through taxes (71%) and Government grants for specific projects (18%).

### *Access charges*

Patients pay a charge to see a healthcare professional. It costs less to see a nurse (around £6) than a GP (around £10) or specialist (around £18). A&E visits are charged at around £15 (there is no charge for under-16s). The County Councils set the level of the fee but there is no great variation across the country. There is no difference in charge between privately run but publicly funded hospitals and public hospitals.

There is an annual limit of SEK 900 (£65) for all outpatient care (including A&E visits and the cost of laboratory tests, X-rays etc). Once this level is reached, the County Council meets the cost.

Inpatient care costs 80 SEK (£6.60) per night. There is no annual cap ie. if a patient is in hospital for 3 months, they will pay for 3 months. People do not insure against this charge (only 2% of the population has private health insurance). Social insurance steps in to assist very poor people who cannot afford to pay.

Sweden has at times been criticised for having a pro-rich system, for example in reports by the European Observatory on Health. There is no clear evidence of a deterrent effect of charges in Sweden though. Research by the Swedish National Institute of Public Health has shown that those on very low incomes might refrain from seeing their doctor.

## *Dentistry*

The under-19s receive free dental care, including the provision of braces, as do disabled people. Everyone else pays, with the state making a small contribution. From age 65 the state makes a slightly larger contribution. The state contributes the same to a county or private dentist. There are discussions ongoing on how to reduce the cost of dentistry. Some studies have shown that poor people tend to refrain from seeing a dentist.

## *Pharmaceutical charges*

County Councils pay for medicines given to inpatients and subsidise medicines dispensed to outpatients, through the Pharmaceutical Benefits Scheme. Patients pay a proportion of the cost of prescribed medicines and most of the cost of over-the-counter (OTC) medicines. In total, 21% of total drug budget is met by patient charges. There is an annual limit on expenditure on all drugs. Once a patient, or a family with children (which are considered together), have spent SEK 1,800 (£134.24), the state pays all drug costs for the rest of the year. Pensioners pay the same as everyone else. Medicines given when a patient is admitted to A&E are free.

All medicines, inpatient and outpatient, are dispensed by a branch of the state-owned pharmacy, Apoteket (see below).

## *Meeting with Parliamentary Committee on Health and Welfare*

The Committee met three members of their counterpart committee in at the Swedish Riksdag; Ingrid Burman, Chairperson (Left Party), Gabriel Romanus (Liberal Party), and Conny Öhman (Social Democratic Party). A range of issues of interest to the Committee were discussed.

The Swedish Members pointed out that the access charges levied by the health service encourage patients to see their GP rather than a specialist in the first instance, as GP fees are low in comparison to those of consultants.

They also drew attention to the exemptions to charges, which are minimal in Sweden. Most County Councils exempt children from paying health charges (outpatient care is free up to age 18 or 20, depending on the County Council). Few other groups enjoy exemption from charges but, for poorer patients, the Social and Welfare Authority will meet the costs of healthcare or dentistry. In some cases, the authority will pay the doctor or dentist directly.

The current levels of charges have been in place for the past 5-6 years. The Swedish Committee felt that a large increase in patient charges was unlikely, but that small increases could occur over the next few years.

The rising cost of the health service will be met through an increased percentage of GDP to be spent on health, alongside strategies to encourage better use of GPs and healthcare services in general.

Levels of unemployment are increasing (4.9% at the moment) and the cost of sick leave to the Swedish Government has also doubled in the past few years. The Swedish parliament is

now considering whether a proportion of sick leave payments should go directly to hospitals to pay for medical treatment for the sick individual, to ensure they receive the necessary therapy. No decision has been reached yet.

### *Meeting with Apoteket*

There are around 850 community and 80 hospital pharmacies in Sweden. All pharmacies are run by Apoteket, and all medicines are received from one of the branches. There are also 15 Apoteket shops which supply only OTC medicines. Unlike the UK, it is impossible to buy paracetamol, for example, from a supermarket or petrol station. It is Apoteket's responsibility to ensure a good supply of medicines, at the same cost, all over the country.

Electronic prescribing is used all over Sweden both in primary care and in all hospitals. Over 55% of new outpatient prescriptions are handled electronically. The information is stored in a database for 15 months (patient consent is not required to store information, but only the pharmacist, prescriber and patient can view the record) and medicines can be dispensed by any pharmacy or posted to patients. Prescribers and pharmacists need the patient's consent to view the record. All pharmacies are linked to the same IT system. Patient records are therefore available at every outlet.

The Pharmaceutical Benefits Board administers the Pharmaceutical Benefits Scheme and decides which medicines and devices will be covered by it. For a medicine to be included on the scheme, it must be proven to be cost-effective. Patients must pay the full price of medicines not included in the scheme. Some medicines are included on the list but their use is 'limited', ie. there are rules that apply before they are included, (eg. to be prescribed Xenical a patient must reduce their body mass index to a certain level). Otherwise the patient meets the full cost of the drug.

Sweden operates a 'stair' model for the County Councils' contribution to the cost of medicines. A greater proportion of the drug cost is paid initially by the patient, but this falls as more medicines are purchased. Up to SEK 900 there is no discount; between SEK 900 and 1,700, there is a 50% discount; between SEK 1,700 and 3,300, there is a 75% discount; and between SEK 3,300 and 4,300 there is a 90% discount. After the cost of the medicines exceeds SEK 4,300 (and the patient has actually paid SEK 1,800) a card is issued which states that all future medicines for the rest of that year should be dispensed free of charge.

The most a patient has to spend on medicines in one year is therefore SEK 1,800, but it is possible that they would have to spend this on the first prescription, if the drug was expensive. Patients may arrange a credit agreement with the pharmacy and pay SEK 150 each month for a year (rather than pay high immediate costs until the discount threshold is reached. Apoteket does not check their income, and this system is used by many people for practical reasons). Patients who have previously had problems paying their bills are blocked from the system. There has been some criticism of this, but those who are really poor can in most cases get their medication paid through the social security system.

Generic substitution has been in place since October 2002. Pharmacies are obliged to substitute prescribed medicines with the least expensive equivalent medicine available. If the patient chooses to have the branded medicine dispensed, in most cases they must pay the price difference.

Although medicines funding is met by the County Councils, the Councils may negotiate with the state for extra funding if there are many costly patients in a particular area.

### *Meeting with Director of Stockholm County Council*

Mr Sören Olofsson, Director of Stockholm County Council, outlined how Council members are elected, and their role, before discussing specific areas of health charging, particularly dentistry, with the Committee.

Stockholm has a regional parliament with 149 members who are elected every 4 years. Healthcare, transport (rail, bus and water) and regional planning are the main responsibilities of the County Council.

Mr Olofsson said that there was no tradition of accessible GPs in Sweden, although this is now changing; surgeries are open later to allow patients to see their doctor after work. A&E is over-used (it costs a similar amount to see a consultant as to visit A&E). It has been suggested that the annual cap on outpatient charges should be raised as a result but this move is not expected in the near future.

Mr Olofsson stated that the current pharmacy system, run by Apoteket, is popular with users, in contrast to the system in Norway. The pharmacies in Norway were privatised, which led to much criticism there.

Regarding dentistry, adults meet 70% of costs. A check-up costs approximately SEK 600 (£43.50) and the price of any treatment required is added to this. Prosthetic treatment can be extremely expensive, even with a cap that is in place for pensioners. Older patients pay a maximum of around SEK 7,510 (£544) for dentures. The maximum charge for dental implants is SEK 37,570 (£2,724). This is an issue for many Swedes.

### *Meeting with the Swedish Association of Local Authorities and Regions*

The Swedish Association of Local Authorities and Regions represents the municipalities and County Councils of Sweden, and supports the authorities in their service development. The Committee met Roger Molin, deputy health of the Healthcare Division. Mr Molin outlined some recent changes in healthcare policy in Sweden before discussing sight tests and the consequences of charging.

As in the UK, there has recently been a move towards providing more care outside hospitals. There has been a reduction in the number of full-scale emergency hospitals and hospital beds. The number of maternity units has fallen alongside levels of infant mortality. Now more women are cared for in larger and more effective units. This means that many women have to travel long distances.

### *Sight tests*

Sight tests for adults are all carried out privately; there is no contribution from the state for either spectacles or the test. Patients visit an ophthalmologist for an eye examination, and pay the same charge as to see any other medical specialist.

Children receive a free basic eye check before they start school. Once at school, they receive a free yearly check with a nurse. There are some subsidies from County Councils for glasses for children up to the age of 18, but uptake is reportedly low.

### *Consequences of charges*

Overall, the impact of patient fees is unknown but around 2.4% of the population do not get medicines dispensed because of cost. These are reportedly mainly medicines for pain and asthma. This is more common among those on low incomes, and among people aged 20–54 rather than older individuals.

Only small differences in inpatient care are observed between those on high and low incomes and car parking charges are not an issue for Swedish patients.

Mr Molin stated that patient charges for health services represented a means of ‘steering’ patients rather than generating income. The system of charges is well accepted overall, but Mr Molin felt that dental charges are likely to change in the next few years.

# Formal minutes

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**Thursday 6 July 2006**

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess	Mike Penning
Charlotte Atkins	Dr Doug Naysmith
Mr Ronnie Campbell	Dr Howard Stoate
Jim Dowd	Dr Richard Taylor
Sandra Gidley	

The Committee considered the draft Report [NHS Charges], proposed by the Chairman, brought up and read.

*Ordered*, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 179 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Annexes read and agreed to.

*Resolved*, That the Report be the Third Report of the Committee to the House.

*Ordered*, That the Chairman do make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the Provisions of Standing Order No. 134.

*Ordered*, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Thursday 13 July at 9.30 am

## Witnesses

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### Thursday 19 January 2006

Page

**Dr Felicity Harvey**, Head of Medicines, Pharmacy and Industry Group, **Mr Mike Brownlee**, Deputy Head of Medicines, Pharmacy and Industry Group, **Dr Barry Cockcroft**, Acting Chief Dental Officer, **Mr Ben Dyson**, Head of Dental and Ophthalmic Services, and **Mr Rob Smith**, Director of Estates and Facilities Management, Department of Health

Ev 1

**Mr Andrew Haldenby**, Director, Reform

Ev 16

### Thursday 2 February 2006

**Dr Anthony Harrison**, King's Fund, **Mr Robert Darracott**, Head of Corporate and Strategic Affairs, Royal Pharmaceutical Society of Great Britain, **Dr Ellen Schafheutle**, Research Fellow and Pharmacist, Drug Usage and Pharmacy Practice Group, The University of Manchester, and **Dr Hamish Meldrum**, Chairman of the General Practitioners Committee, British Medical Association

Ev 22

**Ms Pauline Thompson**, Policy Adviser, Age Concern, **Ms Liz Phelps**, Social Policy Officer, Citizens Advice, and **Mr Martin Rathfelder**, Director, Socialist Health Association

Ev 33

**Mr Peter Cardy**, Chief Executive, Macmillan Cancer Relief, **Mr Robert Meadowcroft**, Director, Campaigns, Policy and Information, Parkinson's Society, **Mrs Rosie Barnes**, Chief Executive and **Ms Lynsey Beswick**, CF Trust Expert Patient Advisor and CF Patient, Cystic Fibrosis Trust, and **Dr Moira Fraser**, Policy Officer, Mind

Ev 42

### Thursday 9 February 2006

**Dr Lester Ellman**, Chairman of the General Dental Practice Committee, British Dental Association, **Dr Maureen Baker**, Honorary Secretary of Council, Royal College of General Practitioners, **Mrs Lynn Hansford**, Chairman, Association of Optometrists, and **Mr David Cartwright**, President of the College of Optometrists and Director of Professional Services for Boots

Ev 50

**Mr Derek Lewis**, Chairman, Patientline, **Dame Gill Morgan**, Chief Executive, NHS Confederation, and **Ms Maggie Elliot**, President, Royal College of Midwives, and Head, Midwifery and Women's Services, Queen Charlotte's and Chelsea Hospital

Ev 61

**Mr Bernie Hurn**, Research and Strategy Manager, Simplyhealth Group Ltd (previously HSA Group), and **Mr Michael Hall**, Chief Executive, Standard Life

Ev 72

**Thursday 16 February 2006**

**Mr Sean Williams**, Board Member and Partner for Competition, and  
**Mr David Stewart**, Director of Investigations, Ofcom Ev 78

**Rt Hon Jane Kennedy**, a Member of the House, Minister of State for Quality  
and Patient Safety, **Ms Rosie Winterton**, a Member of the House, Minister  
of State for Health Services, **Dr Felicity Harvey**, Head of Medicines,  
Pharmacy and Industry Group, and **Mr Ben Dyson**, Head of Dental and  
Ophthalmic Services, Department of Health Ev 81

## List of written evidence in Volume III

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1	Supplementary memoranda from the Department of Health (CP 01A)	Ev 103
2	Supplementary letter from Lord Warner, Department of Health (CP 01B)	Ev 134
3	British Dental Association (CP 11A)	Ev 134
4	Citizens Advice (CP 20A)	Ev 137
5	Association of Optometrists, Association of British Dispensing Opticians and the Federation of Ophthalmic & Dispensing Opticians (CP 26A)	Ev 137
6	Mind (CP 19A)	Ev 139
7	Simplyhealth (formerly HAS Group) (CP 27A)	Ev 139
8	Hammersmith Hospitals NHS Trust (CP 39)	Ev 140
9	All Party Parliamentary Group on Primary Care and Public Health (CP 40)	Ev 141
10	International Glaucoma Association (CP 37)	Ev 146
11	Ms Anna Dixon and Ms Sarah Thomson (CP 44)	Ev 149
12	David Magnus (CP 35)	Ev 153
13	Dr Geoff Searle (CP 38)	Ev 154
14	Professor Peter C Smith (CP 36)	Ev 155
15	Professor John Mohan (CP 45)	Ev 159

## List of written evidence in Volume II

---

1	Department of Health (CP 01)	Ev 1
2	Age Concern (CP 14)	Ev 10
3	Association of Optometrists, Association of British Dispensing Opticians and the Federation of Ophthalmic & Dispensing Opticians (CP 26)	Ev 14
4	Breakthrough Breast Cancer (CP 31)	Ev 17
5	Breast Cancer Care (CP 16)	Ev 19
6	British Dental Association (CP 11)	Ev 23
7	British Medical Association (CP 29)	Ev 26
8	Citizens Advice (CP 20)	Ev 28
9	CLIC Sargent (CP 13)	Ev 34
10	Contact a Family (CP 02)	Ev 35
11	Cystic Fibrosis Trust (CP 04)	Ev 38
12	Diabetes UK (CP 05)	Ev 40
13	Disability Alliance (CP 12)	Ev 43
14	HSA Group (CP 27)	Ev 45
15	King's Fund (CP 24)	Ev 46
16	Macmillan Cancer Relief (CP 23)	Ev 50
17	Mind (CP 19)	Ev 59
18	National Consumer Council (CP 18)	Ev 62
19	NHS Confederation (CP 28)	Ev 63
20	Parkinson's Disease Society of the UK (CP 22)	Ev 64

21	Patientline plc (CP 21)	Ev 67
22	Royal College of General Practitioners (CP 07)	Ev 71
23	Royal National Institute of the Blind (CP 30)	Ev 72
24	Royal Pharmaceutical Society of Great Britain (CP 08)	Ev 73
25	Socialist Health Association (CP 09)	Ev 79
26	Social Market Foundation (CP 33)	Ev 82
27	Standard Life Healthcare (CP 10)	Ev 85
28	Which? (CP 17)	Ev 86
29	Ellen Schafheutle & Peter Noyce (CP 25)	Ev 90
30	Donald Light (CP 03)	Ev 94
31	Ray Thomas (CP 15)	Ev 95
32	Peter May (CP 32)	Ev 97
33	James Halsey (CP 06)	Ev 97
34	Josephine Hyde-Hartley (CP 34)	Ev 98

## Reports from the Health Committee

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The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

### Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815

The following reports have been produced by the Committee in the previous Parliament.

### Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99 (Cm 6635)
Third Report	HIV/AIDS and Sexual Health	HC 252 (Cm 6649)
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42 (Cm 6655)
Fifth Report	The Use of New Medical Technologies within the NHS	HC 398 (Cm 6656)
Sixth Report	NHS Continuing Care	HC 399 (Cm 6650)

### Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

### Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)