



House of Commons  
Health Committee

---

# NHS Charges

---

**Third Report of Session 2005–06**

***Volume II***

*Written evidence*

*Ordered by The House of Commons  
to be printed 12 January 2006*

**HC 815-II**  
Published on 18 January 2006  
by authority of the House of Commons  
London: The Stationery Office Limited  
£14.50

## 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.

### Current membership

Rt Hon Kevin Barron MP (*Labour, Rother Valley*) (Chairman)

Mr David Amess MP (*Conservative, Southend West*)

Charlotte Atkins MP (*Labour, Staffordshire Moorlands*)

Mr Paul Burstow MP (*Liberal Democrat, Sutton & Cheam*)

Mr Ronnie Campbell MP (*Labour, Blyth Valley*)

Jim Dowd MP (*Labour, Lewisham West*)

Anne Milton MP (*Conservative, Guildford*)

Mike Penning MP (*Conservative, Hemel Hempstead*)

Dr Howard Stoate MP (*Labour, Dartford*)

Dr Doug Naysmith MP (*Labour, Bristol North West*)

Dr Richard Taylor MP (*Independent, Wyre Forest*)

### Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via [www.parliament.uk](http://www.parliament.uk).

### Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom)

### Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Eliot Wilson (Second Clerk), Laura Hilder (Committee Specialist), Christine Kirkpatrick (Committee Specialist), Duma Langton (Committee Assistant) and Julie Storey (Secretary).

### Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 6182. The Committee's email address is [healthcom@parliament.uk](mailto:healthcom@parliament.uk).

# List of written evidence

---

	<i>Page</i>
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



# Written evidence

---

## Memorandum submitted by the Department of Health (CP 1)

### PRESCRIPTION CHARGES

#### BACKGROUND

1. When the National Health Service was established in July 1948 the principle was to provide healthcare for all based on need, not on the ability to pay, except where regulations provide otherwise. Initially, the prescription charge was introduced in 1952 based on a charge per form. In 1956 a charge per item prescribed was introduced. The charge was abolished in 1965 and re-introduced in 1968. The categories of exemption are fundamentally unchanged since their introduction in 1968.

2. Government policy in England is that entitlement to help with prescription charges 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.

3. The legal basis of the current arrangements is derived from sections 77, 83A and Schedule 12 to the NHS Act 1977 and in the National Health Service (Charges for Drugs and Appliances) Regulations 2000 and the National Health Service (Travel Expenses and Remission of Charges) Regulations 2003.

4. Charging arrangements are a devolved matter and arrangements in the rest of the UK are a matter for the Devolved Administrations.

#### CHARGES

5. A charge is payable for each item prescribed (ie the NHS medicine or appliance prescribed by a GP or other authorised prescriber) or quantity dispensed unless the patient is entitled to free prescriptions. The charge, as of 1 April 2005, is £6.50. Categories of exemption from the prescription charge can be grouped as follows:

- Age.
- Medical condition.
- Income.
- Type of item prescribed. For example, contraceptives or treatment for a sexually transmissible infection.
- Method of delivery; for example to an in-patient or supplied and administered by a GP.

A detailed list is in annex 1.

6. People who hold a valid Prescription Prepayment Certificate (PPC) do not pay a further charge at the point of dispensing. A PPC costs £33.90 for four months and £93.20 for 12 months, for an unlimited number of items. This means that patients can obtain as many items as they need for less than £2 per week. It also means that the threshold number of items where it is cheaper to buy the PPC is six items for four months and 15 items for 12 months supply.

7. The current arrangements mean that around 50% of the population are exempt from prescription charges and around 87% of prescription items are dispensed free of charge. As a consequence of the current arrangements, a charge was paid for only 8.4% of prescription items, and 4.7% of prescriptions were charged at the reduced PPC rates.

#### IN RESPECT OF THE ISSUES RAISED BY THE COMMITTEE

##### *Are prescription charges equitable and appropriate?*

8. The charge, and fees for PPCs, have been increased over time by varying amounts. Between 1979 and 1998 the charge rose from 20p to £5.80. Since 1998 the charge has increased by 10p each year. This increase has been below the rate of inflation. The level at which income based entitlement to free prescription begins has been increased by the same percentage as increases in Income Support.

9. In 2004, to assist those just above the Low Income Scheme (LIS) limits the cut off entitlement to free prescriptions via the NHS low income scheme was extended to patients whose income exceeded their requirements by up to 50% of prescription charge, currently £3.25.

10. For 2004 (the latest year for which statistics are available) the average net ingredient cost of a non-exempt item was £14.32 when the prescription charge from April that year was £6.40.

*What is the optimal level of charges?*

11. The prescription charge is a flat rate fee. This ensures that:
  - patients know exactly what the cost of the medication will be before they get the prescription dispensed. They do not have to worry about whether they will be faced with a variable price at the point of supply;
  - there is equity between patients at all levels of income;
  - patients can receive the medication that they require and that those requiring more expensive medication are not penalised.
12. For those that do have to pay prescription charges the PPC was introduced to reduce the expense of multiple prescriptions. A PPC holder may obtain as many items as are prescribed (with an average of 46 items per head per annum dispensed in 2004–05) at a cost to the patient of less than £2.00 per week.
13. A 12 month PPC thereby effectively provides a maximum cost ceiling, currently set at £93.20. Similar arrangements operate in other EU countries that operate schemes setting an annual limit on the amount of prescription charges an individual may be required to pay.

WHETHER THE SYSTEM OF CHARGES IS SUFFICIENTLY TRANSPARENT

14. The basic charge is transparent in that each item attracts the current £6.50 charge.
15. The various arrangements currently in place were introduced to ensure that a wide range of patients would either have entitlement to free NHS medicines or an easement of the amount that they would have to pay by using a PPC. The rate of uptake by benefit claimants and those on low income indicates a widespread understanding by these patients of their entitlements.

*What criteria should determine who should pay and who should be exempt?*

16. The following addresses the various types of exemptions:

Age related

Medication needs increase disproportionately with age whilst at the same time income usually decreases. When charges were re-introduced in 1968, free prescriptions matched the retirement age for men and women at that time (ie aged 65 and over).

Children under school leaving age are also exempt as access to medication should not depend on the parents' ability to pay. From 1988 those children who stay in education until they are 19 also receive free prescriptions.

Medical condition

The current arrangements for exemption on the grounds of specified medical conditions have been in place since 1968. The medical conditions qualifying for exemption were agreed in discussion with the BMA. The list of these conditions contains some readily identifiable permanent medical conditions which automatically called for continuous life long (and in most cases replacement) therapy. A person exempt on medical grounds was, and is, entitled to all medication free to avoid doctors needing to specify which medication should be dispensed free; that means that someone with, say, myxoedema (underactive thyroid) can have free prescriptions for, say, gout, heart disease, peptic ulcer, varicose ulcer and anything else as well. Pregnant women and nursing mothers are also exempt from prescription charges if they hold an exemption certificate. This is to protect the health of the unborn child and the nursing mother. The exemption is provided regardless of the mother's income.

Income related

Those who are likely to have difficulty in paying charges may qualify for exemptions which take two forms:

- (1) There is an automatic entitlement to help with health costs for some who therefore do not have to complete a separate claim form. This is called "Passporting" and applies to people receiving some state benefits eg Income Support. "In work" benefits, such as Tax Credits and its predecessors have entitled recipients to free prescriptions, latterly if their total income is below a specified threshold. People receiving Incapacity Benefit or Disability Living Allowance are not "Passported" because these benefits are not income related but they can make a National Health Service Low Income Scheme claim.

(2) The National Health Service Low Income Scheme (LIS) provides income related help for people who are not exempt nor automatically entitled to remission of NHS charges. The scheme covers help with NHS prescription and dental charges, wigs and fabric supports, entitlement to NHS sight tests and optical vouchers and payment of travel expenses to receive NHS treatment.

The LIS provides full help whereby a qualifying patient will not pay any charges. However, those with a slightly higher income may receive partial help with health costs. The extent of any help is based on a comparison between a person's resources and requirements at the date a claim is received by the PPA or the date the charge was paid if a refund is claimed. There is a ceiling based on capital and the calculation is referenced to income support arrangements with "needs" being equivalent to the income support applicable plus full housing costs and council tax payable.

#### Type of item prescribed

Where treatment is desirable on public health grounds (eg vaccination and treatment of Sexually Transmissible Infections) then it is provided free of charge.

Contraceptives prescribed for women are also free of charge. This ensures that women are able to take responsibility for their own reproductive health irrespective of ability to pay.

#### Method of Delivery

Charges are not made where a need to pay could impede the delivery of urgent treatment. Accordingly, treatment in or at hospital, including medication administered at the hospital, is free. Medication to take away is subject to the normal charging arrangements.

#### *How should relevant patients be made more aware of their eligibility for exemption from charges?*

17. The Department has an annual budget of £416K for England held by the Prescription Pricing Authority (PPA) from which it funds a range of posters and leaflets aimed at informing people about how they may obtain help with health costs. All material is provided free on request by phoning the DH publication orderline or by phoning the PPA helpline. The PPA also regularly send mailouts to stakeholders to advise them of changes. Further promotional activities are carried out by the PPA including holding roadshows in shopping malls, broadcasting information over local radio networks, taking part in conferences and training days for professionals and placing advertisements in appropriate free and paid publications.

18. In addition to the above:

(1) Jobcentre Plus offices also hold supplies of the information leaflet and the claim forms for the NHS LIS;

(2) Hospitals, dentists, opticians, doctors and pharmacists are all encouraged to keep supplies of leaflets available for patients and to display posters. Two major supermarkets now hold supplies of the "quickguide";

(3) The Department has a contract with the Waiting Room Information Service which supplies stocks of leaflets to participating GP surgeries; and

(4) New materials have been developed working with NUS and NACAB.

#### *Whether charges should be abolished?*

19. Abolition or an increase in exemptions could increase GP appointments if patients opt to seek medication rather than practise self-care such as healthy activities or modifying diet. The revenue from prescription charges and PPC fees also provides a valuable contribution to the National Health Service. Abolition would increase GPs' workload, increase the Drugs Bill and cost the NHS of some £430 million in lost income (before taking into account extra drugs expenditure).

## DENTAL PATIENT CHARGES

#### BACKGROUND

20. Charges for dental treatment were introduced in 1951 since which time they have been periodically revised: eight times between 1952–79, and 20 times between 1980–2003. Dental charges rose annually each year between 1991–2000.

21. Dental charges became a significant part of the total cost of treatment when they were raised to 75% of the cost of treatment and extended to dental examinations (not just treatment) in 1989; in 1993 the proportion rose to 80%.

#### KEY FACTS

- Dental patient charges apply to adults but not to children, pregnant women, people on income support or those who receive care in a hospital out-patients or from the Community Dental (salaried) service.
- Dental patient charges account for approximately one-third—about £630 million—of overall expenditure on NHS dentistry.
- The current maximum charge is £384. From April 2006, the maximum charge for a course of treatment will be £189.

#### REFORM OF DENTISTRY

22. Primary care dental services are about to undergo the most significant reform since the General Dental Services were established in 1948. From next April PCTs will have resources for dentistry devolved to them and will locally commission services via the new General Dental Services (GDS) and Personal Dental Services (PDS) contracts. Dentists will be paid for a contracted level of activity over the course of a year and not for each individual course of treatment (item of service) performed.

23. This reform requires changes to the system of patient charges, which are currently linked to the individual fees paid to dentists. There are currently 400 different patient charges reflecting the various items of service. The Department has taken this opportunity to produce a much simpler and more transparent system of charges. The proposed new system is based on the recommendations of a working party chaired by Harry Cayton, National Director for Patients and the Public. The working party included representatives from the British Dental Association, Consumers Association, Dental Practice Board and other stakeholders. Over the summer, the Department carried out a 12 week formal consultation on a simplified three banded system of patient charges, based on the working group's recommendations. The three bands of charges correspond to the three bands of courses of dental treatment, which will in future be used to gauge the level of service provided by a dentist over the course of a year.

24. The proposed three charging bands (which have been updated since the consultation to reflect inflation) will considerably simplify a system which the public currently find very hard to understand:

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

25. Regulations covering the new charges were placed before both Houses of Parliament in November for agreement by affirmative resolution during December. The regulations include amendments to take account of some specific concerns raised during consultation (eg a 70% reduction in the charge for repair of dentures or other appliances).

26. The consultation responses confirmed broad support for simplifying the current system of dental charges. Consumer representative organisations broadly supported the reforms, whilst expressing some concerns about the level of charges, particularly for Band 3. The British Dental Association (despite having been represented on the working party) raised a number of concerns, including the lack of testing. Other responses showed strong support for overhauling the current system, but no single common view about how best to do this. Many of the responses indicated a need for the Department to undertake further work to explain the new charging system to patients and the public, and work on a public communications programme is now underway.

27. In publishing the revised charges regulations, the Department has emphasised the following key points:

- (1) the new system reduces a complex system of over 400 patient charges to only three charges;
- (2) the maximum charge for patients will reduce from £384 to £183—the Consumers Association and others have welcomed this move;
- (3) on average, the costs for NHS patients will be no greater than now (in real terms) and may in fact be lower. Under the new NICE guidelines on recall intervals for routine dental consultations, which end the current practice of routine six monthly visits, dentists will use their clinical judgement to recall patients at intervals of between three months and two years. This is expected to reduce the average frequency of patient visits, which in turn should free up time for dentists to see a greater range of patients and reduce the average cost per patient.

---

 IN RESPECT OF THE ISSUES RAISED BY THE COMMITTEE
*Are dental charges equitable and appropriate?*

28. Charges for dental services have existed since 1951, and we believe they are a fair way of raising important revenue that supports the provision of dental services. Public opinion surveys do not cite cost of NHS treatment as a significant reason affecting take-up of NHS dentistry. The most recent Healthcare Commission survey (2003) indicated that, of those patients who had not been to an NHS dentist in the last year, the more important factors influencing their decision were the perception that they did not need to go to the dentist; access to NHS dental services (which the Department has since been tackling through a £250 million programme of investment and workforce expansion); preference for using a private dentist; fear of going to the dentist; and other factors. We have, however, used the opportunity of the forthcoming dental reforms to design a new patient system that will be fairer and more transparent.

*What is the optimal level of charges?*

29. Charges for dentistry have traditionally reflected a percentage of the overall cost of an item of treatment. But the over 400 charges which the previous system generated led to confusion in the public, compounded by some patients paying privately for treatment and not being clear where NHS payment ends and private payment begins. The new system is designed to raise the same overall level of charge income (as a proportion of gross expenditure on NHS dental services), but with much greater clarity for patients as to what they will pay for an overall course of treatment.

*Whether the system of charges is sufficiently transparent?*

30. The simplified three band system of patient charges will make it easier for patients to understand the cost of treatment. With 400 current items of service it is very difficult for patients to understand what they are paying for on the NHS, and even more so when this is combined with private treatment. Patients generally welcome the opportunity to have “mixed” NHS and private treatments from the same dentists. However, this makes it all the more important to ensure that patients understand both the cost of proposed NHS treatments and the cost of any proposed private treatment. The new arrangements will greatly increase transparency in this respect.

## ELIGIBILITY FOR NHS OPTICAL SERVICES

### BACKGROUND

31. Until 1989 everybody was entitled to an NHS-funded sight test. From 1989, eligibility was restricted to children, people on low income or those suffering from or predisposed to certain eye diseases. In 1999, the Government reintroduced NHS-funded sight tests for people over 60.

32. There is no system of NHS charges for optical services. Rather, eligibility for free, NHS-funded sight tests is targeted at children, older people, those with or at risk of eye disease, and people on low incomes. There are similar, though not identical, eligibility arrangements (set out below) for optical vouchers, which patients can use to contribute to the costs of buying glasses or contact lenses.

33. The groups eligible for free sight tests are as follows:

- those under 16 years of age;
- students in full time education aged between 16 and 19;
- those aged 60 or over;
- individuals on low incomes including those receiving Income Support, Jobseeker’s Allowance and Pension Credit Guarantee Credits;
- individuals diagnosed as having, or being at risk of, glaucoma; and
- diabetics.

34. Opticians who provide a NHS sight test currently receive a fee of £18.39 per test. This rate is negotiated with representatives of optometrists and ophthalmic medical practitioners.

35. The Health Bill removes current restrictions on who PCTs may contract with to provide NHS funded sight tests, subject to contracts ensuring safeguards and quality and the use of qualified and registered optometrists and ophthalmic medical practitioners to undertake clinical work. The Bill also creates a more robust framework for commissioning similar to other parts of primary care and which allows for commissioning of enhanced services locally.

36. The Health Bill removes some current restrictions on who may provide NHS funded sight tests. At present, only optometrists, ophthalmic medical practitioners and corporate bodies registered with the General Optical Council may contract directly with Primary Care Trusts to provide sight tests. Businesses owned by dispensing opticians or by lay people (if they are not registered with the General Optical Council)

can only provide services by arranging for one of their employees (ie an individual optometrist or ophthalmic medical practitioner) to enter into an agreement with the Primary Care Trust to be the contractor. The Health Bill will remove this cumbersome arrangement and allow for direct contracts with these practice owners, provided that those undertaking the clinical work are qualified, registered optometrists or ophthalmic medical practitioners on a PCT's "performers list". This will make it more straightforward for a range of providers to enter NHS service provision and will help sustain and promote choice for patients.

37. The Bill also creates an integrated legal framework within which Primary Care Trusts can commission enhanced ophthalmic services. This will support PCTs, where appropriate, in increasing work undertaken in primary care, reducing inappropriate referrals to hospital and enhancing the role of primary care professionals in diagnosing and managing eye conditions. The Department is currently sponsoring a number of NHS pilots that involve expanding the role of primary care professionals in managing low vision, glaucoma and age-related macular degeneration.

38. Subject to the Bill becoming law and being implemented, we envisage the sight testing service operating like the General Ophthalmic Service (GOS) system now. Eligibility for NHS funded sight tests will be maintained for all those currently eligible. Contractors will (as now) be able to establish themselves in areas and have a contract with the NHS provided they meet agreed national criteria. Patients will be able to choose the GOS contractor who provides their NHS funded sight test. We also envisage continuing, as now, to have a centrally negotiated sight test fee. NHS sight testing will, we anticipate, continue as a demand led service with consistent standards across the country and patient choice of the practitioner who they wish to go to for their NHS funded sight test.

39. Patients who have received a NHS sight test, and who need glasses or contact lenses to correct their eyesight, receive a prescription showing the required strength and type of glasses or contact lenses. Eligible patients also receive an NHS optical voucher, which they can use to meet (in whole or in part) the cost of these glasses or contact lenses. Eligibility for optical vouchers is primarily targeted towards children and people on low incomes. There are eight voucher bands, each to a set value according to the strength and type of the prescription. The current voucher values vary from £32.90–£181.40. We recognise that the higher an individual's prescription the more the glasses will cost. This is why the higher the prescription the more financial help an individual would get with costs. The optician who dispenses the glasses or contact lenses redeems the value of the voucher from their local Primary Care Trust.

40. The groups eligible for optical vouchers are:

- those under 16 years of age;
- students in full time education aged between 16 and 19;
- individuals who have been prescribed complex lenses; and
- individuals on low incomes including those receiving Income Support, Jobseeker's Allowance and Pension Credit Guarantee Credits.

#### IN RESPECT OF THE ISSUES RAISED BY THE COMMITTEE

##### *Are funding arrangements equitable and appropriate?*

41. These arrangements are designed to provide support to people most at risk from eye disease or who might otherwise be discouraged on financial grounds from having their eyes examined. Eligibility for optical vouchers relates predominantly to income and is targeted on those who might have most difficulty in purchasing glasses or contact lenses.

42. Vouchers provide eligible patients with flexibility in respect of which glasses or lenses to choose. They allow patients to top up the voucher value (if they wish) to buy a more expensive pair of glasses or lenses.

##### *Whether the system of charges is sufficiently transparent?*

43. The conditions for entitlement are simple and straightforward and are designed to minimise any possible abuse of the system.

44. For example, sight tests are recommended every year for persons over 60 years of age. Further tests within any year are not free of charge unless the optometrist or ophthalmic medical practitioner is satisfied that the sight test is necessary. These arrangements prevent individuals from seeking a sight test for which there they do not have a clinical need unless they are willing to pay privately.

##### *What is the optimal level of funding?*

45. There are no central limits on expenditure on NHS sight tests or optical vouchers. Expenditure is demand-led, in the sense that it is driven by the numbers of eligible patients who visit their optician for NHS-funded sight tests and the numbers of optical vouchers issued as a result of these sight tests. The number of NHS funded sight tests increased by 3.1% from 2003–04 to 2004–05.

46. Levels of funding are also clearly affected by rules on eligibility. In 1999, the Government reviewed the eligibility rules and extended eligibility for sight tests to those over 60. The available evidence suggests that this resulted in a transfer of sight tests from the private sector to the NHS, rather than any material increase in the overall number of sight tests undertaken. This does not suggest that any further extension in eligibility (and the associated increase in NHS funding) is likely to affect significantly the overall number of sight tests undertaken or the associated health outcomes.

*What criteria should determine who may receive funding and those who should not?*

47. As set out above, the eligibility criteria for NHS-funded sight tests (which in turn affect levels of NHS expenditure on sight tests) are designed to ensure that children, older people, other patients who are or may be predisposed to eye disease, and those on low incomes are not discouraged from having their sight tested. The criteria for optical vouchers are, similarly, designed to support those who might otherwise have difficulty buying glasses or contact lenses, either because they are on low incomes or because they require complex lenses.

*How should relevant patients be made more aware of their eligibility for NHS optical services?*

48. Information about the extensive arrangements for providing help with NHS optical services and other health costs are publicised in the leaflet HC11, "Are you entitled to help with health costs?" Posters are also available for display in optical practices and hospital out-patient departments.

*Whether the current arrangements should be abolished?*

49. The Department is not persuaded that extending eligibility for NHS-funded sight tests and/or optical vouchers would be a cost-effective use of NHS resources. As indicated above, the evidence from the most recent extension in eligibility (in 1999) does not suggest that further extensions would significantly alter the overall take-up of sight tests (ie taking into account both NHS and private sight tests).

## CHARGES FOR BEDSIDE TV AND TELEPHONES

### BACKGROUND

50. The NHS Plan "A Plan for Investment, A Plan for Reform" was published in July 2000 and set out Government Policy for investment in the NHS and for reform of the way the NHS delivers care for patients. As part of improving the environment in which the patient is treated and to make available services that they take for granted at home, it was decided to set a target for the availability of bedside televisions and telephones in every major hospital by the end of 2004.

51. NHS Estates undertook two competitive tender exercises (July 2000 and January 2001) and Licensed a number of Providers to install these services in NHS Trusts. The object being to utilise the private sector in the provision of the services so that the installation was funded by the private sector with the recovery of capital operating costs being met by the system users.

52. Installation of these services went well and at the end of 2004, bedside televisions and telephones had been installed in 122 major hospitals (more than 400 beds) and in 33 smaller hospitals (less than 400 beds). Over 75,000 units had been installed at that time, the NHS Plan target was largely met.

53. The Office of Communications (OFCOM) has opened an investigation into the provision of bedside communication and entertainment services recently installed in NHS hospitals under the Competition Act 1998.

54. The terms of the investigation are as follows:

- 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).

55. The Department of Health is co-operating with this investigation. No further action should be taken until the OFT publishes its conclusions.

IN RESPECT OF THE ISSUES RAISED BY THE COMMITTEE

*Why was it decided to charge patients for these services?*

56. These facilities provide additional services to improve the patient environment, and are not related directly to the provision of clinical care. The private providers took the financial risk in installing and operating the systems; they are essentially a free good to NHS Trusts. It would not have been appropriate to divert funding for the provision of essential clinical services to pay for televisions and telephones.

57. If patients wanted to watch TV in the past, they had a choice of watching a communal TV in the dayroom, free of charge, or in some cases could rent TVs to watch at the bedside. Patients have always had to pay to make an outgoing call from the hospital on ward payphones.

*Whether charges for bedside televisions and telephones are equitable and appropriate?*

58. The Project to install the bedside televisions and telephones was structured so that the provider chosen by the NHS Trust would install and operate the bedside communications at its own cost. The NHS patient is charged directly for the services used and the contract is between the user and the provider. It was the intention of the Project that the installation of these services would not be a cost for NHS Trusts. Over £115 million of private funding has been used to introduce these services into NHS hospitals. This capital funding will of course be recouped by the private providers over time, through the revenue streams generated.

*What is the optimal level of charges?*

59. The provision of bedside televisions and telephones was (and is) an emerging market. NHS Estates considered the experience of providers already in the market to assess a reasonable measure of likely costs. The procurement process was designed to establish the market rate for the provision of these services by appealing to a range of applicants to make offers against the parameters set out as part of the tender exercise.

60. Each of the suppliers offers a different range of services and prices. The cost of TV ranges from £2.50 to £3.50 per day. The cost of outgoing telephone calls is around 10p per minute. The cost of incoming telephone calls ranges from 15p to 49p per minute.

*Whether the system of charges is sufficiently transparent?*

61. The suppliers of the service advise the user of the cost of the services when they apply to use the system. In addition, incoming callers are advised at the onset of the telephone call of the charges to be levied (apart from HTS who do not offer this service).

*What criteria should determine who should pay and who should be exempt?*

62. Private providers are responsible for the costs of installation and ongoing operation of the services. In order for them to realise a return on their investment the revenue stream must provide them with an adequate return. Patients and other users pay for the services provided.

63. All providers have offered to provide children with free TV. Some suppliers offer discounts on TV charges for the elderly and long stay patients. In addition, some suppliers offer unused credits handed back by patients to be distributed, at the discretion of ward staff, to those patients who may benefit from the services but are not able to pay for them.

64. For patients who cannot afford or do not wish to use the services provided, TVs usually remain in day rooms and messages from friends and relative can be passed to and from the nurse's station, as happened in the past.

*How should relevant patients be made aware of their eligibility for exemption from charges?*

65. Under the provision of these services, the only patients with a guaranteed exemption for charges are children and they are advised of this as appropriate.

*Whether charges should be abolished?*

66. The services are provided by private providers, most of whom have entered into 15 year contracts with NHS Trusts. The providers are not able to operate the service if they do not get a return on their investment. The only way for charges to be abolished, and to retain these services in NHS hospitals would be for the NHS to pay for the services and buy out the remaining capital charges. There may be a number of other options that could be considered further at a later stage.

---

## INCOME GENERATION ACTIVITIES (INCLUDING CAR PARKING)

### BACKGROUND

67. All NHS bodies have powers to undertake activities to increase the amount of income available to them. It is under these powers that, for example, NHS trusts can charge for car parking on their premises, or rent out retail units (the gift and flower shops found in the main concourse of most hospitals). This part of this Memorandum of Evidence provides some specific information about car parking charges.

### CAR PARKING

68. NHS trusts do not have to provide car parking facilities on their premises. However, if they do, then they will necessarily incur costs in terms of maintenance and security, and even staffing depending on the particular arrangements put in place. If no charges were made, then these unavoidable costs would have to be found from elsewhere, at the risk of taking funds away from patient services. Having said that, NHS trusts are not obliged to charge for car parking, but are free to do so within the income generation rules.

69. Thus, it is a matter for individual Trusts to decide whether they wish to introduce such charges, and if they do, then at what level the charge should be set, taking into account local circumstances. Hospitals' locations differ with regard to the amount of space available for car parking and the pressure they face on available spaces. NHS Trusts must therefore decide on the arrangements for car parking in the light of their particular circumstances, including whether or not, and whom, to charge. When making such judgements, Trusts have to consider the needs of all users of the hospital, including consultants, junior medical staff, nurses, other staff, patients, visitors, emergency vehicles and others. Where spaces are limited, it may be impossible to offer all or any of these groups free or subsidised parking as to do so would affect the space available for others.

70. These factors have meant 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. However, as indicated above, guidance has been in place for some years advising on the range of factors that need to be considered if an NHS trust is thinking about introducing car parking charges. This includes information on the different types of arrangement that might be available, the needs of the various users, consulting and reaching a decision, and how to manage the scheme once it is in place.

Department of Health

7 December 2005

**Annex 1**

### **Prescription Charging Arrangements**

#### FREE PRESCRIPTIONS

No charge for medication (regardless of patient's status or income) which is:

- supplied to hospital inpatients;
- supplied on discharge following inpatient treatment;
- supplied and administered personally by a GP;
- supplied by a GP for immediate treatment (and no prescription form is used);
- administered at a hospital or walk in centre;
- supplied for personal administration by person making the supply in accordance with a patient group direction;
- supplied for the treatment of a Sexually Transmissible Infection (and no prescription form is used, eg supply is by a hospital); and
- which is a prescribed contraceptive (oral or listed appliances).

No charge for prescriptions for patients who are in one of the following categories:

- Children under 16.
- Young people aged 16, 17 or 18 receiving qualifying full-time education.
- Men and Women aged 60 and over.
- Pregnant women and women who have had a child in the previous 12 months who hold a valid exemption certificate.
- People who hold a valid exemption certificate for a War Disablement Pension (but only in respect of medication for the accepted disablement).

- People suffering from the following conditions who hold a valid exemption certificate.
- 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.

No charge for prescriptions for patients in the following groups determined on an income related basis:

Recipients of:

- Income Support.
- Jobseekers' Allowance Income-based.
- Pension Credit guarantee credit—for partners under 60, recipient entitled on age grounds.
- Tax credit awarded and family's annual gross income (from 6 April 2005) is £15,050 or less with:
  - working tax credit and child tax credit, or
  - working tax credit with a disability element, or
  - child tax credit and not eligible for working tax credit
- (and the patient is named on a tax credit exemption certificate)
- the patient named on an HC2 charges certificate for full help (under the NHS Low Income Scheme). Either partner (including civil partners from December 2005) may make the claim with the level of help based on a comparison between income and requirements (needs) of the individual/couple at the time a claim is made (or a charge was paid) subject to their capital being below a specified limit.

---

### Memorandum submitted by Age Concern (CP 14)

#### INTRODUCTION

1. Age Concern welcomes the opportunity to provide evidence to the Health Select Committee on co-payments and charges in the NHS. Age Concern England (the National Council on Ageing) brings together Age Concern organisations working at a local level and 100 national bodies, including charities, professional bodies and representational groups with an interest in older people and ageing issues. Through our national information line, which receives 225,000 telephone and postal enquiries a year, and the information services offered by local Age Concern organisations, we are in day to day contact with older people and their concerns.

1.1 The subject of co-payments and charges in the NHS is a matter of great importance to older people who are the majority users of NHS services. Two thirds of general and acute hospital beds are used by people aged 65 and over (National Service Framework for Older People, Department of Health, 2001). In 2003–04 people aged 65 and over accounted for approximately 47% of the NHS Hospital and Community Health Services budget (Departmental Report, Department of Health, 2005). Older people are thus likely to be the group most adversely affected by the charges. As the committee stated in its press releases the rationale behind many of these co-payments is unclear in a system that is "free at the point of use". In addition to the national charging scheme for certain aspects of the NHS there is evidence of a growth in locally imposed charges to raise revenue for the particular NHS Trust, in particular for car parking which can have adverse effects on the ability of older people to access services or create additional anxiety.

#### 2. *Are charges equitable or appropriate?*

2.1 It is questionable whether any charges for NHS health services are appropriate. Charges may well work against the prevention and well being agenda, and may contribute to the continuing widening of the health inequalities gap. The Government has continued to voice its commitment to an NHS which is free at the point of delivery, with access based on need rather than the ability to pay. There does not seem to be any clear reconciliation of this commitment with the policy of charges for some aspects of care. Health charges inevitably impact most on those in poor health, and the links between poor health and low income have been well researched and demonstrated.

2.2 Within the system there seems to be no logic as to which services are exempt from charges and which are not. The fact that, for older people, eye tests are free yet dental check ups are not appears to have no rationale. (Indeed the only rationale 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). The low income scheme is complex and contains some anomalies by which people in work are able to access free services at a far higher income than those who are not working (which of course is the position for the majority of older people).

### 3. *National charging issues.*

3.1 Dental charges. Age Concern has recently responded to the consultation on changes to charges for dental treatment; the Department of Health has now published it's the outcome of the consultation. Almost half of all older people do not access any form of dental care and among the major contributory factors are the actual cost or the fear of the cost, as well as the difficulty in finding an NHS dentist. Good oral health is particularly important for older people as it is essential to enable individuals to eat, speak and socialise without discomfort or embarrassment. There is clear evidence of links between poor oral health and malnutrition. In spite of the Government emphasising the importance of oral health in public health terms (Choosing Health—making healthy choices easier, Department of Health, 2004), unlike Wales and Scotland there has been no commitment made to introduce free dental check-ups for older people. Indeed the proposals for changes to dental charges introduces a more expensive charge for a basic check-up which is hard to reconcile with the objectives of increasing emphasis on preventive dental care and removing the deterrent for those with poor oral health from seeking treatment because of cost.

3.2 We were extremely concerned that the original proposal was that all replacement dentures would attract the highest of the three bands of charges (£183). Although we are pleased that in response to consultation that the Government has in part listened to these concerns and set the price of replacement for loss and damage at 30% of the highest band (now £189), we are still worried that for replacement due to wear and tear the cost will be £189. This would clearly disproportionately affect older people of whom some 40–45% over 65 have no natural teeth, possibly in part due to dental practices in their younger days. We are still concerned that such a high charge might lead some older people to carry on using damaged dentures or none at all which could have a devastating affect on their health and well being. The Government states that the regulations remain unchanged to allow the Secretary of State to determine no charge in cases of hardship or on the grounds that the loss or damage did not entirely result from lack of care by the individual. It is very important that all information given about charges make it very clear that there is this Secretary of State discretion and in what circumstances it might be considered.

3.3 Optical charges. The voucher system is complex and in most cases leaves a large shortfall between the cost of glasses and the value of the voucher. Currently vouchers normally only cover a fraction of the cost of the cheapest pair of glasses that can be bought at most opticians. Some older people need more than one pair of glasses and it is often not made clear that a voucher can be given for each pair. Although the value of the voucher affects all people on a low income, older people are less likely to be able to shop around to find the cheapest pair. The cost and difficulty of shopping around in rural areas where there is less choice of optician is another factor. We are concerned that some older people, if they have to pay more than their voucher covers, might decide to do without glasses (or not change them as frequently as changes to their eyesight demand), thus possibly putting themselves at risk of falls, or a highly diminished quality of life because they cannot see properly. Opticians are not required to have a selection of glasses within the voucher price, and this is something the committee may wish to consider as a recommendation. Age Concern recommends that there should be a review of the value of vouchers to ensure that they meet the costs of buying an appropriate pair of glasses and that these levels should be kept under regular review.

### 4. *Local charges.*

4.1 Car parking. We are very pleased that the Select Committee has raised this as an issue as it is one that is causing increasing concern to older people. Many rely on getting to hospital by car if they have difficulty managing public transport, or live in rural areas where public transport is not available. As older people are unable to access the mobility component of Disabled Living Allowance, they are further disadvantaged as older people do not have their mobility needs recognised by any payments to help. The way car parking charges are imposed varies enormously between hospitals bringing in yet another post-code lottery to the NHS, in this case without even a possibility of challenge through the courts or via the Ombudsman. Some hospitals have a limited period where there is no charge to enable setting down or for quick visits. Others impose a charge from the start with charges going up in half hour or hourly intervals. The price can vary hugely with some hospitals charging more than the local charges for parking for shopping. Often individuals only find the cost of parking at the hospital when they arrive as no information has been given in the appointment letter. We are also very concerned that any remissions schemes are not generally known about and are idiosyncratic to the hospital.

4.2 The issues around car parking that particularly have been brought to Age Concern's attention are:

- The lack of disabled parking places forcing people to use the main (charged for) car park. Even though there may be a remission using the blue badge scheme, often the offices that deal with this are a long walk from the car park;

- In one area the high costs of hospital parking (£2 per hour up to £10) has meant that the local neighbourhood is affected to the extent that the local authority has brought in a controlled parking scheme around the hospital—this in an area where it is difficult to get to the hospital on public transport;
- Where an older person requires an ambulance the carer is often not allowed to travel with the patient, even where the carer is needed at the hospital to help the patient dress and undress, to go to the toilet, or to transfer from wheelchair to examination couch. The carer has to make their own way to the hospital most often by car and park in the car park. Because ambulances collect patients at any time prior to the appointment to fit with their schedule, parking can be for some hours. For instance we have an example of a patient being pick up a 8.45 am for 10.45 am appointment meaning that the carer was parked for two hours longer than necessary to meet the convenience of the ambulance service, and being charged more for each hour parked;
- Where car parks charge for different time periods individuals are, to some extent, paying for the inefficiency of the hospital. For instance, in a recent example brought to our attention, a routine blood test took over an hour because of the long queue meaning that the patient had to pay more for parking even though the test only took about five minutes;
- Where carers (especially spousal/family carers with terminally ill spouses) need to park, perhaps for long times, the parking charges can be a deterrent if they are on a low income and thus could deprive a person of being able to spend time at this highly emotional period.

4.3 Age Concern recommends that there should be a national review of car parking charges to ascertain the rates being charged; what profit is being made; what people's views are of parking charges and what problems are experienced; what exemptions are made and how this is communicated to the patient and their carers; and that there should be national guidance on car park charging for NHS facilities.

4.4 Bedside phones. Age Concern receives some queries about the cost of some bedside phones which we understand are charged at a premium rate. Although we appreciate a bedside phone aids communication, the charges impact heavily on older people, as they have replaced the "telephone trolley". Older people are more likely to have mobility problems which mean they cannot get to a public phone. For those ringing patients in hospitals it is not always made clear that this may have a higher cost than a normal call. We have had a complaint from one older person ringing his wife in hospital that he only realised the high cost when he received his phone bill. Since older people are more likely to have difficulty visiting relatives in hospital and therefore may rely on telephone contact to keep in touch, they are disproportionately affected by these high charges.

#### 5. *Other costs.*

5.1 Although the Health Committee is looking at NHS charges there are number of "hidden" costs which severely impact on older people. These arise from instances where the NHS fails to provide a comprehensive or fully accessible health service.

5.2 Transport. In developing our response for the White Paper on community health and social care a consistent theme raised in focus groups was concern about the costs and availability of transport to travel for health care. Lack of NHS dentists can mean much longer journeys for older people to access the nearest NHS service. Only travel to hospital comes under the NHS travel scheme, but over the years more services have been transferred to primary care settings for which no financial help is given. For those older people who cannot access public transport, it can mean a considerable cost if a taxi is required. We receive many complaints about the difficulty in obtaining home visits by GPs and other health professionals. Increasingly patients are expected to make the journey to their surgery. In the focus groups we held, this was particularly raised by older carers and those living in rural communities—the costs involved in arranging transport for a GP consultation were considerable.

5.3 We have commented above on the problems of visiting patients in hospital caused by car parking charges, and we are also concerned that the cost of transport can be a major deterrent for older people visiting relatives. For those on pension credit it may be possible to get some help via the social fund, but this entails yet another claim to the DWP adding an additional stress.

5.4 The problems of transport to health facilities have been highlighted for some time. Age Concern London's report "*A Helicopter would be nice*" (2001) outlined many of the problems that older people in a city area experience. Some of these problems are compounded in rural areas. In 2003 the Social Exclusion Unit made a number of recommendations regarding transport to health facilities Making the connections: final report on transport and social exclusion. It is extremely disappointing that so far none of these have been taken forward.

5.5 Chiropody. This is one of the services about which Age Concern receives the most queries and concerns from older people. Although the NHS does not impose charges, failure to commission an adequate service to meet population health needs results in charging by default. Chiropody services have the potential to maintain mobility and therefore secure independence for older people. Many NHS chiropody services have been reduced by tightening eligibility criteria so that only people with "high level" foot health needs (such as some people with diabetes) are able to access the service. This practice is continuing as a way of

managing financial deficits. Where chiropody services are available, waiting lists for treatment are often very long. We have recommended in a submission to the White Paper consultation that a maximum wait for chiropody services should be imposed in line with that proposed for waiting times for other health services.

5.6 The picture is one of significant variation across the country and it is not possible to reconcile this variation with different levels of foot health need. It is clear that in many parts of the country the NHS is failing to provide a comprehensive foot health service. The consequence is that many older people are faced with the stark choice of paying for private care, or receiving no care at all. Although some voluntary organizations such as Age Concern have tried to fill that gap through developing toe nail cutting services, there can still be costs to cover the running of the service. In a recent adjournment debate (28 November 2005) the cut back in podiatry services in the London Borough of Havering was discussed, and a case mentioned where a constituent had to choose between meeting the costs of eating or having her toe nails cut. Another Age Concern has reported to us that financial difficulties in the local PCT has meant a severe tightening in the eligibility criteria for people to access chiropody services, with the result that even people who are blind or have severe arthritis can no longer have an NHS chiropodist. Age Concern recommends that there should be national standards on eligibility for NHS funded chiropody and that consideration should be given to how the policy of 'choice' could be made to work in this area (given that there is not a workforce shortage).

5.7 Dental care. We have highlighted above the fact of poor access to an NHS dentist for many older people and the implications of this for health and well-being. The distances many would need to travel in order to visit an NHS dentist often makes this an unrealistic option. In these circumstances the existence of NHS charges or help with health costs becomes irrelevant. The lack of a comprehensive NHS dental service forces many older people to choose to either pay for private dental care or not to have any care at all. Age Concern has received anxious enquiries from older people whose dentist has decided to stop providing NHS care; the people concerned, on low fixed incomes, are unable to see any way in which they could afford either dental insurance or the costs of private care as it arises. A survey undertaken by one Age Concern found that the main reason why older people had a private dentist was because of a change of practice from NHS to private by their own dentist.

#### 6. *Transparency of charges and exemptions.*

6.1 Not only are charges complex (hence the consultation to try to simplify dental charges), but the system of getting help with charges seems designed to confuse and put people off applying for help. The fact that the leaflet HC11 "*Help with Health Costs*" on the Department of Health website runs to 77 pages indicates the level of complexity with the contents list alone running to three pages. This leaflet does not even attempt to explain the "low income scheme" merely referring the person to form HC1. This is perhaps not surprising given that the rules for qualifying on the low income scheme require the completion of a form similar to that of income support/pension credit.

6.2 Those older people who are above the pension credit guarantee levels but who may be eligible for help with health costs have to fill in yet another form (much of the information required will perhaps have been given to the DWP in an application for the savings credit, or to the local authority to apply for council tax benefit). With the exception of people aged 65 and over whose income is exclusively dependent on state benefits, the certificate only lasts for 12 months and the form therefore has to be completed on a regular basis. The DWP has recognised that older people's means do not change regularly and have accounted for this in setting awards of Pension Credit for five years in the majority of cases. It would seem sensible for the Department of Health to follow this rationale for the Low Income Scheme and have a similar five year award for all older people. Knowledge of the Low Income Scheme is poor and all too often we find that older people do not have a current HC2 or 3 certificate and so are faced with having to try to get a refund, or are put off from applying for a refund once they have paid.

6.3 For those in receipt of pension credit, changes to the system have added to the complexity of older people receiving the help with health costs which they are entitled to. Older people no longer have order books which prove that they are on pension credit, many older people do not know if they are on the guarantee credit or just the savings credit, and as benefit is awarded for a five year period they may well have lost their notification letter. Few realise that they need to take it with them to the dentist or optician or hospital. It would be an improvement if the DWP could issue a card—similar to membership cards for older people to carry with a clear explanation with them that the card will be needed for dentists, opticians and hospital visits.

6.4 In addition to the complexity of the system for claiming help with health costs, and the fact it involves an intrusive means test often for one off payments, we are also concerned about how little it is advertised or promoted. There is no requirement on health professionals such as GPs, dentists and opticians to display leaflets about getting help with health costs. They also do not have to have copies of the forms. Age Concern recommends that PCTs should be required to promote the scheme through GP surgeries, dentists and opticians and a regular supply system set up so that the most up to date leaflets are always available to overcome the perennial problem of out of date leaflets. Given that the costs are reported as putting people off seeking early treatment and advice, it seems that a major chance of helping move forward on the prevention agenda is being missed. The Department of Health should work with the DWP to develop joint approaches to coordinate and improve benefit take-up. There should also be better joint working between

the pension service and local authorities with targeted campaigns designed to improve knowledge and take-up of all benefits. Likewise support to improve take-up should be undertaken by housing departments for those applying for disabled facilities grants and housing benefits.

7. *The optimum level of charges.*

7.1 Age Concern believes that charges for health services are not appropriate and that older people, wherever they live, should have free and fair access to health services to promote and maintain their physical and mental health and to treat illness. Charges work against the Government's agenda of the prevention of illness, and against the commitment to reduce health inequalities, as they inevitably affect the poorest and those with the greatest health needs. We are not aware if there has been any study on the cost of running the low income scheme and policing the exemption schemes. More difficult to cost but a highly important factor is the possible later cost to the NHS caused by older people not having treatment because of worries about charges.

8. *What criteria should determine who should pay and who should be exempt?*

8.1 As stated above, Age Concern is opposed to charges that are fundamentally at odds with the principles of a NHS service free at the point of delivery with access based on clinical need. If charges are to remain it is imperative that they do not discriminate against older people. Help with costs should be based on the principle that no one should be forced to choose not to access health services or care because of concerns about cost. To achieve this would require a more generous and easily accessible system of means testing, with greater passporting if for instance those in receipt of housing or council tax benefit getting full help with health costs.

8.2 Equally care must be taken to ensure that those with the highest health needs are not penalised by charges across a range of services they require. There is currently no way of ensuring that those people who are not eligible for the low income scheme and who need a variety of services for which a charge is levied, or require many hospital visits, are not having to spend large sums of money which they cannot afford. There is no equivalent to the pre-payment scheme for prescriptions to help keep the costs down.

9. *Conclusion.*

9.1 We hope that the above helps the committee in their inquiry. The charges which are the subject of this inquiry currently create many problems for older people. We are particularly worried that *ad hoc* local charges such as those for parking have become a way for NHS Trusts to reduce their budgetary pressures at the expense of the local community, with little scrutiny on the way they are imposed or their impact on patients. We hope that this inquiry will shed some light on this subject.

9.2 Age Concern strongly recommends the abolition of direct charges for health care. Given that the choice agenda will allow patients to choose to go to a private hospital funded by the NHS, there is a strong argument that the same should apply to primary and community based services such as chiropody and dentistry. There should be a review of help with transport costs to hospital and other health services such as GP and dental practices and regulation of charges locally determined charges, such as parking.

Pauline Thompson  
Age Concern

December 2005

---

**Memorandum submitted by the Association of Dispensing Opticians, Association of Optometrists and the Federation of Ophthalmic and Dispensing Opticians (CP 26)**

1. OVERVIEW

1.1 There are over 7,300 opticians premises in Great Britain. They range from large stores with multiple consulting rooms to small practices in local shopping parades. Optical practices are equipped to carry out full eye examinations and the diagnosis and monitoring involved in co-managing patients with GPs or hospital ophthalmologists. After a sight test, patients are issued with a prescription or a statement saying that a prescription is not required. Patients are also informed if the prescription has not changed. Patients can have spectacles or contact lenses dispensed in accordance with their prescription wherever they choose. NHS vouchers are available to qualifying groups to help with the cost of spectacles or contact lenses. They vary in value according to the lens powers prescribed. Vouchers can be used as a contribution towards the cost of any spectacles or contact lenses.

1.2 The current NHS sight test fee is £18.39. This is for the final year of a three year agreement. The profession negotiated with the Department of Health for revised fees from 1 April 2006. The current sight test fee is about half the actual cost of providing a sight test (estimated at about £37). With advancement in technology and an ageing population requiring more information and assurance, the sight test now takes longer to perform and has become more expensive to deliver.

1.3 The total GOS spending has hardly changed in real terms since 1999–2000 and excluding the effect of the extension of free sight tests has been static as the table 1.4 below shows. Without the increased exemptions total spending can be estimated at £127.9 million in 2003–04. In contrast the total NHS expenditure rose by 20% in real terms over these three years and by 45% over the whole 10 years.

1.4

<i>Year</i>	<i>GOS spending on sight test fees at 2003–04 prices omitting extension of free tests £m</i>
1994–95	110.6
1999–2000	117.6
2000–01	122.3
2001–02	126.6
2002–03	125.6
2003–04	127.9

1.5 It is clear that the optical sector has provided improved value for the NHS. The sight test fee at £18.39 is well below the cost of providing the test (£37). The fee to the NHS has been subsidised through the sales of spectacles. This has not been an example of good practice in government contracting where fair prices are agreed without hidden cross-subsidies on third parties. It is widely accepted that: (a) the Government should pay a fair market price for services, and (b) that it should minimise distortions to free economic activity.

1.6 According to a recent survey carried out by FODO, the average interval between sight tests has increased from 23 months to 26 months. We estimate the average interval for working-age adults is over 30 months.

1.7 At present there are no current definitions of strategic priorities for improving health in the optical field. A National Service Framework or a set of quality standards, which could serve as the basis for definitions of quality in service, does not underpin the current GOS. Nor is there much information on visual standards or on problems that could be encountered as a result of poor sight. The lack of information is one reason for the almost total absence of any emphasis on the importance of eye health or visual/ophthalmic standards from government review or strategies. Neither the recent White Paper on public health nor the latest DoH paper on NHS improvement, mention visual standards: nor did any of the Wanless Reports. The only issue to gain any attention has been that of waiting times for cataract operations.

## 2. WHO IS ELIGIBLE FOR AN NHS SIGHT TEST?

### 2.1 NHS Sight tests

<i>Sight tests (GB)</i>	<i>% of NHS sight tests</i>
Aged 60 or over	42.3
Children under 16	21.6
Under 19 in full time education	4.4
Benefit Claimants—Income Support, income based Jobseekers Allowance, Pension Credit Guarantee Credit, etc	17.8
Named on a valid HC2 or HC3 certificate—the sight test fee (or voucher) will be reduced by any amount the claimant is assessed as being liable to pay	1.5
Diabetes or Glaucoma sufferer	6.0
Relatives 40 and over of Glaucoma sufferers—(parent, brother, sister, son or daughter)	5.4
Registered blind or partially sighted	0.2
Needing complex lens vouchers	0.4
<i>Vouchers (GB)</i>	<i>Percentage of vouchers</i>
Children under 16	26.5
Under 19 in full time education	6.0
Benefit Claimants/HC2—HC3 (see above)	55.6/5.9
Complex lenses—a registered optician can advise on entitlement	0.8

### 3. BUYING SPECTACLES, CONTACT LENSES AND GETTING AN NHS EYE TEST

3.1 Around two thirds of the 7,300 optical practices in the community stock a range of spectacles within the price of the lowest value NHS voucher, currently £32.90. Many patients exercise their right to use a voucher as part payment to purchase more expensive options. This is reflected in the figures below.

3.2 6% of sight tests resulted in patients choosing contact lenses. According to the Association of Contact Lens Manufacturers Annual Report 2004 the number of people wearing contact lenses in 2004 rose to 3.21 million—6.5% of the adult population, an increase of 16% since 2001. The majority wear frequent replacement lenses. Over one million adults (34% of wearers) wear daily disposable lenses, 180,000 (6%) wear silicon hydrogel lenses and 345,000 wear rigid contact lenses (11%).

3.3 According to a RNIB report and Laing & Busson over one million older people live at home or in care, unable to visit a high street optician unaided yet only 344,000 domiciliary sight tests were carried out last year. This suggests that a great deal more needs to be done in this area. Research shows over 189,000 people with visual impairments fall each year at an estimated cost to the NHS of £269 million (research carried out by the University of York). Of course visual impairment doesn't just result in trips and falls, it can cause painful headaches which make life exceptionally difficult.

### 4. AVAILABILITY OF NHS EYE EXAMINATION IN THE FUTURE: OUR VISION FOR THE FUTURE

4.1 We believe that as an essential NHS service the eye examination should be available to patients on a national basis irrespective of where they live and independently of the funds available locally. Eye care is an essential primary care service and should be available without restriction to eligible citizens on the basis of need. The current non cash-limited funding system ensures that all eligible patients who have a genuine need can have a NHS sight test whenever and wherever they need it. It also provides the essential foundation without which the current vigorously competitive market could not operate. This gets new providers to enter the market freely, set up in business to provide eye care (subject to General Optical Council and primary care organisation quality controls) and offer alternatives to existing providers on the basis of quality, access and cost.

#### 4.2 *A wider range of procedures should be available for NHS patients*

The eye examination should be redefined to include a wider range of procedures offered on the basis of patient need and the practitioner's clinical judgement. An essential part of any health service should be health. The current GOS sight test which has existed largely unchanged for the last 60 years is primarily a refraction service to provide spectacles but with elements of health screening and opportunistic health checks included. This has led to the current sight test being primarily a means to provide spectacles or contact lenses, rather than acting as the primary examination in response to a range of eye symptoms and conditions. The more advanced optometric techniques that can currently be performed are either charged for privately, or provided free to the patient and the NHS as a gesture of goodwill. This is a poor model for providing essential care. If services are not properly designed for the needs of patients, patients will not access them and the service will not satisfy their requirements. If the service is inadequately funded there is every likelihood that the service will just not be provided to a consistent and high enough standard. The fact that optometry provides such a high level of service under these conditions and with such a low level of complaints is testimony to the commitment of opticians and ophthalmic medical practitioners to their patients. However it is not a situation that can continue. A new NHS eye examination has been developed in Scotland which removes the mandatory refraction and allows practitioners greater professional freedom. It will consist of a primary and a supplementary examination, both of which will attract funding more appropriate to the actual time spent with patients. This will allow practitioners to examine patients and provide a more appropriate service. This will also act as the corner-stone for an integrated service amongst optometrists, ophthalmic medical practitioners, dispensing opticians, GPs and social workers in primary care and ophthalmologists and orthoptists in hospital.

#### 4.3 *A properly funded NHS examination*

The eye examination should be properly funded on the basis of an independent survey of full costs. It is widely recognised that the current NHS sight test fee is significantly under-priced not least by Department of Health negotiators who rely on the cross-subsidy from the sale of spectacles and contact lenses—in effect making it a loss leader for product sales. This has suited successive governments who have not wished to invest in NHS eye care. However, there have been significant downsides. In particular the public has come to undervalue the importance of eye care and the need for regular checks and to view the eye examination as simply a test for correcting sight and a “grudge payment”. As a result patients attend for eye checks less frequently than they should. This will in turn have led to missed pathologies and blindness involving far higher long-term costs to the NHS. The last costs survey was carried out in 1992. It concluded that the cost of providing an eye examination was £18.42 (£25.97 at 2005 prices) and this was conducted at a time before a number of significant technical advances which are now commonplace and which have enhanced the clinical effectiveness of the sight test but made it more expensive to equip for and deliver. As the population grows older and as patients generally become better informed and require more information and reassurance, the average sight test now takes longer to perform. The optical sector is very happy to participate in a new

independent survey of the costs of providing a sight test and other aspects of eye care. Additional NHS eye care services should also be properly funded. Such a survey could also include the costs of services described as “additional primary care” and “enhanced services” as is in the Health Bill.

#### 4.4 *End cross subsidies*

There should be no cross subsidy between clinical services and sale of product. It is well established that subsidies distort markets. The NHS has not paid for improved standards of sight testing. Rather, the sight test fee represents a declining proportion of the costs. There has been increasing cross subsidisation of the costs of the sight test fee by sale of spectacles. Total General Ophthalmic Service expenditure in England has risen from £248.8 million in 1999–04 to £321.6 million in 2003–04. However, much of this rise has been accounted for by the extension of eligibility for free sight tests in 1999–2000. Since then, total gross expenditure has risen from £315.2 million in 2000–01 to £321.5 million in 2003–04.

It is not in the long-term interests of the NHS, the optical sector or patients for providers to be inadequately remunerated for the clinical care they provide. The current low level of the NHS sight test fee means that, effectively, NHS patients who, following a sight test, need spectacles or contact lenses, are subsidising eye examinations for those who do not. This contravenes the founding principles of the NHS and is the reverse of the situation in the rest of health care.

#### 4.5 *New Business Services Authority*

Submission of claims and optical payments should be centralised in the new Business Services Authority (in the same way as for pharmacists and dentists) to improve efficiency and reduce bureaucracy costs and fraud. Common services agencies and PCTs (even when merged) will always be relatively small organisations. It is inefficient to deploy scarce resources on payment functions at this level. It was for this reason that the Department of Health established the Dental Practice Board and Prescription Pricing Authority at the start of the NHS for dentist and pharmacist payments. These bodies are now being merged into a new NHS Business Services Authority (BSA) for the NHS.

They have well-established and efficient payments systems which could easily include optical payments. It would therefore make sense for optical payments to be handled centrally by the BSA on behalf of primary care organisations. It would also make sense for optical payments to be built into systems developments at the BSA from the outset to avoid greater costs later on. As all costs impact on prices, improved efficiency will benefit patients and increase the value of NHS investment. Additional benefits for the NHS would be greater efficiency, freeing-up resource at local level, a rich database for interrogation, policy monitoring and development, and effective electronic monitoring for counter-fraud purposes.

## 5. HOW ARE SCOTLAND AND WALES DIFFERENT FROM ENGLAND

5.1 Optometry Scotland has been working with the Scottish Executive Health Department and ministers to develop a new contract in Scotland. It includes new primary and secondary eye examinations, new fees and new investment. It is the most significant change in legislation concerning the provision of eyecare in Scotland for 60 years and places optometry firmly within the NHS as the principal provider of eyecare.

5.2 The Welsh Assembly Government (WAG) has continued to achieve great success with the development of WECEs (Welsh Eye Care Examination) and the PEARS (primary eye acute referral scheme) provided by over 80% of the optometric workforce. Similarly, the Wales Low Vision Examination has been operational for 17 months, moving the provision of low vision services into primary care. Waiting time and appliance provision has dropped from 18 months to eight weeks. Both schemes have been developed as a result of WAG funding, and with all with participants being able to participate to ensure equity in patient choice. Significant savings in secondary care have accrued as a result.

*John O'Maoileoin*

Association of British Dispensing Opticians (ABDO), Association of Optometrists (AOP) and Federation of Ophthalmic & Dispensing Opticians (FODO)

*December 2005*

---

### Memorandum submitted by Breakthrough Breast Cancer (CP 31)

#### 1. INTRODUCTION

1.1 Breakthrough Breast Cancer is the UK's leading breast cancer charity and is committed to fighting breast cancer through research and education. Breakthrough has established the UK's first dedicated breast cancer research centre, in order to obtain our vision: a future free from the fear of breast cancer. Breakthrough campaigns for policies that support breast cancer research and improved services, as well as promoting breast cancer education and awareness amongst the general public, policy makers, health professionals and the media.

1.2 Our memorandum reflects the views of Breakthrough and members of its Campaigns and Advocacy Network (Breakthrough CAN), many of whom have personal experience of breast cancer.

1.3 Breakthrough welcomes this inquiry. Our memorandum focuses specifically on the issue of co-payments and charges for NHS wig services, as an example of how co-payments and charges in the NHS can impact on the patient. Breakthrough staff and CAN members would be willing to provide oral evidence to this inquiry, if the committee would find this useful.

## 2. ARE CHARGES FOR TREATMENTS AND HOSPITAL SERVICES EQUITABLE AND APPROPRIATE?

2.1 Women and NHS Trusts have reported real concerns over the quality and accessibility of wig services in many parts of the country, and in particular regarding patient dignity and sensitivity, lack of choice of wigs, and payment for wig services.

2.2 There are major discrepancies in the cost of the service depending on where people live and whether they receive their chemotherapy treatment as in-patients (where people are entitled to a free wig) or as out-patients (where people are not entitled to a free wig).

“In our experience, each hospital is different—they may give a prescription (for a wig) if they are an outpatient but usually only to in-patients. The majority of patients are outpatients when they have chemotherapy. Also the prescription can only be used towards NHS wigs and these are very low quality (compared) to what’s generally available. We’ve had lots of queries from women who want to use the prescription for a non-NHS wig and put money towards the amount but this is not allowed”. Breast Cancer Care northern regional office.

“Members are not happy that they have to pay for the first £50.00. Lots of ladies are pensioners or unemployed and don’t have it to spare. The breast care nurse has to go to charities for help”. Hartlepool Breast Care Support Group.

2.3 Many patients are unhappy with what they see as a lack of choice in who can provide their wigs, as they are limited to NHS suppliers. It is essential that patients be offered a full-range of wigs, taking into account hair colour, style and type.

“When our patients can’t get what they prefer locally many get their wigs from other sources, for example local markets that are cheaper or other specialised wig shops which are out of the area and are usually expensive . . . some patients complain that they feel pressurised to purchase their wigs from the local shop which is contracted to the hospital.” Chemotherapy Sister, Newham.

## 3. WHAT IS THE OPTIMAL LEVEL OF CHARGES?

3.1 Breakthrough believes patients using wig services should be given greater flexibility to make part-payment towards a wig of their choice.

## 4. WHETHER THE SYSTEM OF CHARGES IS SUFFICIENTLY TRANSPARENT

4.1 There needs to be much greater transparency in how patients are told about their local wig service facility and its payment system.

“Interestingly, no-one seems to know that inpatients requiring a wig do not have to pay for it. I suspect that people are discharged before they learn that this facility is available to them!” Chiltern Breast Cancer Support.

## 5. HOW SHOULD RELEVANT PATIENTS BE MADE AWARE OF THEIR ELIGIBILITY FOR EXEMPTION FROM CHARGES

5.1 The majority of CAN members involved in our wig service consultations paid a prescription charge for their wig. Breakthrough believes it is best to be informed of charges at the earliest possible time.

“I was told straight away that I would have to pay a prescription charge for the wig. I was then given a slip with the details of how to pay, with the wig.”

5.2 Good practice should demonstrate wig suppliers offering advice on how to maximise the use of the prescription charge.

“I chose to buy two wigs and was advised to buy the dearer one from my NHS payment rather than using my own money.”

5.3 Wig suppliers should also be aware of the sensitivity of a patient’s needs when using the wig service, in particular regarding their financial situation. One scheme that stands out as good practice is provided by a women’s group in Brigg who sponsored a patient’s wig.

## 6. WHETHER CHARGES SHOULD BE ABOLISHED

6.1 The Department of Health should consider the impact the abolition of prescription charges in Scotland and Wales may have on wig payments.

## 7. RECOMMENDATIONS FOR ACTION

7.1 The Department of Health should review payments for wigs with a view to tackling the lack of choice and inequalities inherent in the current system.

7.2 The review could consider the feasibility of introducing a system which would allow top-ups to prescriptions. One advantage of such an approach is that it would allow women to make part-payment towards a wig of their choice. However, any work on the feasibility of this type of system would need to consider the potential impact on equalities of having a system in which the quality of wigs is, in part, dependent on ability to pay.

7.3 It might also consider the impact the abolition of prescription charges in Scotland and Wales may have on wig payments.

## 8 BACKGROUND TO HAIR LOSS

8.1 Breast cancer is the number one health concern for UK women and remains the most common cancer in UK women—nearly 41,000 women and around 300 men are diagnosed each year. On average 63 women are diagnosed with breast cancer in each constituency every single year.

8.2 Many patients diagnosed with breast cancer will undergo chemotherapy (treatment using drugs designed to destroy or control cancer cells) as part of their treatment programme and may, as a result of such treatments, suffer varying degrees of hair loss. Some will opt to wear a wig during their treatment time. Other people diagnosed with other cancers also undergo chemotherapy, possible hair loss and as a result may wear a wig. Therefore the number of people accessing wig services is considerable.

8.3 For some people, coping with hair loss is the most distressing side effect of treatment. Hair can be very much part of a person's self-image and losing it may affect confidence and self-esteem.

8.4 It is also a very visible side effect of cancer, often leaving a person feeling vulnerable and exposed, and for women in particular feeling unfeminine and unattractive.

8.5 Hair loss impacts even further in cultures where hair is seen as a symbol of fertility and desirability, or alternatively as a sign of health and status.

*Vicki Nash*

Breakthrough Breast Cancer

*December 2005*

---

### Memorandum submitted by Breast Cancer Care (CP 16)

#### 1. SUMMARY OF RECOMMENDATIONS

1.1 Breast Cancer Care believes that all cancer patients should be exempt from prescription charges. We feel it is unreasonable that they should have to pay for life saving drugs or for drugs to combat the debilitating side effects of their cancer treatment. This includes hormonal therapies that are prescribed to breast cancer patients for several years after their initial treatment.

1.2 Breast Cancer Care would like to see hormonal therapies prescribed for longer periods, to cut down the cost and inconvenience of frequent prescriptions for a long term medication. We would also like to see uniformity across the country to ensure all breast cancer patients are receiving prescriptions of the same length.

1.3 Breast Cancer Care would like to see more being done to ensure all cancer patients are informed of the Prescription Pre-Payment Certificate (PPC). Many breast cancer patients find the PPC invaluable in helping them cover the cost of their prescriptions but a concerning number of those we spoke to do not use the PPC despite the fact that it could benefit them financially.

## 2. INTRODUCTION

### 2.1 *Breast Cancer Care*

2.1.1 Breast Cancer Care is the UK's leading provider of information, practical assistance and emotional support for anyone affected by breast cancer. Every year we give direct support to over 22,000 people with breast cancer or breast health concerns through our helpline, peer support and other direct services. In addition, we respond to two million requests for support and information about breast cancer or breast health concerns through our publications, website and outreach work. All our services are free. We are committed to campaigning for better treatment and support for people with breast cancer and their families.

### 2.2 *About this response*

2.2.1 A diagnosis of breast cancer often has many long term financial implications attached to it. A major issue we frequently hear about from people affected by breast cancer is prescription charges. Over the past months we have been gathering views and experiences related to prescription charges from people across England who have been diagnosed with breast cancer. In total, 115 women completed the survey. We have used our findings to develop and illustrate this response which is mainly focused on the issue of prescription charges. Key findings from the survey:

- 98% of respondents think cancer patients should be exempt from paying prescription charges
- 38% of respondents think prescription charges should be completely abolished
- 43% of respondents have experienced financial difficulties as a result of paying prescription charges
- 39% of respondents use a Prescription Pre-Payment Certificate
- 15% of respondents have decided not to get their prescription dispensed because of the cost

## 3. *Are charges equitable and appropriate?*

3.1 Breast cancer is a potentially life threatening condition and it seems inequitable to breast cancer patients that they have to pay for their prescriptions when people diagnosed with other conditions are exempt. Respondents to our survey feel they are being discriminated against, even though they have developed breast cancer through no fault of their own.

“Most life threatening conditions such as diabetes and thyroid problems are exempt from prescription charges so I think by not exempting breast cancer we are discriminated against. How can the authorities say one condition is more serious than another?” Sarah Clark, Kent

“We have a life threatening, long term condition. In this respect cancer patients are no different from those with diabetes or thyroid conditions. Why are we discriminated against?” Jackie Igoe, Wirral

“Psychologically you feel that you are being punished for getting cancer.” Tracey Harrison, Cheshire

3.2 Some breast cancer patients feel the very principle of having to pay for prescriptions for life-saving drugs is unjust. One reason given is that people who develop a life threatening illness such as breast cancer, who have worked and therefore paid their National Insurance contributions for many years, have a right to receive their healthcare for free, including prescriptions. Others state economic reasons, in that they believe it would be cheaper to cover the cost of prescription charges for cancer patients, and thereby ensure all patients are able to take the drugs they need and maximise the chances of recovery, than it is to pay for the care of terminally ill secondary cancer patients.

“I have always been a firm believer in a National Health Service funded from general taxation and free at the point of need. I see this principle being increasingly eroded, not least by the ever-rising cost of prescriptions.” Breast cancer patient, Oxfordshire

“Reducing the numbers of people who go on to develop secondary cancers reduces the overall cost to the NHS. The longer a person remains healthy the less the cost to the NHS in the longer term.” Jacqueline Tipple, Kent

3.3 Breast cancer patients feel that having to pay prescription charges exacerbates an incredibly stressful situation. They are already having to cope with the inevitable concerns and emotions a diagnosis of breast cancer brings and feel they should not have to add finances to their list of worries. People may have to find money for a whole range of co-payments and other expenses, including hospital parking fees, travel and childcare, at a time when they may be on a reduced income as they are unable to work due to their illness

and treatment. We have particular concerns about people affected by secondary breast cancer, as they will often require significantly more drug treatments than others and will therefore be under more of a financial burden from prescription charges.

“Dealing with a terminal disease is difficult enough without worrying about the cost of life-saving prescriptions.” Pat Montgomery, Leicestershire

“Many like myself are unable to work and are only receiving SSP from their employer and simply cannot afford to pay these charges along with other costs of getting to hospital, car parking etc.” Breast cancer patient, Staffordshire

“The diagnosis brings lots of financial pressures in addition to prescriptions: travel for treatment, car parking, heating, clothing, wigs, food. Why should you have to pay for being ill?” Barbara Thomas, Norfolk

“There are many additional expenses that you incur once you have been diagnosed with cancer such a vitamins and supplements to improve your immune system. Additional purchases when going through chemotherapy. Extra petrol, car parking due to many attendances at hospital. It’s certainly not cheap being ill.” Janet Clegg, Lancashire

3.4 43% of respondents to our survey reported that the cost of prescription charges impacts on other areas of their finances or causes them financial difficulty. This is of great concern, because, as was stated earlier, a diagnosis of breast cancer is extremely stressful without the added difficulty of financial pressures. This also shows that the financial support provided by the current exemptions system does not extend far enough, as in theory, all those who are not eligible for exemptions should be able to afford their charges. This is clearly not the case for the 15% of respondents who have decided not to get their prescriptions dispensed because of the cost.

“I have a family of five and therefore have to pay for a lot of outgoings. We’re not all made of money and extra money spent on prescriptions means less money spent on my children’s education or we have to reduce our food budget.” Secondary breast cancer patient, Berkshire

“I had to cut my family’s food budget down to afford the prescription charges which made me feel guilty on top of being ill.” Patra Aretakis, Cambridgeshire

“My heating bills went up as did my petrol bill because of travel to hospital. I am still paying off the debt on my credit card for from money I spent on these extras. I feel I should not have paid for my prescriptions.” Christine Clover, Lancashire

“Sometimes when I didn’t have much money I spent it on food instead of prescription charges.” Breast cancer patient, West Yorkshire

3.5 Some breast cancer patients feel they should be able to access free dental treatment while they are being treated for breast cancer, as a common side effect of chemotherapy is a sore mouth and gums, infected mouth sores and the exacerbation of any existing dental problems. As these problems are directly related to chemotherapy, they should be free of charge for the duration of the treatment.

3.6 Paying for wigs is another expense that breast cancer patients feel strongly about. Many breast cancer patients lose their hair as a result of chemotherapy and while inpatients are entitled to a free wig, outpatients have to pay a prescription charge of £53.10 for a basic NHS wig. Breast cancer patients do not think this is equitable. Hair loss can be one of the most distressing side effects of chemotherapy and can deeply affect a patient’s self-esteem, body image and sense of dignity, regardless of whether they are an inpatient or an outpatient. Patients who have to pay for their wig feel they are being penalised financially. This could become a more prevalent issue as new methods of treatment, such as oral chemotherapy drugs, allow growing numbers of people to receive treatment as outpatients.

“I would have had a free wig had I received my chemo as an inpatient. This didn’t make much sense to me. If I’d been sick enough to be in hospital a wig would have been the last thing on my mind. However it was an expense I had to make as my confidence had sunk so low I couldn’t have gone without a wig.” Breast cancer patient, Lincolnshire

3.7 The main prescription charge encountered by breast cancer patients is for hormonal treatments such as tamoxifen and Arimidex. Breast cancer patients feel it is extremely unfair they should have to pay for a drug that is vital in preventing the recurrence or spread of breast cancer. Hormonal therapy is just as important to a breast cancer patient’s recovery as inpatient treatments such as radiotherapy and chemotherapy, yet it has to be paid for simply because it is taken at home rather than in hospital.

“You are prescribed with a life saving drug by your clinician, as part of your treatment after surgery, chemotherapy and radiotherapy. As this is part of the means by which your cancer is hopefully kept under control, you should not have to pay prescription charges at all for such drugs.” Breast cancer patient, Surrey

3.8 The long term nature of hormonal treatment means breast cancer patients can have to find the money to pay for their prescriptions, both for their hormonal treatment and for drugs to combat any side effects, for up to five years, which can be an ongoing pressure on their finances. In the future this could increase to as much as 10 years, with the introduction of new aromatase inhibitors (one type of hormonal therapy). Another issue that breast cancer patients feel strongly about is how often they receive their prescriptions. There are discrepancies across the country, with some women being prescribed their hormonal therapy for

three months at a time, others for two months and others for just one month. Some respondents told us that they had asked to receive more than one month's supply of their treatment on each prescription but were told it was not possible. This variation in prescribing habits is penalising those breast cancer patients who have to pay for a prescription every month. There does not seem to be any uniformity as to how often prescriptions for hormonal therapies are issued and naturally some women feel they are being unfairly treated.

“If hormone treatments are not to be exempt they should be given once a year so that we only have one prescription charge per year.” Sarah Clark, Kent

“I can't understand why prescriptions cannot be given for a longer time span which would save time and cost all round.” Caroline Way, Norfolk

#### 4. Exemptions

4.1 Breast cancer patients feel that any condition that is either life threatening or long term, or both, should be exempt from prescription charges and other co-payments. This includes all types of cancer. One of the reasons given by respondents to our survey as to why cancer should be added to the list of conditions that are exempt from prescription charges is the changing nature and length of treatment. Survival rates are increasing and people can now receive long term treatment for their condition, for both primary and secondary cancers. As stated earlier, hormonal treatments for breast cancer are routinely taken for five years, which could rise to ten with the introduction of new aromatase inhibitors, and new developments, such as oral chemotherapy, are reducing the amount of time that patients have to spend in hospital. This also means that patients are liable for more prescription charges than ever before. The current system of charges needs to be updated to take this into account—as it stands it is out dated and full of anomalies.

“Many years ago a cancer diagnosis was as good as a death sentence so I can imagine that policy makers did not consider it a ‘lifelong’ illness. Now treatment has improved greatly and the diagnosis is not always a death sentence but can be managed by medication. . . . There could be a new drug on the market and I could be prescribed that therefore I could live for decades thanks to medication. Cancer treatment has become more and more long term and I therefore believe long term medications should be free.” Helen Eastham, Lancashire

#### 5. Awareness of eligibility for exemption

5.1 Despite the fact that most people diagnosed with breast cancer will take a hormonal treatment, along with drugs to combat any side effects, for several years after inpatient treatment and that many are only prescribed one month's supply per prescription, only 39% of respondents to our survey use a Prescription Pre-Payment Certificate (PPC). This is a surprisingly low number and suggests that breast cancer patients are not routinely being made aware of the PPC. This is worrying, as those who do use a PPC are overwhelmingly positive about its financial benefit and it could no doubt assist many others who report financial hardship as a result of co-payments and charges. We believe more should be done to ensure that all cancer patients are informed of the PPC.

“I found out by chance all too late about pre-payment. I wish the hospital had informed me about this.” Patra Aretakis, Cambridgeshire

#### 6. Should charges be abolished?

6.1 Breast Cancer Care believes that cancer patients should not have to pay co-payments and charges for anything that relates directly to their cancer treatment, whether as an inpatient or outpatient. The overwhelming majority of people who responded to our survey, 98%, believe that cancer patients should be exempt from paying prescription charges.

6.2 There were mixed opinions from respondents to our survey over the complete abolition of prescription charges with the majority, 62%, opposed to the idea. Many of the breast cancer patients we spoke to are happy to pay prescription charges for other items, but feel they should be exempt for drugs and treatments that are related to their cancer.

“I don't mind paying for one off prescriptions but long term medication should be free.” Julie Ulvmoen, Middlesex

“I feel that if you can afford it you should normally pay for prescriptions—after all we all go to the supermarket and stock up with aspirin etc. However after a cancer diagnosis I feel there should be a waiver—it is scary enough as it is and the drugs are a necessity.” Hilary Duckett, Wiltshire

Jenny Priest  
Breast Cancer Care

December 2005

---

---

**Memorandum submitted by the British Dental Association (CP 11)**

1. The British Dental Association (BDA) is the trade union and professional association for dentists practicing in the UK, representing 22,000 members working in all aspects of dentistry, including general practice, salaried services, the armed forces, hospitals, academia and research. In September 2005 the BDA responded to the Department of Health's (DoH) *Consultation on the draft National Health Service (Dental Charges) Regulations 2006*, which can be downloaded from the BDA website [www.bda.org](http://www.bda.org)

2. The BDA would be pleased to offer oral evidence to the committee on this subject.

**BACKGROUND**

3. NHS patient charges or co-payments are a controversial area of healthcare finance. The Government has been levying charges for NHS dental treatment since 1951 with NHS dental charges in England currently raising revenue in the region of £485 million each year.

4. Tax-financed healthcare systems (along with insurance-based systems) commonly have the problem of potential excess utilisation of healthcare services, and consequently patient charges (or co-payments) are often, therefore, introduced to discourage excess utilisation.

5. Economic evidence indicates that at the level of the individual, introduction of a co-payment does lead to a reduction in the utilisation of healthcare (relative to healthcare that is free at the point of delivery). Most of this reduction in utilisation is by people in lower income groups and even children; further still demand for effective treatment is also reduced (ie treatments that have a real impact on health outcomes).

6. A recent study by the British Association for the Study of Community Dentistry (BASCD) 2005 has revealed a widening gap in the levels of decay in children's teeth in the poorest and richest parts of Britain. Areas with the lowest rates of tooth decay are exclusively in the south of England and the Midlands. The worst areas are restricted to parts of Wales, Scotland and the north of England. Five-year-olds in some of the poorest parts of the country, such as Merthyr in Wales, North Kirklees in Yorkshire, and Argyll and Clyde in west Scotland, have an average of almost four decayed, missing or filled teeth, while their counterparts in Maidstone Weald in Kent, and Suffolk Coastal, near Felixstowe, have an average of under 0.5.

7. Further still, the Adult Dental Health Survey (1998) indicates that adults, where the head of the household is from a higher social class, are less likely to be edentate (ie with no natural teeth); 7% of adults where the social class of the head of the household is I, II, or IIINM are edentate, compared with 14% of adults where the social class of the head of household is III M, and 21% of adults where the social class of the head of household is IV or V.<sup>1</sup>

8. Further, and putting such inequality issues aside, at the macro level of the healthcare system as a whole, charging patients for care in high income countries is very often unlikely to save overall healthcare costs if the healthcare providers remain free to concentrate their demand-inducing abilities (or practice cream skimming<sup>2</sup> of patients) on those who can afford to pay.

*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?*

9. The proposed draft regulations on NHS dental charges establish a three banded charges system (with an urgent treatment charge band) which is to be introduced from 1 April 2006. Some treatments will be free of charge and there will be guarantees that, should certain treatment be necessary within a defined period, no further charge will be made.

10. However, according to the Government, the NHS Plan has at its core a continued commitment to the founding principles of the NHS. These founding principles can be summarised as, the provision of care that:

- meets the needs of everyone;
- is free at the point of need; and
- is based on a patient's clinical need not their ability to pay.

11. These core principles imply that there should be no NHS dental patient charges, and that the proposed charges system is therefore inappropriate and diametrically opposed to the core principles of the NHS.

12. The BDA believes that the proposed NHS dental charges system significantly hinders preventative care, and encourages patients to delay treatments so as to maximise value for money.

---

<sup>1</sup> These social classes are assigned on the basis of the occupation of the head of household using the Registrar General's Standard Occupational Classification. Occupations are assigned to six social class categories: professional occupations (I); managerial and technical occupations (II); skilled occupations (III) with IIINM as non-manual and IIIM as manual occupations; partly skilled occupations (IV); and unskilled occupations (V).

<sup>2</sup> This is where a healthcare professional chooses which types of patients that they treat; as a general rule of thumb these patients will be lower risk patients that generally require less (and in many cases less costly) healthcare intervention.

13. The polarised incentives that such a system creates between patients and dentists will, the BDA believes, be detrimental to the longer term quality of patient care. In addition, the Government has alarmingly chosen not to pilot the proposed new patient charges system in any of the much lauded 3,000 plus practices that have entered into Personal Dental Service (PDS) arrangements. As such, neither the BDA nor the Government have the evidence base to conclude fully on the appropriateness or equity implications of such an untested system.

14. Under the proposed new patient charging system access to NHS dentistry comes at an up front charge of at least £15 to the majority of the population, with preventative care no longer being free. In addition those patients from lower socio-economic backgrounds, who have higher dental needs, will continue to pay more for their treatments.

15. As with many co-payments in the NHS, exemptions are absolute. Consequently, there will be a large proportion of the population on the cusp of exemption criteria. The BDA does not consider this an equitable approach for dental co-payments and those who marginally fail to qualify for exemption are significantly financially disadvantaged.

16. Finally, the increments between the three bands in the proposed charges system are excessive. For example, the patient charge increases by almost 175% between band 1 and band 2 and rises by almost 350% between band 2 and 3. The BDA is convinced that such increments will prove to be a barrier to accessing appropriate NHS dental care and as such is not equitable and contravenes core NHS principles. The new charges system has failed to address the impact on those people who will find the new system unaffordable.

For example, an older person on a fixed income who needs a partial denture will be paying significantly more under the proposed patient charges system than under the previous fee per item patient charges system. Concerns such as this seem inequitable and need to be addressed immediately.

*What is the optimal level of charges?*

17. The BDA cannot comment on what the optimal level of NHS dental charges should be. However, we would wish to see a charging level that maximises oral health and minimises oral health inequalities.

*Whether the system of charging is sufficiently transparent?*

18. The proposed banding system for NHS dental charges is significantly more transparent to patients than the current system of 400 plus individual items of treatment. However, the BDA has not been informed by the Government as to how this new charging system, and its intricacies, is to be communicated to the general public. For example, under the current system an exam with x-rays incurs a patient charge of £9.84 compared with £15.50 under the new system. The Government not only needs to communicate the transparency of the new system to patients but also needs to provide justification for why in many cases the patient charge incurred has risen. It is also important to make the public aware that these charges are not directly part of the dentist's earnings nor do they reflect the full cost of providing that particular treatment.

19. Underlying the reforms of NHS dentistry is the Government's vision of an integrated NHS dental care system, where patients can seamlessly move between the various components of primary care as and when is appropriate for patient needs. The proposed patient charges system does not explicitly define the charging situation across the differing components of an integrated NHS primary dental care system, particularly for Salaried Primary Dental Care Services (SPDCS). Consequently, the lack of clarity on the NHS charges is likely to result in different charges being levied across the various components of an integrated NHS dental care system. Such a situation is confusing for patients, creates perverse patient incentives thereby leading to inefficient outcomes and does little to promote an integrated primary dental care service. The BDA believes that whichever patient charges system is finally implemented that it be uniform and transparent across the whole of NHS primary dental services.

20. Although the proposed new NHS dental patient charging system has greater transparency in the sense that a patient knows that he/she will be paying one of three possible charging bands, there remains an asymmetry of information<sup>3</sup> between the patient and the dentist. The patient will only know the exact amount of the patient charge for their NHS dental care on the advice of the dentist after an examination, which has a charge of £15.50.

21. The BDA is opposed in principle to NHS dental charging, the fact is that consequent Government's have positioned charges as a fundamental component of the NHS dental budget. However, given that NHS dental charges have been commonplace for over 50 years, the BDA strongly supports the notion of transparency and equity where NHS dental charges are levied. Unfortunately, the Government continues to send out mixed and confusing messages to the public. For example, during the debate on the Health and Social Care (Community Health and Standards) Bill on 19 November 2003, Dr John Reid, then Secretary of State for Health, stated: "The Bill represents the next important stage in improving and revitalising our

<sup>3</sup> Asymmetry of information describes a situation where two economic agents in a market transaction have different amounts of relevant information. So for example a dental patient may go for a check up (believing that the charge would be £15.50) but in fact needs a filling which would have a charge of £42.40.

National Health Service. Let me make it plain right from the start that, to Labour Members, that means a National Health Service built on the founding principle that everyone in this country should have equal access to healthcare free at the point of delivery—a principle that will be defended and protected as long as this Government are in power”. This sentiment was further echoed by Prime Minister Tony Blair in his keynote speech to the Labour Party’s 2005 conference when he stated: “I will never allow the NHS to charge for treatment.” The BDA believes that the Government’s failure to send out clear messages about the reality of charges for NHS dentistry will mean that the benefits in terms of transparency of the new patient charges system will continue to be compromised.

*What criteria should determine who should pay and who should be exempt?*

22. The core principles of the NHS imply that there should be no NHS dental patient charges and as such the issue as to who should receive exemptions is a moot point. However, the Government has not taken the opportunity, as would be in line with the NHS core principles, to abolish NHS dental charges as part of the current reforms to NHS dentistry.

23. The BDA is not in a position to offer criteria on who should pay and who should be exempt from NHS charges as the BDA is opposed in principle to charging for NHS dentistry. However, given the reality that the Government continues to levy charges for NHS dental treatment, the BDA does have concerns about access and provision of oral healthcare for older people.

24. In the BDA’s 2003 report *Oral Healthcare for Older People: 2020 Vision*, the BDA emphasised that the reform of the NHS dental charging system needed to take account of the anticipated growth in the number of older people in England; the fact that older people are more likely to require more complex treatment in the future; and that they also tend to be among those least able to pay. The BDA advocates a free oral health risk assessment for patients aged 60 and above, with referral to a dentist for a strategic long-term oral healthcare plan, for those older people identified as likely to need complex restorative care. Combining this with free NHS examinations for patients aged 65 and over is likely to improve the oral health of the nation’s older person’s population greatly. However, given that the BDA would support “in principle” the ending of NHS dental charges, the action points above, were charges to be abolished, should be encouraged as “good practice” in the provision and delivery of oral healthcare for older people.

*How should relevant patients be made more aware of their eligibility for exemption from charges?*

25. It is clear that patients are currently not always sure as to whether or not they are exempt from NHS dental charges. There needs to be a more coordinated approach, firstly, between Government departments and, secondly, with patient and professional organisations (such as the BDA) on the most appropriate way for making people aware of their eligibility for exemption from charges.

26. The current HC11 *Help with health costs* published by the Department of Health (DoH) is a complicated document and attempts to cover all aspects of charging in the NHS in one document. The BDA would like to see a stand alone DoH document that focuses solely on dental charges and exemptions within NHS dentistry. The document should obtain the Crystal Mark from the Plain English Campaign, be available in Braille, on audio cassette tape, on disk, in large print and in a range of foreign languages.

27. The BDA would also look to the Government to send a clear message to the public that for those who do not qualify for exemptions, the NHS patient charge they pay does not contribute towards practitioners’ earnings and that it is Government policy to levy charges for NHS dentistry.

*Whether charges should be abolished?*

28. In a statement to BDA members, in 2005, the BDA’s General Dental Practice Committee (GDPC) reiterated that “GDPC continues to reject the principle of charging patients for NHS dental treatment.”

29. Currently, 30% of the total expenditure on NHS dentistry comes from patient charges. The BDA believes that should charges be abolished, this 30% currently paid by dental patients should be made up from central Government funding to ensure that the overall total expenditure on NHS dentistry remains unchanged.

30. Missed or late cancellations are an avoidable waste of valuable NHS resources and under the current system NHS dentists often make a small charge for this waste. Should NHS charges be abolished the BDA would support a capped charge to act as a deterrent for patients missing appointments or for late cancellations.

31. The abolition of NHS patient charges for dental treatment will remove a key barrier for access to dental care for parts of the population, many of which have far greater dental care needs than those who currently access the system. In the longer term, removal of charges will also contribute in reducing the prevalence of oral health inequalities across England.

32. It is worth remembering that oral health means more than good teeth: it is integral to general health and essential for wellbeing, enabling an individual to eat, speak, and socialise without active disease, discomfort or embarrassment.

*James Clark*  
British Dental Association

6 December 2005

---

### **Memorandum submitted by the British Medical Association (CP 29)**

In the following paragraphs we make some brief points in relation to prescription charges, which is the area of co-payments and charges that the BMA sees as the priority issue for review. The paragraphs are structured to answer the questions set out in the press release announcing the inquiry. We hope that you might consider calling the BMA to present oral evidence to the Committee to enable us to expand on some of the issues we raise.

#### **WHAT CHARGES ARE EQUITABLE AND APPROPRIATE?**

The argument against charges is that they generate little income as many patients are exempt from the charges. At present 85% of prescriptions are obtained free of charge. However, charges play a role in limiting demand. The prescription charge scheme first came into existence in 1952 and has remained in place apart from a brief period between 1966 and 1968. During that time there was a sharp rise in prescriptions dispensed.

The current system in England is anomalous, unclear and difficult to defend. A fundamental review of the system is needed.

#### **WHAT IS THE OPTIMAL LEVEL OF CHARGES?**

This is a difficult question to answer and needs further exploration. As we say below, there is a case for reviewing exemptions, for removing charges altogether or for removing exemptions and making everyone pay a low amount, say £1. But the answer partly depends upon context. Some argue that in the future the growth of pharmacogenetics will mean drugs will be individually tailored, which is likely to significantly boost production costs and therefore price. Technological advances could change the whole basis of the conversation.

Until this happens, we still see situations in which the current level of charging is a financial challenge. There is some evidence that the charges are too high for some groups. In 2001 the National Association of Citizens Advice Bureaux published evidence from its own survey and related work by MORI, showing that 28% of those who had paid prescription charges had failed to get all or part of the prescription dispensed because of the cost (38% of single parent households and 37% of those with long term problems). MORI estimated that around 750,000 people fail to get their prescriptions dispensed because of cost.<sup>4</sup>

The report identified a “poverty trap” in which patients just above the level of income support, for example those receiving incapacity benefit, get no help at all, and those with long term health problems were more likely to find charges difficult to afford, despite the season ticket scheme.

Doctors within the BMA have experiences that reflect this. Patients ask if all the medicines prescribed are really necessary as they are unable to pay for them all. There are patients with chronic chest disease who openly admit they will not be able to afford to have all their treatment dispensed because of the cost. There are also patients who want large amounts of drugs dispensed to reduce the number of prescriptions. There are patients who are unable to pay for all the items on the prescription at once who seek several prescriptions (one for now, one for later). There are cases where there is a failure to use asthma inhalers correctly because of the cost. These scenarios result in an overall increase in morbidity with attendant expense.

---

<sup>4</sup> National Association of Citizens Advice Bureaux. *Unhealthy charges: CAB evidence on the impact of health charges*, 2001, NACB.

---

## ARE CHARGES SUFFICIENTLY TRANSPARENT?

Charges are not sufficiently transparent.

## WHAT CRITERIA SHOULD DETERMINE WHO SHOULD PAY AND WHO SHOULD BE EXEMPT?

Patients should be exempt from charges on the grounds of income and on the grounds of catastrophic cost associated with treatment.

Exemptions on the grounds of income are important. In 2004 Lexchin and Grootendorst surveyed literature from a range of countries including England and concluded, "Virtually every article we reviewed supports the view that cost sharing through the use of co-payments (charges) or deductibles decreases the use of prescription medicines by the poor and the chronically ill".<sup>5</sup>

At the moment, patients are exempt from prescription charges dependent on their age, receipt of various benefits, pregnancy status, degree of disability or medical exemption criteria. The medical exemptions have remained unchanged since 1968 and there is scope for reviewing this list.

The BMA has long held the view that the current system of medical exemptions do not adequately reflect need as it exists in the community, particularly in relation to people who have chronic conditions or other diseases that rely on multiple and on-going medication. There is no logic behind the exemptions.

- Patients who require thyroxine replacement therapy for their underactive thyroid are prescription charge exempt for all medicines although thyroxine is one of the cheapest produced drugs and patients are unlikely to require other medication related to their condition. However patients with asthma and heart disease who may require multiple medication for a prolonged period, are not prescription exempt and must pay out considerable costs.
- Cystic fibrosis is a long-term condition which means people need to consistently take a large number of drugs throughout their life. When the list of medical exemptions was drawn up in 1968, the condition was not included as sufferers were not expected to survive beyond childhood.

Derek Wanless, in his report of April 2002, concluded that "the Review believes that the present structure of exemptions for prescription charges is not logical, nor rooted in the principles of the NHS. If related issues are being considered in future, it is recommended that the opportunity should be taken to think through the rationale for the exemption policy." The issue of prescription charge anomalies is periodically raised by politicians but there has been continual resistance to reviewing and changing the current system.

## HOW SHOULD RELEVANT PATIENTS BE MADE MORE AWARE OF THEIR ELIGIBILITY FOR EXEMPTION FROM CHARGES?

The whole system needs to be made more clear.

## SHOULD CHARGES BE ABOLISHED?

There are three possible directions for changing prescription charges: a revision of the exemption categories; the removal of all charges; lower level payments for all prescriptions. There has been discussion of each option within the BMA.

### *Revision of exemption categories*

The BMA has long supported the policy that the exemption categories should be revised in line with actual burden of illness and the increased need for medication. It is grossly unfair that those who are most in need of medication may fail to access it for financial reasons. There is an enormous amount of information in the NHS relating to health costs, prescriptions costs, and burden of illness, which means that such a revision should not be an impossible task.

### *Removal of all charges*

The removal of charges is already beginning in Wales and a possibility for Scotland. The change in prescription policy in Wales currently means there is no prescription charge for anyone under 25 and the cost per prescription for others is £4. All prescription charges should be removed by 2007. There has not so far been much alteration in the number of prescriptions dispensed.

There is an argument for removing prescription charges altogether. If the health service is to be truly free at the point of delivery, then patients should be able to receive the medicines they need without charge. It would also ensure that those patients who experience inequalities because they are not prescription exempt but nevertheless on a low income do not suffer adversely as is currently the case.

---

<sup>5</sup> Lexchin J and Grootendorst P, *Effects of prescription drugs users fees on drug and health service use and on health status of vulnerable populations: a systematic review of the evidence* International Journal of Health Services 34:1 pp101–122 2004.

*Low level payment on all prescriptions*

A third option might be the most realistic alternative to the current system. This would see the removal of all exemptions and the introduction of a low level payment, 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.

The BMA's view of the Wanless "fully engaged scenario" is that there is likely to be an increased demand for drugs as the population lives longer and has more time to develop chronic conditions, normally associated with older age. Experience from the recently introduced Quality and Outcomes Framework in general practice shows that if you are going to manage conditions such as diabetes and heart disease effectively, you will need to use an increasing range of medicines. Although there is the possibility of improved lifestyles, including diet, smoking and exercise, lessening the incidence of chronic conditions, this is unlikely to stem the demand for drugs because at best, it will delay the onset of these conditions rather than prevent them.

*Sally Watson*  
British Medical Association

*December 2005*

---

**Memorandum submitted by Citizens Advice (CP 20)**

INTRODUCTION

Citizens Advice welcomes the opportunity to submit evidence to the Health Committee's inquiry into co-payments and charges in the NHS. In recent years there has been a significant increase in CAB outreach work in health settings and bureaux now provide advice in over 1,000 GP surgeries and hospitals, as well as delivering the independent Complaints Advocacy Service in six of the nine Government health regions.

The impact of health charges is a long-standing concern for CAB clients and we estimate that around 20% of the 73,000 health problems which bureaux deal with every year relate to health charges. In 2001 we published an evidence report *Unhealthy Charges*, detailing the problems raised and our recommendations for reform. Regrettably, with the exception of Wales, there has been little progress on tackling these issues since then, despite the significant reforms and additional investment which has taken place in the NHS over this period, and despite the government's explicit agenda to reduce health inequalities. We are therefore very pleased that the Committee is now undertaking this inquiry.

In our 2001 report we concluded that many people faced financial difficulty in accessing the health care they needed because of the impact of health charges. Bureaux working in health settings reported advising clients who had not had their teeth or eyes checked for years because of anxiety about charges, and a MORI survey we commissioned for the report indicated that as many as 750,000 people in England and Wales were failing to get their prescriptions dispensed because of the cost.

ARE HEALTH CHARGES EQUITABLE AND APPROPRIATE?

Health charges are not equitable because they inevitably impact most on people in poor health, many of whom may already be struggling to manage on a reduced income because of their health. There are also inequities across health charges, in relation to entitlement to exemptions. For example:

- People aged over 60 are entitled to free prescriptions but must pay for any dental care.
- They are also entitled to free eye tests but not dental check ups, despite the valuable role of the latter in identifying oral cancer.
- There is no medical rationale for the limited number of diseases which entitle patients to exemptions. Whilst people suffering from diabetes are entitled to free prescriptions, other life-threatening illnesses such as cancer and heart disease which are the subject of National Service Frameworks are not included.
- In relation to income, there are huge inequities in entitlement to exemption from charges depending on whether or not someone is in work. A person in work and in receipt of Working Tax Credit including a disability element is exempt from all health charges if their gross annual income does not exceed £15,050 (this equates to £289 per week). On the other hand if they then become unable to work because of ill health and their income drops, they will nevertheless lose entitlement

to free prescriptions if their income exceeds their income support entitlement plus half the value of a prescription charge. For a single person aged 25 or over and not entitled to any premium, this is £56.20 plus £3.25 = £59.45 per week.

Below we examine CAB evidence of the problems patients face with the current system of NHS charges, and then consider the remaining issues raised by the Inquiry in the light of that evidence.

## PRESCRIPTIONS

Around 80% of prescriptions are dispensed free of charge. However, 80% of people aged between 18 and 60 have to pay prescription charges. The affordability of prescription charges has long been the key concern identified by bureaux. There are two key problems here.

Firstly there is no tapered help with charges as incomes rise above the level entitling the person to free prescriptions, as there is with dentistry and optical vouchers. Historically the reason for this was presumably that prescription charges were so small that the added complexity which tapered help would cause was not considered necessary. This argument no longer stands, given that a person can easily leave a doctor's surgery with three items on a prescription, and face a charge of £19.50. Affordability problems can be compounded for patients with long term health problems where GPs seek to avoid wastage of medicines by writing prescriptions for shorter periods—a practice which is encouraged by the Department of Health but which can have considerable financial implications for patients:

A CAB in Surrey reported the case of a client who needed a repeat prescription and is not eligible for assistance with charges. He used to be issued a prescription for six months but this has been reduced to two months, tripling the prescription charges. The GP has told him this is in order to cut down on wastage.

Secondly the mechanism for helping heavy prescription users cap their expenditure—the pre-payment prescription certificate (PPC)—is not designed to help people on low incomes, who are not be able to afford the upfront charge of £33.90 for four months or £93.20 for 12 months. Citizens Advice has argued that the way to overcome this problem would be to include the PPC into the low income scheme so that it is priced on a sliding scale depending on a person's income.

A CAB in Wiltshire reported a couple in their 50s and in poor health who were both in receipt of incapacity benefit. They were not therefore entitled to free prescriptions and were paying over £30 each in prescription charges. They would find it hard to raise the one-off sum to buy two PPCs. The bureau calculated that had they not worked and paid national insurance contributions entitling them to incapacity benefit, they would in fact have been better off now on a weekly basis as they would receive full housing and council tax benefit and free prescriptions.

An easement on help with prescription charges was introduced from April 2004 in response to CAB lobbying. Prior to that date, people on incapacity benefit could find themselves floated on or off entitlement to free prescriptions just because of the differential rate at which means-tested and non-means tested benefits were uprated in a particular year. From April 2004, the regulations were amended to allow entitlement to free prescriptions via the low income scheme where a person's income is within IS entitlement plus half the value of a prescription charge. This has been effective in ending the problem facing this client group, as long as they claim under the low income scheme. However, many people continue to fall through the net because they have failed to claim for this means-tested help. It is also not well suited to cases where people need urgent unplanned access to prescriptions:

A CAB in Lancashire reported the case of a client who was moved from income support to incapacity benefit following a week in hospital as a result of a heart attack. The client found himself having to pay £12 in prescription charges in one week and had to take out a crisis loan to cover the costs. The client was very distressed that whilst he is on incapacity benefit he is not automatically entitled to free prescriptions and that he has to go through the process of completing a HC1 form.

A CAB in Cambridgeshire reported the case of a client who is not automatically entitled to free prescriptions as her incapacity benefit is more than her income support entitlement. The client was not aware that she could claim help via the HC1 form on low income grounds. The client has been going without prescriptions because she cannot afford them.

In other cases, clients, particularly if they are in receipt of incapacity benefit, have wrongly assumed that they were entitled to free prescriptions. This can result in patients facing accusations of fraud, penalty charges and even threatened prosecution. This is despite the fact that it seems probable that the vast majority are cases of error rather than deliberate fraud, and where the underlying problem is one of poverty. Moreover there is no formal means of appeal against such a decision.

The penalty charge is five times the charge that the client should have paid, up to a maximum of £100. The client will also be asked to pay the original charge itself. If the client does not prove her/his entitlement to help with health costs, and she/he does not pay the amount stated in the penalty charge notice, the NHS may take court action to recover the debt. The penalty charge is increased by 50% of the penalty charge if she/he does not pay within 28 days of the date the penalty charge notice is sent.

A CAB in Wales reported the case of a client who is on incapacity benefit and disability living allowance and therefore does not receive automatic entitlement to free prescriptions. He had claimed free prescriptions on low-income grounds but his HC2 had expired. He has mental health problems which affect his motivation, and he suffers from depression. He therefore has trouble keeping his HC2 up to date. The client reported ticking the "income support" box on his prescriptions to get them free and is now subject to proceedings for false exemption claims.

A CAB in Greater Manchester reported the case of a client who signed a prescription form stating he was in receipt of income support when in fact he received incapacity benefit. The client did not pay the first penalty within the time limit and as a result the penalty was increased by 50%. The client was very worried about the threat of court proceedings and so contacted the relevant authority to request an appeal. He was told this was not possible but he managed to negotiate a repayment of £5 per month. He only has his incapacity benefit from which to pay this, and the nature of his condition means that he has no immediate prospects of finding work.

There is evidence that some health professionals may also be confused about entitlement to free prescriptions and therefore give wrong advice. Pharmacists in particular are in a key position to help patients complete the back of the prescription form, especially if they have difficulty with reading English. It is therefore of serious concern if, as a result of poor advice, such a vulnerable patient group then faces harsh enforcement measures.

A CAB in Gloucestershire reported the case of a client who does not speak English. She does not work so the pharmacist assumed she was eligible for free prescriptions. The client has now been fined £32 as well as £6.40 for the prescription charge. This has created humiliation and upset.

A CAB in Sheffield reported the case of a client who is illiterate and on incapacity benefit and disability living allowance. His pharmacist had been ticking the income support section of his prescription forms and getting the client to sign. The client thought he was entitled to free prescriptions and had been receiving them free for years. The client has now received two penalty charges for prescriptions and is paying off one at £10 per month. The client is concerned that there may be more penalty charges in the pipeline.

## DENTAL CHARGES

Dental charges work very differently from prescription charges. For example people over 60 are not exempt from charges, and tapered help is available with dental charges under the Low Income Scheme. Historically the main problem has been the very high level of many charges. In England patients pay 80% of the cost of a course of treatment up to a maximum of £384. Thus those with the highest oral health needs are severely penalised and many more are likely to be put off seeking treatment for fear of the possible health. Our 2001 report included a survey of clients which found that that 44% of people registered with an NHS dentist found the charges difficult to afford, rising to 75% among patients charged £200 or over. People with poor oral health can find themselves facing huge bills over a period of time:

A CAB in London reported a client who had been charged some £5,000 over the last five years for successive courses of treatment including crowns, fillings, extractions, bridges and false teeth plates to try to address serious dental problems. All have proved ineffective and he has lost several teeth and been left with an uneven bite which means he often damages his cheek when eating. He was advised by hospital consultants that the only effective long term remedy was dental implants but these were not available on the NHS because of the cost. The client therefore wrote to the Health Minister who replied that in fact implants are available on the NHS: the consultant should make the case to the PCT which would decide whether to fund the procedure. In the event he has been refused and is now pursuing a formal complaint.

From April 2006 however, there will be significant changes to dental charging necessitated by the reform of the dental contract. There is therefore currently a key opportunity to reform dental charges and ensure they are both equitable and appropriate for the new patient-centred NHS.

Citizens Advice was pleased to be represented on the Department of Health Working Party which worked up proposals for this reform. Regrettably radical reform such as exempting older people from charges altogether or reducing the percentage of the patient contribution were ruled out by the terms of reference which required that any revised scheme should raise the same level of income from charges as is currently the case. However, there was the opportunity to develop a system which was more transparent and where the maximum charge is significantly reduced. The Working Party proposed moving from the current system of over 400 individual items of dental treatment, with a maximum charge of £384, to a system of three Bands, the costs of which should be weighted so as to give greater protection to those with highest dental needs.

We are, however, concerned that the 2006–07 rates for the Bands (£15.50, £42.40 and £189) are significantly higher for Bands 2 and 3 than would have been predicted by uprating the illustrative figures which the Working Party proposed based on the 2003–04 take (£15, £27 and £130). It appears that there has been a shift in the Department's language—from requiring patient charges to raise the same *level* of income (£485 million at 2003–04 rates) as under the existing scheme (as was the remit of the working group) to requiring them to raise the same *proportion* (£645 million at 2006–07 rates) of the significantly increased funding which will be required under the new contract.

We regret that the opportunity has not been taken to reduce the very high percentage (80%) of treatment fees currently paid by patients, by ensuring that the income raised from charges did not increase by more than inflation as a result of the shift to the new contract. By not taking this approach, patient charges overall will have increased faster than patients' incomes and will therefore become less affordable. People with poor dental health and with incomes only just above the level for help through the NHS low income scheme will be particularly affected.

In contrast, dentists have received undertakings regarding the protection of their incomes in the early years of the new contract.

People requiring dentures, who will mainly be older people on fixed incomes, appear to be among the losers under the reforms. Patients requiring replacement dentures due simply to wear and tear, may find the charge more than doubles. Currently the cost for a partial denture ranges from £61.85 to £97.50. Under the new scheme, the charge from April 2006 will be £189. Indeed the BDA has suggested that there may in future be little difference between NHS and private charges for such procedures.

In our response to the consultation, Citizens Advice urged the Department to reconsider the proposed levels of charges, particularly for the higher Bands, and at least ensure that people requiring replacement dentures, who will overwhelmingly be older people on fixed incomes, are not penalised by the reforms. We also argued that future increases in dental charges should be determined having regard to the levels at which patients' incomes rise, and therefore do not exceed the level of general inflation.

The Department has now published its conclusions. There has been no reduction to Bands 2 and 3; in fact all Bands have been increased slightly above the levels quoted in the consultation paper. The only concession made in response to our concerns, is that the charges for replacement dentures as a result of loss or damage will be 30% of the Band 3 charge. However this does not apply to replacements for other reasons such as wear and tear, although the cost of the work involved would presumably be the same. The Department has also failed to make any commitment regarding future increases in dental charges.

#### OPTICAL CHARGES

The system for charging for optical services represents yet another approach to charging. Here the service is basically delivered privately, but help is provided for people on low incomes through a complex system of vouchers. The main problem reported by bureaux is that clients can find that, even if they are entitled to the maximum voucher, there can be a significant shortfall between the value of their voucher and the cost of the glasses. Opticians are not required to provide glasses within the voucher value and for many people, shopping around is not an option, either because they have health or mobility difficulties or because they live in a rural area where accessible alternatives are few.

A CAB in Hampshire reported a woman in her 70s and in receipt of pension credit whose voucher only covered around one quarter of the cost of her glasses. She had to use her savings to pay for the remainder. She commented that if she had not had savings, she would have had to do without.

A CAB in Berkshire reported the case of a client in receipt of incapacity benefit who faced a bill of £350 for glasses with the complex lenses she required. The NHS partial voucher only entitled her to £60. The client could not afford to pay the balance and so was unable to get the spectacles she needed.

A CAB in Yorkshire reported a client with poor eyesight as a result of diabetes. He is in receipt of income support and therefore entitled to a full voucher. However the voucher was for only £54, leaving the client to find a further £130 from his benefit income.

#### HELP WITH TRANSPORT COSTS

Where patients require health care which is not available in their local area, the costs of travel can be a major barrier to accessing health care for people on low incomes. Some help with hospital travel costs is available through the Low Income Scheme. CAB evidence has long demonstrated a range of failings both in terms of the scope of the help available and the complexity of the claiming process.

A key problem is the fact that help is only available with costs to hospitals, despite the direction of NHS policy to transfer more health care to primary care settings. In some cases however, patients' medical conditions prevent them from accessing even local facilities without incurring travel costs:

A CAB in Kent reported a case of a client in receipt of Pension Credit (guarantee) who has an ulcerated leg having to travel by taxi each week to her GP surgery to have her dressing changed. If this treatment was undertaken in the hospital she could reclaim the cost but as this takes place in a GP surgery she is offered no assistance with costs. The bureau reported that the travel costs make up 7% of the client's weekly income, placing her under immense financial strain.

In other cases there is no local primary care provision and patients have to travel. This is particularly the case in relation to NHS dentistry because of the longstanding access problems. Bureaux regularly report that clients are unable to travel the lengthy journey to their nearest available NHS dentist. Earlier in the year we conducted a brief survey of people accessing the CAB website for advice on any issue. 62% of those who had not been able to access a dentist said that the reason was that the only available NHS dentist was too distant or expensive to travel to. We therefore raised with the Department whether help with travel costs could not be extended to NHS dentists to help cope with the problem. However we were told that Primary Care Trusts would be commissioning local services so that this would not be necessary.

Whilst a local service is obviously the preferable option, we remain concerned that it may not be possible to deliver this in the near future, and meanwhile people on low incomes, who are least able to afford private dentistry, are facing additional barriers in accessing NHS dental services.

A further problem is that help with transport costs does not extend to people visiting relatives in hospital. For them, the only help available is through the community care grant element of the social fund, which is budget limited and only available to people on income support levels of income. Where patients are in hospital for lengthy periods this lack of support can be particularly hard.

A CAB in the North West reported that a client who has a 14-month year old child in hospital with spinal muscular dystrophy has faced continuous problems in receiving help with travel costs. The child is in hospital on a long-term basis, having not left hospital since birth. The client reports that he has to get two buses to see his daughter, and on some days is unable due to lack of money, causing distress to the client and his daughter. The client has applied to the social fund on numerous occasions but has repeatedly had his claim turned down.

This help compares unfavourably with that available to family members of prisoners, who are entitled to help with travel costs under the low income scheme for up to 26 visits per year.

The payment system can also cause problems. Despite the Department of Health guidance stating that providers should ensure that clients are able to obtain travel cost refunds at all times, a number of clients have experienced problems with this.

A CAB in Lancashire reported the case of a client who has difficulty claiming payment as a result of the Bursars office shutting at 4 pm. Making the claim by post could take up to anywhere between two weeks to one month which would result in the client getting into debt in other areas.

Many of these problems were recognised by the Social Exclusion Unit (SEU) in its February 2003 report *Making the connections: final report on transport and social exclusion* (Chapter 11). That report estimated that each year 3% of or 1.4 million people miss, turn down or simply choose not to seek healthcare because of transport problems. These percentages are doubled for those in the most deprived wards or in car-less households, and more over-75s find access to hospital difficult than any other age group.

The SEU report made a number of clear Government commitments—that new guidance would widen eligibility to the Patient Transport Service to include primary care facilities and to include circumstances such as inadequate public transport or where patients are on a low income, that greater help should be extended to visitors, and that there should be a “one stop shop” to provide advice and information on help with travel to health care facilities. We would be concerned if any of these proposals replaced the entitlement to help through the Hospital Travel Costs Scheme, rather than being used to extend patient choice. However, our main concern is that it is now nearly three years since the SEU report was published and yet little appears to have changed on the ground.

This is despite the fact that patient choice of providers is a key element of the Government's planned health reforms. In the patient choice pilots, free transport was provided and it was clear that this was a key element in ensuring equity of patient participation. Yet despite this, the Government has recently announced that in the national roll out, free transport will only be provided for those already entitled under existing schemes.

This is a missed opportunity which we believe will have serious implications for the equity of the patient choice agenda.

---

## CAR PARKING AND OTHER CHARGES

Bureaux are increasingly reporting client concerns over the very high car parking charges which some hospitals impose. In many cases patients may have no choice but to use car transport, if they live in a rural area, if there is inadequate public transport or if they have serious mobility problems. And there is of course no help available with these costs. Even blue badge holders are not necessarily exempt from charges.

Problems are compounded because patients have no control over how long a visit will be required:

A CAB in south London reported a client who attended A&E on the advice of her GP, following an accident to her foot. The car park charge was £3.75 for the first two hours and £7.50 thereafter. She was 10 minutes over the two hour period and therefore had to pay the higher charge. She also questioned the fact that charges were reduced to £1 per hour after 6 pm. Had she known, she could have postponed her trip til then, but that would have been a busier time for A&E.

ICAS bureaux also report the resentment felt by patients pursuing an NHS complaint who need to attend the hospital for a meeting regarding their complaint. It adds insult to injury that they then have to face high car parking charges in order to pursue their complaint, especially as no financial compensation is available through the complaints process.

There is also growing concern regarding the very high cost of telephone charges to hospital in-patients. Where friends and family are unable to visit, either because of the inadequacy of the financial help provided or because they themselves are unable to travel, telephone contact becomes an important means of contact.

A CAB in Essex reported that people wishing to telephone patients were being charged 49p per minute at peak time and 39p off-peak. The bureau commented that this compared poorly with advertised rates to USA of 3p per minute.

A CAB in Gloucestershire reported a client who is disabled and had been unable to travel to visit her husband in hospital. The husband, who is blind and therefore found it difficult to dial out, was depressed and in need of support from his wife. The client received a telephone bill for nearly £1,200 for calls to the hospital number. There had been no indication that the calls would be more expensive than the normal rate. The Trust's position is that they have to make the line rental self-financing.

We welcome the fact that Ofcom is currently investigating the prices charged to people making telephone calls to hospital patients.

## WHAT IS THE OPTIMAL LEVEL OF CHARGES? SHOULD CHARGES BE ABOLISHED?

We have taken these two questions together as we consider it difficult to justify any charges given firstly the basic principle that the NHS is free at the point of delivery, secondly the well-established links between health and poverty, and thirdly the Government's clear objective to end health inequalities. The main arguments against charging are well known:<sup>6</sup>

- They are inequitable because, for those above the "low income levels" (which are set at a very low level), the charges impact most on the worst off and on those who have most need of treatment.
- They may be cost ineffective to the health service if they result in deferred treatment.
- They involve significant administrative costs in terms of collection, anti-fraud measures, and the promotion and administration of full and partial exemption schemes.
- They are not required in order to prevent unnecessary use of health resources since access to these is already controlled by health professionals.

It is therefore difficult to make any comment about what would be an optimal level of charges. What is however clear, is that if charges are to remain, they must be set and uprated having regard to their affordability for patients, not in order to raise a certain level of revenue, as appears to the case in relation to the recent proposals on dental charges.

In relation to prescriptions a priority must be to reform the PPC in order to ensure that heavy prescription users on low incomes can benefit from this budgeting tool.

In relation to optical charges, there is a need to establish a mechanism to ensure that glasses within the value of the NHS vouchers are available from all opticians providing NHS treatment.

## IS THE SYSTEM OF CHARGES SUFFICIENTLY TRANSPARENT?

The answer to this question must be no. Health charges have developed in an *ad hoc* way, with different mechanisms and different exemptions applying across the various charges, as has been outlined above. The result is anything but transparent, as is evidenced by the fact that the Department of Health leaflet helped with health costs (HC11) runs to 77 pages and the claim form HC1 has 16 pages of questions and four pages of notes.

---

<sup>6</sup> See for example Eversley, J and Sheppard, C, Thinking the Unthinkable: the case against charges in primary health care, *Health Matters*, 1998.

Patients are frequently confused by the fact that they may be exempt from some charges and not others and that exemptions may be made on grounds of income, or age, or medical condition, and these vary across the charges. The system for optical vouchers is particularly obscure, and patients often assume the figure given is the amount they have to pay, not the amount by which their charge is reduced.

The result is that bureaux regularly report clients who have missed out on the help they are entitled to. We are not aware that the Department has made any estimate of the extent of this problem. It is also highly likely that people already socially excluded, who are in any event likely to have greater health needs, will be the greatest losers.

#### WHAT CRITERIA SHOULD DETERMINE WHO SHOULD PAY AND WHO SHOULD NOT?

The underlying principles must be to ensure that:

- No one is prevented from accessing healthcare, or indeed from benefiting from the planned choice agenda, because of financial difficulties. Income-related help must be the first priority.
- The scheme supports rather than undermines the health inequalities agenda. This would suggest weighting charges away from those with highest health needs.
- The system is simple, transparent and easy to claim. This would suggest maximising exemptions and passporting from other benefits (for example housing, council tax and disability benefits), and ensuring similar rules apply across the different charges.

There would also be a need for transitional protection in any reform to ensure no-one lost out at the point of change.

#### HOW SHOULD PATIENTS BE MADE MORE AWARE OF THEIR ELIGIBILITY FOR EXEMPTION FROM CHARGES?

There is currently a chronic lack of information and advice for patients at the places and times when that advice is needed. Whilst the Government has seen for example the promotion of benefit take up as a key means of tackling pensioner poverty, there seems to have been no parallel recognition that promoting take-up of the available help with health charges—both exemptions and the low income scheme—should be a key plank in efforts to tackle health inequalities.

Part of the problem is that the Department of Health is not able to require GPs, dentists, pharmacists and opticians to even display posters or hold claim forms, despite the fact that they are undoubtedly best placed to promote take-up. This could be addressed by making such requirement part of the contract with these professions for the provision of NHS services. It is also regrettable that the HC1 is not downloadable from the Department's website, as is the case for DWP benefits such as income support, housing benefit and disability living allowance.

More generally, there is a need to develop greater links with DWP so that the promotion of help with health costs is fully integrated into other benefit take-up work.

*Liz Phelps*  
Citizens Advice

*December 2005*

---

### **Memorandum submitted by CLIC Sargent (CP 13)**

#### INTRODUCTION

CLIC Sargent was formed in January 2005 through the merger of two existing cancer charities, CLIC (Cancer and Leukaemia in Children) and Sargent Cancer Care for Children.

Supporting children, young people and their families throughout the UK, CLIC Sargent provides the clinical, psychosocial, emotional and financial help needed by those affected by childhood cancer.

The result, in part, of our combined 65 years of experience in cancer care and treatment, some seven out of ten children and young people diagnosed with cancer will survive. CLIC Sargent is committed to improving this figure still further through its specialist care and funding both of clinical and social research projects.

Stronger together, CLIC Sargent is now the UK's fourth largest cancer charity by turnover and the single authoritative campaigning voice on cancer care in children and young people. Our remit extends to comment on all aspects of policy relevant to the well-being of children with cancer and their families. Priorities in our first year include lobbying on such issues as the cost of cancer, and the bureaucracy surrounding benefit claims and entitlement for the under 16s.

We welcome the opportunity to contribute to the Health Select Committee Inquiry into co-payments and charges in the NHS.

#### SPECIFIC REMARKS

In its terms of reference for this Inquiry the Committee makes specific mention of several types of co-payment, including car parking charges, that can be demanded of those attending hospital appointments.

CLIC Sargent welcomes the Committee's consideration of co-payments but we note that the scope of this inquiry is limited, perhaps as a consequence of the Committee's remit, to matters directly affecting the operation of the NHS. As such it appears to discount other costs which result wholly and unavoidably from the illness for which the patient is receiving NHS treatment.

Indeed, car-parking charges at NHS hospitals, while an unwelcome additional cost for family members accompanying a child during their cancer treatment, are a very small part of the expenses incurred by these families over the course of an illness like cancer or leukaemia in children.

Far more significant costs are accrued as a result of travel to the hospital for the child's treatment, overnight accommodation for parents near hospitals, extra food and clothing for the child undergoing treatment for their cancer, and higher utility bills when caring for the child at home.

Although non-means tested benefits—primarily Disability Living Allowance—are available in most cases of child cancer, the payment of this benefit is substantially delayed.

From diagnosis of their child's cancer to first payment of DLA a family will have to wait for at least 17 weeks. In this time, the average family will spend more than £1,500 to provide the care and support their child requires while undergoing treatment. For some families, the figure can be far higher.

And the weekly benefit, once received, is backdated only to the point at which the claim became eligible. It will not cover the first 12 weeks of the child's cancer care. It will not meet the costs incurred when treatment is at its most intensive and parental worry at its peak.

We note that the administration of DLA is a matter for the Disability and Carers Service, and is, therefore, an issue that might more neatly fall within the remit of the Work and Pensions Select Committee. However, we also observe that very strong links exist between the Department of Health and the Department for Work and Pensions on the costs of care resulting from illness, and therefore the issue of the full financial cost of an illness cannot be considered solely a matter for the DWP or the Parliamentary Committee scrutinising its work.

CLIC Sargent urges the Committee to acknowledge that the full financial costs of an illness such as childhood cancer fall largely outwith the health care system. These costs are of a far higher magnitude than the co-payments that can accompany NHS treatment more narrowly defined. We ask the Committee to highlight this broader concern in the conclusions of its Report, and to communicate this issue clearly both to Government and Work and Pensions Select Committee.

*David Ellis*  
Chief Executive, CLIC Sargent

6 December 2005

---

#### Memorandum submitted by Contact a Family (CP 2)

#### CONTACT A FAMILY RESPONSE TO THE HEALTH COMMITTEE INQUIRY INTO CHARGES IN THE NHS

#### INTRODUCTION

(1) Contact a Family is a charity providing advice, information and support to families with disabled children across the UK. Each year we advise over 18,000 families through our helpline and information services. We draw on the experiences of these families in submitting our evidence.

#### SUMMARY

(2) Families with disabled children face additional costs in terms of visiting sick children in hospital which is not usually possible to get help with. They experience disproportionate levels of poverty and bureaucracy in their everyday lives which NHS charges can only exacerbate. They often remain unaware of their entitlements to help with NHS charges.

#### (3) Recommendations

That the statutory scheme for helping with the costs of attending hospital for treatment should be extended to cover the cost of visiting a sick child.

That consideration is given to abolishing NHS charges altogether and that the administrative savings are taken into account when costing such a proposal.

That if charging remains in operation, consideration is given to funding training for NHS staff and voluntary sector take up campaigns.

#### THE COSTS OF VISITING CHILDREN IN HOSPITAL

(4) For many years we have been particularly concerned with the costs faced by parents when visiting children who are staying in hospital.

(5) Both Contact a Family and another charity, Action for Sick Children, have long argued that there should be greater financial assistance for families with the costs of visiting sick children in hospital. Our two organisations campaigned jointly in the early 1990s. The issue was once again brought to the forefront of our minds by the Bristol Royal Infirmary Inquiry Report. One of the recommendations of Professor Kennedy's report specifically concerned the need to assist families to meet the costs arising from travelling and being away from home so that they may be with their sick child in a tertiary care centre.

(6) The difficulty, in essence, is that help with the costs of travelling to hospital for treatment are met through a statutory scheme for low income families. However the costs of travelling to hospital for visiting are not included within the scheme. The only way of having these costs met is through the discretionary Social Fund, which is a cash limited fund restricted to families on Income Support. Low income families who are working or on benefits other than Income Support receive no help at all.

(7) There is a statutory scheme to help people visit family members in prison and it seems unfair that this is very different to the situation of a sick child in hospital whose parents may receive no assistance at all with the costs of visiting their child.

(8) There has been clear recognition by government that children need to have parents with them when they are in hospital, including overnight. The Department of Health's own guidance paper "Welfare of Children and Young People in Hospital" is explicit on this point—stating that family support is essential and not a luxury. For some families, staying overnight is sadly not possible because of the need to look after other children, or to keep up work commitments. In these circumstances there is universal agreement that it aids the recovery of children for parents to visit as often as they can.

(9) However, the government refused to accept the recommendations of the Kennedy report. We had suggested that they might wish to introduce statutory help for all low-income families to cover the costs of hospital visiting, which would target help on those on the lowest incomes.

(10) There is already a comprehensive scheme for help with travel costs to hospital for treatment for low income groups. The patient applies for a certificate and pays their own fare in advance, shows the hospital fares office their certificate of entitlement and receives a refund on the spot. Refunds can also be claimed up to three months later. The simplest way forward is that this scheme is extended to pay for travel costs to hospital for the purposes of visiting a child who is an in-patient.

(11) Additionally, we believe that those parents whose children are receiving care in a tertiary centre some way from their homes should receive help towards visiting costs, regardless of their means. We also believe that car parking at hospital should be free of charge. Action for Sick Children recently carried out some research into car parking at hospitals ("Park the car, park the charges" 2004). They found that of 67 hospital trusts seven offered free parking and 25 offered concessions. However, the average charge for a 24 hour stay is £8.50 and in one case it would be £55.20.

(12) One of Contact a Family's medical advisory panel of senior consultants, who wishes to remain anonymous, said "its dearer to park at my hospital than it is at the airport".

(13) Although there is a cost to the introduction of such a scheme, this could at least in part be offset by the more rapid emotional, psychological and physical recovery of children who receive the care and attention from their families that they need.

(14) In 2002 a Conservative Member of Parliament, Andrew Lansley, tabled an Early Day Motion (no 866) on this matter. 101 MPs signed.

(15) The matter was brought up by Baroness Pitkeathley in the House of Lords on 25 March 2002 and she was told that the matter was under consideration.

(16) Parents affected by the cost of visiting a child in hospital are absolutely furious about it. The following are representations to us from parents on this issue.

“I am appalled by the fact that anyone should be charged to park outside a hospital.” Parent

“The free car park is quite a walk away when a child is ill.” Parent

“This is an issue that I have always felt very strongly about. My son Richard was in a hospital out in the Shropshire countryside 25 miles away with no direct public transport option and he was regularly in for between six to 12 weeks. I often lost my benefits and add to this the cost of the petrol, eating lunch out in the canteen plus childcare for the other kids when I couldn’t get back to pick them up cos Richard was too bad to leave, plus being expected to do the bulk of the non-medical caring... I was seriously out of pocket! The memory of it still makes my blood boil.” (Patricia, parent)

“My son spent many months on and off in hospital having various operations to correct his deformity. My husband was self employed at the time. We received no financial help in any way shape or form for anything. My husband’s business went down the pan and we were practically penniless. Assistance with visiting costs would have taken at least a little pressure off. I never wish to open the cupboard doors and be faced with emptiness again.” (Lindsay, parent)

“I live in West Wales where there is no neurology service for children. My daughter has uncontrollable epilepsy and we travel to GOSH in London frequently. I would like to see changes that incorporate assistance with costs for families travelling outside their Health Authority area, the cost of fuel is an issue in rural areas as is care for other siblings.” (Sara, parent)

“My daughter will be in GOSH for two weeks and we live in Bristol. On benefits only but not Income Support as my husband is medically retired. We will want to visit as often as possible. This is going to be very expensive for us but we will do it.” (Mrs L parent)

“It’s a 40 mile round trip each day to visit my son after his tracheotomy. He’ll be in for two months. Only one of us is allowed to stay over but we have a new baby and my husband has to work anyway, so neither of us can stay. I’d say we spend £20 on petrol every other day. The food there is really expensive too. Because he works, we don’t get any help.” (Mrs M, parent)

“You have the full backing of the Down’s Heart Group on this one. It is something we brought up with the Brompton enquiry and Bristol and we feel very strongly about it. As the likelihood of cuts in the number of paediatric cardiac units increases and therefore travelling distances increase we see this as becoming even more of an issue. I have a family from Hertfordshire whose son is in hospital in Paddington for the second time in six months and the current stay is already five weeks, the majority of which he was in intensive care. There are younger twin siblings at home so you can imagine how difficult this is.” (Downs Heart Group)

“I am a chair of a support group for families with HME, an orthopaedic condition that often requires treatment at a specialist centre. Travelling costs can be very expensive as the specialist centre may not be local to their homes. One of our parents says that it is three hours each way from Preston to Sheffield, £14 plus £4 for a cab to the hospital because the youngest child cannot manage the walk from the bus stop to the hospital.” (Group leader, HME)

“This is an increasing issue for our families as care becomes concentrated in just a few centres.” (Chief Executive, Cleft Lip and Palate Association)

(17) Contact a Family was involved in a review of patient transport carried out by the Social Exclusion Unit and has been told that hospital visits are to be reviewed by a Department of Health working party. We understand that this working party has met, however there was only one representative selected from the voluntary sector, who was from Age Concern. Despite our frequent enquiries we were not informed as to any progress.

(18) In summer 2004, Marion Roe (then an MP), on behalf of the Child Health Group made an enquiry as to whether hospital visits were still on the agenda of the Department of Health working party. She was told that the matter was still “under consideration”. We have heard nothing since and urge the Health Committee to recommend that the Government addresses this as a matter of the urgency. It is not a complex issue, nor a new one, it is blatantly unfair, simple to resolve and causes extreme hardship at a most difficult time. It is overdue for resolution.

#### CHARGES MORE GENERALLY IN THE HEALTH SERVICE

(19) As Contact a Family deals mainly with disabled children, the issue of prescription charges, dental charges and so forth does not generally arise, as these services are provided free for children. In general TVs, computers and video games are provided free of charge in children’s hospitals. Most hospitals will allow children to phone home at no charge, although parents are asked to use a payphone. This is all part of making hospital a more pleasant and less frightening experience for children and we would suggest that adult patients deserve no less.

(20) Parents of disabled children are of course liable for ordinary NHS charges like any other group. However there is much evidence that families with disabled children are more likely to live in poverty (55% of disabled children grow up in or on the margins of poverty) and experience greater levels of debt than other families. For this reason, we would welcome a review of whether NHS charges are really appropriate. Having charges then automatically involves a complex system of subsidies, rebates, exemptions which often involve complex means tests. Such systems also require policing and fraud prevention measures which are in themselves costly. We would recommend that the Government looks at the potential administrative savings which may result in abolishing charges.

(21) Our experience is that families with disabled children are already subject to extensive claiming processes for various forms of help—for example, Disability Living Allowance, Carers Allowance, Income Support, Council Tax disability reduction, Council Tax Benefit, Disabled Facilities Grants to name but a few—as well as all the other assessment processes for services (such as Special Educational Needs assessments, social services assessments). For this reason alone, we know that they would welcome one less set of forms to fill out.

(22) However, it should be noted that even if all charges were to be abolished, it would still be necessary to continue a system of refunding fares to hospital, as these costs are incurred in petrol, train fares or mini cab fares rather than charged for by the NHS. Indeed as we say above, we would like to see an extension of this system to cover the costs of visiting a sick child in hospital.

(23) There are other costs which families with disabled children incur as a result of receiving inadequate assistance from the NHS. The most frequent enquiry we receive from parents concerns the supply of incontinence pads. This is usually described as totally inadequate, which means that parents have to supplement supplies using their own resources.

#### ENSURING FAMILIES KNOW ABOUT THEIR ENTITLEMENTS

(24) If charges are to remain, it is vital that parents are informed about their rights to receive financial support. Contact a Family often hears from parents who have gone without their rightful entitlements, often for many years.

(25) We do not believe that it is the responsibility of already hard-pressed NHS staff to learn the ins and outs of a hugely complex benefit and tax credit system. However, it would not seem unrealistic for staff to have a basic awareness of specific help around NHS costs (for example, the low income scheme for help with dental charges). We also see that it would be entirely appropriate for staff to gain a reasonable idea of which client groups may be entitled to additional help (eg pensioners, disabled people, single parents, low income earners) and purely to sign post them to the many excellent voluntary organisations which can advise them in detail.

(26) For example, for health service staff to suggest to pensioners that it would be worth their while checking with Help the Aged whether there are any benefits or concessions that they can benefit from. Contact a Family has recently started a three year joint project with the Royal College of Paediatrics and Child Health to ensure that all paediatricians refer families with disabled children to Contact a Family, so that we can make sure that they are getting their full entitlements and are in touch with appropriate support groups. Very often, the voluntary sector is in an ideal position to provide expert, impartial help and advice and is already trusted by patients and their families. We also support initiatives such as basing Citizens Advice Bureau outreach workers in health settings.

(27) We would recommend that health service staff are given signposting training and support to make appropriate referrals. The health benefits to individual patients of increasing income should be stressed. There is reasonable evidence of greater reported wellbeing as a result of welfare rights advice such as reduced stress and fewer visits to GPs.

*Jill Harrison*  
Contact a Family  
*November 2005*

---

#### Memorandum submitted by the Cystic Fibrosis Trust (CP 4)

##### SUMMARY

Cystic Fibrosis is a life-threatening condition for which there is no cure. Although the outlook has improved for people with Cystic Fibrosis (CF), many of those affected still die in their teens and early twenties. The average life expectancy is 31 years, and people with CF only live this long as a result of a daily regimen of medication and treatment. Before such treatment was available, most died as babies or very young children.

At present, all adults with CF in the UK—unless they contract diabetes—must pay prescription charges for medicines that they have to take on a daily basis, and without which their life expectancy and quality of life would be severely compromised.

This situation is demonstrably unjustifiable. The Labour Party in opposition accepted that Cystic Fibrosis should be on the list of conditions that are exempt from prescription charges, but failed to deliver on its promise to abolish prescription charges for adults with Cystic Fibrosis.

The Cystic Fibrosis Trust has demonstrated that costs to the NHS to abolish prescription charges for Cystic Fibrosis would be minimal.

In conclusion, the Cystic Fibrosis Trust believes that all adults with Cystic Fibrosis should be exempt from prescription charges.

## 1. CYSTIC FIBROSIS

Cystic Fibrosis is the UK's most common, life-threatening inherited disease, affecting over 7,500 people in the UK. One in 25 people carry the faulty gene that causes CF, and one in every 2,500 babies in the UK is born with Cystic Fibrosis.

## 2. CYSTIC FIBROSIS TRUST

The Cystic Fibrosis Trust was founded in 1964 and is the UK's only national charity working to fund research into a cure and effective treatments for Cystic Fibrosis and to ensure appropriate clinical care and support for people with Cystic Fibrosis. It aims to ensure that people with CF receive the best possible care and support in all aspects of their lives, and provides information, advice and support to anyone affected by Cystic Fibrosis.

At present, and on request, the Cystic Fibrosis Trust pays the first year's prescription charges for all adults with CF, to help ensure that they are able to get their medication.

For further information, please visit the Cystic Fibrosis Trust website: [www.cftrust.org.uk](http://www.cftrust.org.uk)

## 3. TERMS OF REFERENCE

(a) *Are charges for treatments including prescriptions, dentistry and optical services, and hospital services (eg telephone and TV use and car parking) appropriate?*

For those who require regular or longer periods of hospital stay, telephone and TV charges in hospital can be prohibitive, as can car parking costs. Many CF patients fall into this category. These charges can be particularly problematic for people on low incomes, which is often the case for people with Cystic Fibrosis, who may be financially disadvantaged as they may have been unable to take up certain career/educational opportunities due to their illness.

(b) *What is the optimal level of charges?*

The Cystic Fibrosis Trust accepts the principle of charging for prescriptions at the current levels for conditions that are not on the exempt list. However we would argue that Cystic Fibrosis should be on the exempt list.

(c) *Is the system of prescription charges sufficiently transparent?*

The Cystic Fibrosis Trust believes the current system of prescription charges is sufficiently transparent, but is unfair.

(d) *What criteria should determine who should pay and who should be exempt?*

The Cystic Fibrosis Trust believes the current criteria to be acceptable. However, although Cystic Fibrosis fits all of the criteria, it is not on the exempt list.

(e) *How should relevant patients be made more aware of their eligibility for exemption from charges?*

A joint effort between the Government, medical workers and the relevant supporting body/organisation/charity should inform all patients of their rights.

(f) *Should charges be abolished?*

The Cystic Fibrosis Trust does not believe all prescription charges should be abolished. However, as

stated, the Trust firmly believes that prescription charges for Cystic Fibrosis should be abolished, for the following reasons:

- (i) Cystic Fibrosis is a life-threatening, inherited condition for which daily medication is essential.
- (ii) Adults with CF are often considerably disadvantaged in economic terms, because their condition prevents them from pursuing certain academic/career pathways. Further financial hardship is caused by having to pay prescription charges.
- (iii) For those adults with CF in financial difficulty, prescription charges may deter them from seeking essential treatments, at serious risk to their health.
- (iv) It is illogical and unjust that people with similar or less serious conditions are exempt from prescription charges, whilst those with CF are not. This is a source of considerable upset and frustration for people with Cystic Fibrosis and their families.
- (v) Cystic Fibrosis meets the requirements set out by the British Medical Association in 1968 and accepted by the Government as criteria for exemption; specifically that it is a one of several “readily identifiable conditions, which in virtually all cases call for prolonged continuous medication.”

#### 4. FURTHER INFORMATION

The list of medical conditions for which people are exempt from paying prescription charges was drawn up in 1968, and has not been revised since. However, it no longer accurately reflects the improved prognoses of people with Cystic Fibrosis. In 1968, most babies born with CF did not live beyond childhood, so prescription charges for people with Cystic Fibrosis were not an issue, and CF was not placed on the list. Thanks to improved treatments, today many people with CF reach adulthood. But on turning 16, they now have to pay for their prescription charges.

Adults with Cystic Fibrosis are only exempt from prescription charges if they develop diabetes, a condition that approximately 20% of CF patients will develop, and a condition that is on the exempt list. This means that approximately 80% of adults with CF have to pay for daily medications without which their health would be severely endangered.

Finally, the Cystic Fibrosis Trust has consulted extensively with consultants caring for CF patients, CF patients and their families. All agree that Cystic Fibrosis meets the criteria for inclusion in the exempt list. The Trust assumes that the Government has received no advice from any professional body that it would be inappropriate to include Cystic Fibrosis on the exempt list. Furthermore, exemption from prescription charges for those with CF would cost the NHS little over £100,000/year—from a total drugs bill of £6.88 billion. The benefits for the person with CF far outweigh any strain placed on the NHS.

*Rosie Barns*  
The Cystic Fibrosis Trust  
2 December 2005

---

#### Memorandum submitted by Diabetes UK (CP 5)

Diabetes UK is one of Europe’s largest patient organisations. Our mission is to improve the lives of people with diabetes and to work towards a future without diabetes through care, research and campaigning. With a membership of over 170,000, including over 6,000 health care professionals, Diabetes UK is an active and representative voice of people living with diabetes in the UK.

#### FACTS ABOUT DIABETES

- There are two million people with diabetes in the UK, equivalent to 3% of the population.
- Diabetes is set to increase. It is predicted that diabetes prevalence will double world-wide, rising to at least 5% by 2010, accounting for 3.07 million people in the UK.<sup>7</sup>
- Diabetes affects the young and old, and has particularly poor outcomes in those of lower socio-economic status and in those from black and minority ethnic groups.<sup>8,9</sup>

---

<sup>7</sup> Amos AF, McCarty DJ, Zimmet P. The Rising Global Burden of Diabetes and its Complications: Estimates and Projections to the Year 2010. *Diabetic Medicine*. 5: Volume 14. 1997.

<sup>8</sup> Chaturverdi N, Jarret J, Shipley MJ, Fuller JH. Socio-economic gradient in morbidity and mortality in people with diabetes: Cohort study findings from the Whitehall Study and the WHO multinational study of vascular disease in diabetes. *BMJ* 1998; 316: 100–106.

<sup>9</sup> Mather HM, Chaturverdi N, Fuller JH. Mortality and morbidity from diabetes in South Asians and Europeans: 11 year follow-up of the Southall Diabetes Survey, London, UK. *Diabetic Medicine* 15: 53–59.

- Evidence is available supporting the need for improved education of people with diabetes and their carers if better control and improved outcomes are to be achieved.<sup>10,11,12</sup>
- Diabetes, if undetected or not well managed, can lead to many complications and have a devastating impact on quality of life.

## INTRODUCTION

The NHS makes charges for certain treatments, for example prescriptions, dentistry and optical services and for certain amenities for example TV and telephone use and for care 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?

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?*

- Many people with diabetes have informed us that they have had problems getting access to blood glucose testing strips on prescription. Some PCTs and GPs have tried to limit the number of blood glucose testing strips that are given on prescription in order to save money. The National Institute for Clinical Excellence (NICE) has issued guidelines for Type 2 diabetes and the management of blood glucose<sup>13</sup>. The recommendations state that: “Self-monitoring can be used in conjunction with appropriate therapy as part of integrated self-care”. The guidelines focus on the use of HbA1c for giving healthcare professionals and people with diabetes a good picture of overall control and for that control to be stable. It is difficult, however, to make recommendations and take action on treatment adjustment, without at least some home monitoring. To use the guideline as a basis to restrict access to home monitoring is a misinterpretation of the guideline and was not the intention of the Guideline Development Group and it is both inequitable and inappropriate.
- Diabetes UK believes that people with diabetes should have access to home blood glucose monitoring based on individual clinical need, informed consent and not on ability to pay. Home monitoring is essential in the context of diabetes education for self-management in order to enable the person to make appropriate treatment or lifestyle choices. Blood glucose testing enables self-care in order to maintain optimum control. Key to this is being able to maintain blood glucose levels at as near normal levels as possible. The only way this can be accurately assessed and actions taken, is by monitoring blood glucose levels regularly. HbA1c is a valuable method of assessing overall control and is a good indicator of the risk of developing long term complications, however, a person with diabetes can have good HbA1c results and have poor day to day control with extremes in blood glucose levels. Stability of glucose levels is only measurable and achievable through home monitoring.

<sup>10</sup> UK Prospective Study Group (UKPDS). Effect of intensive blood glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34) *The Lancet*. Vol 352, 12 September 1998.

<sup>11</sup> Diabetes Control and Complications Trial (DCCT) Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *The New England Journal of Medicine*. Vol 329: 14. 30 September 1993.

<sup>12</sup> UK Prospective Diabetes Study Group (UKPDS). Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes (UKPDS 38). *BMJ* Volume 317, 12 September 1998.

<sup>13</sup> McIntosh A, Hutchinson A, Home PD, Brown F, Bruce A, Damerell A, Davis R, Field R, Frost G, Marshall S, Roddick J, Tesfaye S, Withers H, Suckling R, Smith S, Griffin S, Kaltenthaler E, Peters J, Feder G (2001) Clinical guidelines and evidence review for Type 2 diabetes: management of blood glucose. Sheffield: SchARR, University of Sheffield. Guideline for Type 2 diabetes—management of blood glucose, September 2002, National Institute for Clinical Excellence. Available at URL:<http://www.nice.org.uk>

- Individual need, choice and circumstances will dictate, the most appropriate form and frequency of testing. There are times when it will be appropriate for people to test more frequently than is usual for them. It is unacceptable that people with diabetes should be restricted or deprived of home blood glucose testing equipment and supplies because of postcode prescribing, blanket bans or restrictions imposed by Primary Care Trusts (PCTs) or through clinicians' inadequate knowledge of diabetes or the individual patient's needs.
- People with diabetes value being able to monitor their blood glucose levels for themselves as it enables them to better manage their diabetes, help prevent devastating and potentially costly complications, and take control of their own diabetes. Restrictions on the type and numbers of testing strips is unacceptable as this does not meet individual needs and circumstances. Such a policy is against Standard 3 of the National Service Framework (NSF) for diabetes relating to patient empowerment<sup>4</sup>.
- There are considerable cost savings to be made from supporting self management, by reducing the frequency of support needed from the NHS and preventing people with diabetes from needing hospital treatment either with diabetes emergencies or long term complications.

*What is the optimal level of charges?*

- All people with diagnosed with diabetes (on insulin, tablet and diet treatment) should have access to blood glucose testing strips free on prescription. However, the costs of blood glucose monitoring are considerable. In order not to waste resources therefore it is important that people with diabetes are able to utilise home monitoring effectively through diabetes education. Without this education to know when and how to test, and what to do with the results, there is little point in home monitoring. The purpose of improving and facilitating people's ability to self-manage their diabetes is to improve their blood glucose control, with a view to preventing complications both long and short term. There are potentially, considerable cost savings to be made from reducing the number of people with diabetes needing to be admitted to hospital either with diabetic emergencies or with the consequences of long term complications eg for treatment of foot ulcers. There are also cost savings to be made on reducing the number of visits to GPs and other primary care professionals, if people are able to manage the condition more independently.
- It has been cited that more is spent on testing strips than on oral glycaemic agents. The implication being therefore that this is not a good use of resources. What this does not consider is that for some people with diabetes, being able to monitor blood glucose levels may be as beneficial to them as taking the tablets. In any case to restrict blood glucose testing strips when they are used effectively for self-management is, in our view, contrary to Standard 3 of the National Service Framework for diabetes on patient empowerment<sup>14</sup>.

*What criteria should determine who should pay and who should be exempt?*

- All people diagnosed with diabetes (on insulin, tablets and diet treatments) should be able to receive free blood glucose testing strips on prescription.

*How should relevant patients be made more aware of their eligibility for exemption from charges?*

- When people are diagnosed, they should receive more information about their eligibility for exemption from charges.

*Whether charges should be abolished?*

- Prescription charges for blood glucose testing strips should be abolished for all people with diabetes (on insulin, tablet and diet treatment).

Diabetes UK

2 December 2005

---

<sup>14</sup> National Service Framework for Diabetes: Standards, Department of Health, London. December 2001, available at: URL:<http://www.doh.gov.uk/nsf/diabetes.htm>.

---

## Memorandum submitted by Disability Alliance (CP 12)

### 1. INTRODUCTION

1.1 Disability Alliance is a national registered charity with the principal aim of relieving the poverty and improving the living standards of disabled people. Our eventual aim is to break the link between poverty and disability.

1.2 We are a membership organisation with over 340 members which range from small self-help groups to major national disability charities. We are controlled by disabled people who form a majority of our Board of Trustees.

1.3 We provide information on social security benefits and tax credits to disabled people, their families, carers and professional advisers; undertake research into the needs of disabled people—with a particular emphasis on income needs, and promote a wider understanding of the views and circumstances of all people with disabilities.

1.4 We are best known as the authors of the Disability Rights Handbook, an annual publication with a print-run of 30,000, but also have a range of other user-friendly guides to benefits. We provide an information service and a popular website and have recently launched a Tribunal Support Unit to assist local disability and advice agencies with their advocacy work.

1.5 Our policy work is informed by our daily contact with disabled people and those who provide services for them. We undertake research into the needs of disabled people—with a particular emphasis on income needs. We have recently completed a major piece of work, together with the Centre for Research in Social Policy at Loughborough University, into the extra costs faced by disabled people—*Disabled people's cost of living—more than you would think*. Other recent work has covered disabled parents, families with disabled children and families with more than one disabled child. In 2003 we published *Withdrawing benefit from sick people* a short report highlighting the hardship caused by the rules under which disability benefits are stopped for people in hospital. (Although the Government has since extended the period that benefits such as retirement pension can be paid while someone is in hospital, disability benefits still stop after four weeks).

1.6 We welcome the opportunity to submit evidence to this Inquiry.

### 2. TRAVEL TO HOSPITAL

2.1 There are a range of problems people have raised with us concerning the current arrangements. Under the current rules low income households can only get help with fares if they are attending hospital for treatment, or in the case of a child, accompanying the child for treatment. Many families tell us of the financial hardship they encounter because there is no help available for hospital visiting.

2.2 Families with disabled children who took part in our survey, published as *Helter Skelter*<sup>15</sup>, told of their experiences with hospital visits and medical appointments.

2.3 One of the mothers reported on the problems she had with hospital appointments when her twins were babies “It really was such a struggle. I had to get cabs everywhere. People forget that I didn’t just have a Down’s syndrome boy I had another baby as well . . . my whole life was geared around . . . double feeds—and umpteen hospital appointments, and I had no choice, I had to take M, and A was in hospital with bronchial pneumonia, asthma . . .”

2.4 Another mother outlines the costs involved in taking her disabled daughter to Moorfields. “we go by train . . . if two of us go I the rush hour plus V it works out at £17 per adult, and if you get an early appointment you can’t get a cheap day return . . . we usually go to McDonalds or something after the appointment, which is another tenner, so it’s about £50 just to go to Moorfields . . .”

2.5 A further family whose disabled son was in hospital reported “he’s allergic to hospital bedding so we’ve had to take bedding in for him. . . we take everything home . . . we’ve got duvet covers and sheets coming home everyday and we’re doing the washing at home”. This family had lost their child’s disability benefit because of the length of time he’d been in hospital and the father had taken unpaid leave from work. Their financial situation was serious.

2.6 Problems with the costs associated with hospital visiting was also a key issue to emerge in our survey of families with more than one disabled child, published as *Hard Working Families* in 2005. Families who took part in the survey reported that “everything costs more with hospital visits”, particularly when the child stays in for a protracted period, and a parent stays with them. This is now accepted good practice and is encouraged by the health service. Transport backwards and forwards to see the children who are at home and parking fees can be considerable additional costs. There are other issues relating to extra costs which are beyond the scope of this Inquiry but which put pressure on families—food for the parent staying with the child, loss of disability benefits (and consequent loss of carers allowance), care for children left at home.

---

<sup>15</sup> Helter Skelter, by Gabrielle Preston 2005, Centre for Analysis of Social Exclusion and Disability Alliance.

2.7 Families tell us that hospitals rely on a parent to help care for a child or disabled adult son/daughter. We heard from a mother of an adult daughter with severe learning disabilities who was in hospital for a lengthy period. The mother had to stay in with her daughter because she could not feed herself and needed constant care. The hospital had insufficient staff to provide this. Yet the daughter lost her disability living allowance after 4 weeks and the mother lost her carers allowance.

2.8 One family with two teenage daughters, both of whom are severely disabled, and a six year old son with ADHD and allergic reactions told us of their experiences. The son is in and out of hospital “sometimes twice a month” because of his allergic reactions. When the girls are admitted to hospital they tend to go in for three or four weeks, during which time their mother stays with them. As her husband is also disabled when any of the children are in hospital the family has to pay someone to help out at home and prepare evening meals. “I have to pay somebody to get a child into a wheelchair, get them ready for school. Before they get my son ready they have to catch him first . . . There have been instances when we haven’t been able to provide both morning and evening support” in these instances the mother has had to rush home from the hospital to help get the children up and ready for school and then return to the hospital. Although the hospital is reliant on her to help care for her son, it “provides nothing”. She has to pay her own fares and provide her own food.

2.9 Another family, living in East London, whose disabled son was admitted to a hospital in Stanmore (outer North West London) told us of their difficulties. While her son was in hospital his mother stayed with him. She had no car so had to travel by public transport. She had to return home every two to three days to sort out clothing, food, school uniforms, washing and ironing for her severely disabled daughter and three younger children. Her husband had to balance constant visits to the hospital to bring food with his caring responsibilities at home. The family did apply to the Social Fund for extra help but were turned down.

2.10 There can also be extra costs for medical appointments even when these are for the parent. A, who has two severely disabled sons, told us of an occasion when she had to take the boys with her when she had to see the doctor. “They were both a bit poorly and my car broke down so I had to go by cab. As soon as we got there the eldest one crapped himself. The other little one was in the buggy. He was violently sick. The doctor told me to go home. That was another £8.”

### 3. HOSPITAL CAR PARKING

3.1 This is an issue that has been raised with us by many disabled people and families with disabled children. It has also been a key issue for cancer patients and is explored in detail in the recent report from Macmillan Cancer Relief “Free at the point of delivery”. Macmillan’s report concentrates on the problems encountered by patients attending for treatment. We would fully endorse their findings which echo our own experiences. However, parents who are having to remain in hospital to care for or just be with their disabled child report major problems paying high car parking fees. Yet the car can be necessary to transport other siblings around, or to bring in food and clothing or take home bedding. Families particularly resent these costs because they feel they are providing care which the NHS is not. Where this is coupled with the loss of disability and carers benefits the financial hardship is keenly felt.

### 4. ACCESS TO INFORMATION

4.1 One crucial problem is lack of information about the low income scheme under which it is possible for people to get help with fares to attend hospital. People told us how they discovered about the scheme by talking to other patients or came across the information almost by accident. There seems to be little effort put into informing families of the help available to them.

4.2 Disability Alliance is a key source of information for disabled people, our Disability Rights Handbook and our website are popular because they bring together information from a variety of sources. For organisations like ourselves obtaining information from the Department of Health about prescription charges and the low income scheme is problematic. The DoH website does not give information about the position in Northern Ireland, Scotland or Wales and nor does it refer visitors to primary sources (statute, regulations, guidance etc). I attach a page from the website as an example of the issue—the capital limits shown do not apply in all countries of the UK.

### 5. PRESCRIPTION CHARGES

5.1 Some people are exempted from charges due to their condition (eg diabetes, epilepsy) and the need for them to take ongoing medication. There are a range of other conditions that also need ongoing medication which are not included in the list of exemptions and the logic for this is not clear to people.

5.2 People on income support are automatically exempt from prescription charges; people in receipt of some other benefits (such as pension credit guarantee, working tax credit with a disability element) or who qualify through the low income scheme can get an exemption certificate. The calculation for the low income scheme is very complicated and seems out of proportion to the amounts of money involved. We come across many examples of people with incomes just above the limit who need several items and cannot afford to get them all. This particularly affects people on incapacity benefit.

5.3 It is not cost effective for the Health Service to invest time and resources in a GP consultation, and possibly also further tests, and then have the patient failing to take the prescribed medication because they cannot afford all the items.

## 6. RECOMMENDATIONS

6.1 Expand the hospital fares scheme to cover visiting as well as attending for treatment.

6.2 Review and set limits on car parking charges.

6.3 Extend the period for which disability living allowance and attendance allowance can be paid while people are in hospital to bring this into line with the rules for retirement pension, income support and incapacity benefit.

6.4 Ensure that hospitals are obliged to provide food and laundry facilities for parents/carers who are staying in to care for a patient.

6.5 Improve the provision of information to patients and visitors about benefits and help with fares.

6.6 Provide better central information about NHS charging schemes across the UK.

6.7 Extend the range of conditions that qualify people for exemption from prescription charges, following consultation with the relevant disability and patient organisations.

6.8 Simplify and expand the low income scheme.

*Lorna Reith*  
Disability Alliance

*December 2005*

---

## Memorandum submitted by HSA Group Ltd (CP 27)

### 1. INTRODUCTION

1.1 The HSA Group Limited is a mutual organisation based in Andover, Hampshire. The HSA Group also includes Leeds-based health plan provider LHF (The Leeds Hospital Fund), Manchester based HealthSure and Bristol-based BCWA. As its early name (Hospital Saving Association) implies, HSA was originally established in 1922 to help save hospitals from closure in the pre-NHS days.

1.2 The HSA Group provides health cash plan insurance, known as Health Cash Plans (HCP), which in essence provides cash benefits to cover the cost of health care treatment, expenses associated with hospital treatment and post operative care. Our plans aim to meet the cost of everyday healthcare, with cash benefits covering a broad spectrum of treatments such as optical, dental, osteopathy, chiropractic, complementary therapies, consultation, health screening, chiropody, physiotherapy and hospital in-patient stay. Today we are the largest mutual HCP provider, covering in excess of 1.1 million policyholders, providing health cover for more than two million people across the UK.

1.3 In 2004 we paid claims to the value of approximately £166 million, projected to rise to over £200 million in 2005, to our members, of which a very substantial amount related to the accessing of NHS provided healthcare. The HSA Group therefore welcomes a new inquiry into co-payments and charges in the NHS.

1.4 Any evidence submitted or recommendations for action are based on most accurate and up to date information available to us, as well as information received from members.

### 2 THE HEALTH COMMITTEE ENQUIRY

#### 2.1 *Equitable and appropriate charges*

2.1.1 Our main areas of activity, relating to the co-payment and charges in the NHS referred to in the terms of reference of the inquiry, are treatments (day surgery and hospital in patient stay), dentistry and optical services. These items of benefit (as referred to in HCP terms) form the common denominators of most packages of benefit offered across the HCP market. These items of benefit achieve a combined figure of 73% of the total value of benefits paid across the HCP market, representing a substantial proportion of member activity. (Laing & Buisson UK Health & Care Cover 2005.)

2.1.2 The number of lives covered in the UK by HCP and Private Medical Insurance (PMI) would lead us to conclude that significant proportion of the general public is able and willing to take appropriate measures in order to reduce the impact on their personal cash flow of the NHS charges or co-payments incurred.

2.1.3 Such charges can only be regarded as equitable and fair in an environment where the service user perceives the cost incurred as affordable and proportionate in relation to the service received and the level of personal responsibility accepted.

2.1.4 We would encourage fair and equitable charges, consistently applied. A possible example of such an instance is the proposed dental patient charges (as set out in the Consultation of the draft National Health Service (Dental Charges) Regulations 2006) which would appear to be a step in the right direction for the patient, as it attempts to simplify and introduce a fair and equitable charging system, as well as defining the instances of exemption from charges.

2.1.5 As the NHS is subject to rising costs due to a number of well-documented reasons and the demand for access to a widening range of services are increasing year on year, it is felt that the charges are broadly speaking not inappropriate. It is appreciated that organisations representing specific interest groups may highlight areas of inequity or inappropriate charging.

## *2.2 Optimal level of charges*

2.2.1 It would not be considered appropriate for the HSA Group to speculate as to the optimal level individual charges should be set at, as this does not lie within our remit to do so.

## *2.3 Transparency of system of charges*

2.3.1 Based on our experience (tens of thousands of customer interactions on a daily basis) we would suggest that not all charges are sufficiently transparent to the general public. An example would be the current system of dental patient charging, which has been recognised as lacking in transparency.

2.3.2 A question of transparency to the service user also arises in the event of private sector involvement in the provision of a service. In this instance a concise, plain language communication of what is “covered” or chargeable by the NHS will aid tremendously to the public’s understanding and ability to exercise choice.

2.3.3 Transparency is only achievable as a consequence of openness, consistency and education. We would encourage these principals to be applied to all areas of charging and co-payments throughout the NHS.

## *2.4 Criteria for payment and exemption*

2.4.1 Affordable shared responsibility are the criteria we would propose for the determination of payments. Payments should be affordable to all and payments should be applied to all, as this is a fair and equitable way of encouraging publicly shared responsibility. Government intervention is suggested in the instances of disaster and an element of means testing or exemption should be applied for the elements of society unable to contribute.

## *2.5 Awareness of eligibility of exemption*

2.5.1 The Financial Services industry is regulated by the Financial Services Authority, who places regulatory requirements on financially regulated organisations, in order to protect the interest of customers. As co-payments and charges in the NHS may impact on people who could be perceived to be more vulnerable than they normally would be, at the moment of interaction with a NHS service, a code of self regulation, in reference to the fair treatment and transparency of co-payments and charges, subscribed to by all providers of NHS services (as described in the terms of reference to the new inquiry) is suggested.

## *2.6 Abolishment of charges*

2.6.1 The abolishment of charges could place a greater burden on the NHS and would not encourage the acceptance of personal responsibility for being able to access healthcare.

## *3 Recommendations*

3.1 A broadening of charges or the establishment of an affordable shared responsibility premise based charge, with Government intervention in cases of disaster or “means tested need” is recommended.

*Bernie Hurn*  
HSA Group Ltd

*December 2005*

---

### **Memorandum submitted by the King’s Fund (CP 24)**

This paper is a formal response by the King’s Fund to the House of Commons Health Select Committee’s consultation on co-payments and charges in the NHS. The King’s Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding. We are a major resource to people working in health, offering leadership development programmes; seminars and workshops; publications; information and library services; and conference and meeting facilities.

---

 INTRODUCTION

The Committee's inquiry into the topic of patient charges poses a number of questions:

- 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 the optimal level of charges should be.
- Whether the system of charges is sufficiently transparent.
- What criteria should determine who should pay and who should be exempt?
- How relevant patients should be made more aware of their eligibility for exemption from charges.
- Whether charges should be abolished.

These are all relevant and pertinent questions. However, we would suggest that patient co-payments and charges are part of a broader issue concerning access to health care. Apart from the impact on a person's disposable income, the health "cost" of imposing charges is to reduce access for some sections of the (charge-exempt, but not well-off) population.

However, *improving* access has been and remains a key policy goal for government in many areas, such as access to services (eg walk-in centres), advice and information (eg NHS Direct) plus the plethora of targets for reducing hospital waiting times. Improving access in these areas has cost an (unknown) amount of money, but we believe it to be substantial.

The broad question regarding charging and co-payments is two-fold: first, is this policy consistent with the rest of the government's access policy? And second, given that charges raise money and that their abolition has a cost to the NHS, would it better to spend money (that is, forego charge income) abolishing charges rather than on other ways of promoting access?

In this memorandum, while the King's Fund, like many others,<sup>16</sup> acknowledge the inconsistencies of the current system of charging, but given the broader question about access to care, here we set out our views on the key issue: should current patient charges levied by the NHS be abolished?

## KING'S FUND VIEW ON NHS PATIENT CHARGES

The principal reason for the creation of a health service free at the point of use was that access to health care (and by implication, health) was considered not only an important right but also a socially desirable goal that should not be restricted by any non-health attribute—in particular the ability of an individual to pay for their own consumption of health care. This principle is as correct today as it was in 1948, and is supported by the overwhelming majority of the population.<sup>17</sup>

Nevertheless, while the vast majority of services are provided by the NHS according to this principle, NHS patients have for many years been charged a proportion of the cost of their individual consumption of certain services and facilities, notably dentistry, eye tests,<sup>18</sup> prescribed medication, "amenity" rooms in hospital and services such as telephones and car parking. In addition, some services (for example, the supply of spectacles) have been moved out of the NHS and are largely paid for privately (with a voucher discount scheme for certain population groups).

The key justifications for such charges is that:

- Charges raise essential revenue for the NHS in addition to Exchequer funding;
  - Charges act as a deterrent to "frivolous" or inappropriate demand and thus combat the "moral hazard" of over-consumption in a service without a price restraint;
  - Some services are not generally considered part of the basic NHS "package of care" and therefore should not be paid for from general taxation
  - The introduction of charges/payments in the context of a private market stimulates innovation and higher quality through competition.
- 

<sup>16</sup> For example, the New Labour 2005 General Election manifesto stated that, "Healthcare is too precious to be left to chance, too central to life chances to be left to wealth. Access to treatments should be based on your clinical need not on your ability to pay." And, as the Wanless review of future NHS funding noted, "The system of free prescriptions in the United Kingdom is illogical, irrational and works against the principles of the National Health Service." (Wanless, 2002).

<sup>17</sup> For example, the latest British Social Attitudes Survey for 2004 show that nearly eight out of 10 people—a proportion that has hardly changed since the first BSA survey in 1983—oppose the idea of making the NHS available only to the poor, and with a consequent reduction in taxes and the better off purchasing private medical insurance. (Appleby and Alvarez A, (2005) *Public responses to the NHS reforms* In British Social Attitudes, 22nd Report (Eds: Park A *et al*), Sage, London, 2005.

<sup>18</sup> There is some irony in the fact that dentistry and ophthalmic services were most in demand on the inception of the NHS.

However, the King's Fund is not convinced that these arguments either justify the adverse or undesirable consequences of charging—in particular the known risk that some people will be dissuaded from seeking clinically needed care, or that they constitute an efficient means of achieving their goals such as raising money for the NHS or dealing with the moral hazard of “over-consumption” of a service free at the point of use.

Below we critique the main arguments put forward in favour of patient charging.

### 1. *Charges raise essential revenue for the NHS*

NHS patient charges undoubtedly raise revenue for the NHS: overall, prescription charges raise around 6% of the total drugs bill and dental charges around 30% of the total cost of the General Dental Service. As a proportion of the total cost of the NHS, however, patient charges account for a much smaller fraction—around 1%. This revenue will be reduced by an unknown amount due to the costs of administering the charging system.

However, charging patients for a proportion<sup>19</sup> of the costs of their own consumption of health care is inimical to the basic principle of the NHS founded principally on breaking the link between health care consumption and ability to pay in order to promote the socially desirable goal of equity of access to health care.<sup>20</sup>

An associated equity argument is sometimes proffered as a reason for at least retaining charges (if not extending them). Abolishing patient charges will lead not only to unfairness, but inefficiency: those who could easily afford to pay charges will receive services free of charge. However, this muddles the roles of the taxation and health care systems; it is the job of the former to deal with society's views about the equity of contribution to funds which pay for health care, and the job of the NHS to ensure equity in delivery of services.

Furthermore, while the NHS will benefit in the short term from the additional revenue raised by charges, there is an unknown cost associated with increased ill health the NHS may have to deal with in future as a consequence of charging deterring needed health care. For example, in a review of prescription charges in the UK, Theodore Hitiris,<sup>21</sup> concluded that:

“Prescription charges have an inverse effect on the demand for drugs by patients liable to pay the charge. Increases in charges are associated with a significant reduction in utilisation of prescribed drugs among non-exempt patients . . . there is also evidence that the short-term target of using charges to raise revenue is pursued at the expense of the long-term health of persons, and this may cost more to the NHS than the increase in revenue. *Therefore, the introduction of co-payments is not an efficient policy [our emphasis].*”

Overall, if the NHS needs to rely on the money raised by charges, there are alternative ways in which to raise such revenue which avoid potential adverse health and utilisation consequences; money from a taxation system which, in a mildly progressive way, goes some way to equalising the tax sacrifice born by different income groups already funds the vast majority of services provided by the NHS and should be used in place of current charges.

### 2. *Charges act as a deterrent to “frivolous” demand*

In relation to demand management—in particular the argument that charges act as a financial disincentive to “frivolous” or unnecessary demand—charges are generally misapplied: levying patients when demand is actually a supply side issue. Patient “demand” for prescription medicine and dental care is mediated by the “suppliers” of health care (eg it is doctors who prescribe, not patients).

If “frivolous” demand is a problem (although there is little hard evidence of its scale) then there are more effective and less inefficient ways of dealing with it—primarily on the supply side, through, for example, the incentives faced by practitioners, their clinical training and support through, for example, review of individual prescribing by prescribing advisers and monitoring of variations in levels of dental activity.

<sup>19</sup> For prescriptions, this may in fact exceed 100% if the actual cost of the prescribed item is less than the charge.

<sup>20</sup> Indeed, as the Government's own NHS Plan has stated: “Charges are inequitable in two important respects . . . [they] increase the proportion of funding from the unhealthy, old and poor compared with the healthy, young and wealthy . . . [and] charges risk worsening access to health care by the poor.” (NHS Plan, 2000).

<sup>21</sup> Hitiris T (2000) Prescription charges in the UK: A critical review. Discussion paper 2000–04. Department of Economics, University of York.

Moreover, charges unrelated to ability to pay disproportionately burden the poor<sup>22</sup>—for whom there is no reason to suppose have a greater tendency to “frivolous” demand than the rich, and impact on clinically needed care.<sup>23</sup> Although the current system of exemptions alleviates this burden somewhat, and while a system based on ability to pay would go further in this regard, as we have already noted, why invent such a system when there already exists a charging mechanism which embodies such exemptions and variations based on ability to pay—it’s called taxation.

### 3. *Some services are not considered part of the NHS*

The argument that some clinical services are not really medical or that they are unrelated to an individual’s health status and should not therefore be supplied and paid for by the NHS has some validity. While, in the current charging system, this argument may apply to the more cosmetic end of dentistry, it is hard to see how it applies to other aspects of dentistry, or ophthalmic services, or prescription medicine. Although all the charging regime in all these services operate a system of exemptions of one sort or another, it seems difficult to make a coherent or logical argument in favour, for example of exemption from charges for eye tests for people suffering from certain illnesses, but not others; is the optical correction of myopia purely a cosmetic intervention?

However, there is a general problem in deciding what should be in and what should be outside the NHS (and hence funding on a universal basis from general taxation). Although historically some services and treatments have been excluded from the NHS on the grounds of clinical ineffectiveness, and, more recently, on the basis of NICE appraisals, on the grounds of lacking cost effectiveness, the NHS has never defined in a systematic way its basic “package of care”. There is also the question of what could or should be supplied by the NHS: for example, given the health-enhancing benefits of exercise, should gym membership be wholly or partly subsidised by the NHS?

There are perhaps more obvious non-clinical services—such as bedside televisions and telephones, and car parking—which are offered to NHS patients at a charge. While it could be argued that access to, for example, a bedside telephone in hospital contributes to a patient’s quality of life during their stay, the contribution to the main purpose of the NHS—patients’ health-related quality of life—is perhaps more difficult to establish. Given competing calls on a limited NHS budget, therefore, it is equally hard to make a case for the free provision of such clinically-peripheral services.<sup>24</sup>

### 4. *Charges/payments in the context of a private market stimulates innovation and improves quality*

The argument that charging patients in the context of a private market improves innovation and quality (through competition) perhaps goes beyond the Committee’s agenda on NHS charges, but is, we think related (particularly to argument 3, above). For example, one argument put forward for the deregulation of ophthalmic services was that opening up this service to more extensive market competition would improve the range and quality of spectacles on offer. And indeed, this is what has happened.

Of course, such improvements have come at a price (literally) for those no longer eligible for free sight tests. And the voucher system introduced to offset up to 100% of the full cost of spectacles for children and eligible adults is of course dependent on the prices charged by opticians as the vouchers are fixed in value. A government survey in 2001 indicated that only 37% of vouchers were redeemed within the value of the voucher and that between half and a quarter (depending on type of prescription) of all opticians surveyed could not supply the required spectacles within the value of the voucher.<sup>25</sup>

Whether the optical market in general is operating in the best interests of consumers is an open question (and one, perhaps, worth investigating). But, there is a prior question: should certain services (for certain people) be excluded from the general NHS package of services in the first place? As we noted above, not only is it hard to make a logical argument in favour of exemptions from sight test charging on some grounds and not others, but also hard to argue that optical correction of poor sight is not a clinical intervention similar to many other therapies available on the NHS which are paid for from general taxation.

<sup>22</sup> The RAND Health Insurance Experiment, considered the definitive study on this issue, found that co-payments led to a much larger reduction in the use of medical care by low-income adults and children than by those with higher incomes (see: Newhouse J, (1996) *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge: Harvard University Press, 1996).

<sup>23</sup> For example, The RAND Health Insurance Experiment of user charges which took place in the US during the 1980s showed that clinically needed care is just as likely to be cut back as care that is not needed. There are many other studies which have also shown the adverse health consequences of user charges, especially on low income groups and the elderly—see for example, Robyn Tamblyn, *et al*, “Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons,” *Journal of the American Medical Association*, 285(4): 421-429, January 2001.

<sup>24</sup> However, there remains a question concerning the reasonableness and consistency of charges for such services across the NHS.

<sup>25</sup> Government Statistical Service (2003) Optical Voucher Survey, July 2001. (<http://www.dh.gov.uk/assetRoot/04/06/09/92/04060992.pdf>).

## CONCLUSION

The King's Fund's view on charges and co-payments in the NHS is that while the current system is, in the words of Lord Lipsey, "... a dog's dinner lacking any basis in fairness or logic and stuffed with anomalies and inconsistencies",<sup>26</sup> more fundamentally, co-payments are generally an inefficient way of achieving objectives which could be obtained more easily and with fewer undesirable consequences by other means.

However, we would recognise that abolition of existing charges raise a number of issues depending on the service incurring a charge. However, the general question is whether the costs of abolition are worth the benefits.<sup>27</sup> Although research has been proposed into the impact of the phased abolition of prescription charges in Wales,<sup>28</sup> in general there is little or no empirical analysis of the costs and benefits of abolition for the UK. Nevertheless, there is, for example, international evidence of the detrimental health effects of co-payments and charging and evidence in the UK that charging reduces utilisation of non-exempt services. Moreover, there is the principled argument that given the fundamental founding objective of the NHS, it is anomalous to maintain patient charges for, primarily prescriptions, but also including aspects of dentistry and ophthalmic services.

*Daniel Reynolds*  
King's Fund

*December 2005*

---

## Memorandum submitted by Macmillan Cancer Relief (CP 23)

### 1. SUMMARY OF RECOMMENDATIONS

Patients who undertake regular visits to hospital for cancer treatment should be exempt from hospital parking charges.

Department of Health guidance on parking should be more prescriptive and should instruct hospitals to offer exemptions to specified groups of patients, including cancer patients who travel regularly to hospital.

All patients travelling to hospital for regular cancer treatment should have their travel costs reimbursed through the Hospital Travel Costs Scheme (HTCS) on a non-means tested basis.

Compliance with Departmental guidance on HTCS should be seen as a "must-do" requirement and not an optional extra. All hospital trusts should be routinely informing patients about HTCS and local parking concessions through posters and appointment letters. We urge the Committee to ask the Department of Health to outline the action it intends to take to ensure that trusts comply with this guidance.

Patients undergoing treatment for cancer should be exempt from prescription charges for life-saving cancer drugs or for drugs and treatments to control the debilitating side effects of treatment. Terminally ill patients receiving palliative care at home should be exempt from prescription charges.

The Disability Living Allowance (DLA) and Attendance Allowance (AA) hospital downrating rules should be relaxed in recognition of the additional costs, including phone and TV charges, incurred by hospital in-patients.

Before treatment commences patients should be routinely advised about the range of charges and expenses they are likely to incur during the course of their treatment.

All cancer patients should be offered specialist benefit advice at diagnosis and at key points in the patient journey. Referral mechanisms should be built into care pathways so that patients are given advice about the right benefits and concessions at the right time.

### 2. INTRODUCTION

2.1 Macmillan Cancer Relief helps people who are living with cancer. Each and every day over 600 people in England are told they have cancer. More than one million people in the UK today have had a cancer diagnosis, and more than one in three will be diagnosed at some time in their life. As well as taking action today to support people from the moment they suspect they have cancer, Macmillan is shaping the future of cancer care. Our increasing range of services, including our Macmillan nurses, doctors and other health and social care professionals, cancer care centres, cancer information, practical help at home and help with money, is funded entirely through the generosity of our supporters.

---

<sup>26</sup> SMF Health Commission (2004) *User charges for health care*. SMF, London.

<sup>27</sup> Costs would not only include loss of net revenue, but also knock on consequences such as greater take up of previously charged for services (although this may also be considered a benefit, of course).

<sup>28</sup> Prof David Cohen, University of Glamorgan, has submitted a research proposal to the Wales Office for R&D to study the effects of abolishing prescription charges in Wales on behalf of the Welsh Health Economics group: Personal communication.

2.2 Macmillan welcomes the opportunity to contribute to the Health Committee's Inquiry into Co-payments and NHS Charges. In November 2004 Macmillan launched the Better Deal campaign to highlight the financial costs of cancer. The evidence about hospital travel and parking policies in this submission is taken from studies commissioned as part of the campaign and from the personal stories of cancer patients who have contacted us after hearing about the campaign.

2.3 Financial worries are a major source of stress for patients. Over three quarters (77%) of respondents to a survey of the CancerVOICES network said they had incurred extra costs as a result of cancer.<sup>29</sup> Patients typically incur a wide range of additional expenses including hospital travel and parking, domestic duties, prescription charges, childcare costs, clothing (due to weight loss/gain), wigs, complementary therapies, and diet supplements. In 2004 our Macmillan Grants service provided financial assistance to 17,102 people affected by cancer and this year we expect to support over 20,000 people. To date this year we have assisted 2,411 people with hospital travel costs (including parking costs), 753 people with hospital visiting costs, and 174 people with prescription charges.

### 3. ARE NHS CHARGES EQUITABLE AND APPROPRIATE?

#### 3.1 Hospital parking charges

3.1.1 Parking charges at NHS hospitals have become an increasingly important source of revenue since hospital car parks ceased to be Crown properties in the 1980s. One hospital trust source told the Health Service Journal that their trust raises more than £250,000 a year from parking charges: "Charging is a big money-maker for trusts. In the last five or six years, trusts have cottoned on to the revenue potential of charging for car parks and turned it into a tax on health".<sup>30</sup> Hospital parking charges in England are not regulated by the Department of Health (DH). In 2003 then health minister John Hutton said: "It is a matter for individual hospitals to decide whether or not to charge for car parking and the cost of such charges in the light of local circumstances".<sup>31</sup>

3.1.2 Macmillan's 2005 report *Free at the point of delivery?* is the most comprehensive survey to date of hospital parking charges in the UK.<sup>4</sup> Between June 2004 and January 2005 Macmillan conducted a telephone audit of 285 of the 292 UK hospitals that have cancer centres or cancer units. In England, information was collected from 227 of the 229 hospitals providing cancer services. The data from the audit was analysed by Dr Foster Ltd and the key findings about parking charges were:<sup>32</sup>

- 92% of hospitals in England charged patients for parking;
- Parking charges are more prevalent in English hospitals than in the rest of the UK—53% of hospitals in Wales, 20% of hospitals in Northern Ireland and 6% of hospitals in Scotland charged patients for parking;
- Hourly rates in English hospitals ranged from 30p to £4.00 an hour, with an average hourly rate of £1.22;
- Charges for 24-hour stays in English hospitals ranged from 50p to £30 a day, with an average charge of £5.67 a day;
- Six out of 10 hospitals (59%) that charged patients for parking did not provide concessions for cancer patients.

3.1.3 Macmillan believes that charging patients for parking when they are attending hospital for potentially life-saving cancer treatment is inappropriate and morally unjustifiable. Firstly, cancer patients in particular are penalised by parking charges because they need to make multiple trips to hospital for chemotherapy and radiotherapy. Secondly, the changing nature of cancer treatment means that patients are increasingly receiving these treatments not as in-patients but as outpatients. Four out of five patients receive radiotherapy treatment as outpatients. Finally, the unsuitability and unreliability of public transport and hospital transport means that cancer patients have no alternative but to travel to hospital by car.

3.1.4 In order to explore the travel problems faced by cancer patients, Macmillan commissioned Opinion Leader Research to conduct patient focus groups.<sup>33</sup> The findings from the focus groups highlighted the number of hospital visits that cancer patients are having to make:

- Outpatient radiotherapy involves daily round trips to hospital, five days a week, for up to six weeks;

<sup>29</sup> Macmillan survey of CancerVOICES network (2003—unpublished). CancerVOICES is a network of people affected by cancer that is supported by Macmillan.

<sup>30</sup> Health Service Journal Special Report, *No walk in the park: how trusts manage their car parking*, 16 September 2004.

<sup>31</sup> House of Commons Written Answers, 28 April 2003, Col 278W.

<sup>32</sup> Allirajah D, Herbst K, Morgan L, *Free at the Point of Delivery? Exposing the hidden cost of hospital travel and parking for cancer patients*, Macmillan Cancer Relief in association with Dr Foster Ltd (2005).

<sup>33</sup> Opinion Leader Research (June 2005), Macmillan Cancer Relief Better Deal Costs. The findings from this study were published in Allirajah et al *Free at the Point of Delivery?* (2005).

- Outpatient chemotherapy commonly involves two-three journeys to hospital a week but the length of time spent in hospital is longer than for radiotherapy sessions, with chemotherapy patients often having to park for a whole day;
- Patients who took part in the focus groups undertook on average 20–30 round trips to hospital for radiotherapy treatment alone, with some patients making up to 50 visits;
- Adding in repeat visits for diagnostic tests, consultant appointments, and follow-up appointments, patients made an average of 60 hospital visits throughout the duration their treatment with the number of visits ranging from 30 to 120;

The following cases illustrate the cumulative cost of parking charges for cancer patients.

#### Carol, Breast Cancer Patient, Bristol

After having surgery to remove the tumour, Carol had to travel to Bristol Royal Infirmary to receive radiotherapy and chemotherapy treatment, every day (Monday to Friday) for five weeks. Car parking costs £1.50 for a two hour stay. A course of treatment lasting five weeks has cost her an estimated £162.50 in parking charges.

#### Sally, Leukemia Patient in her early Thirties, West Midlands

Sally was diagnosed with acute lymphoblastic leukaemia just before Christmas 2004, and has been undergoing high-dose treatment—about 10 types of chemo and radiotherapy—at Birmingham Heartlands Hospital. She had an autograft (stem cell/bone marrow support) in July. She and her husband spent £8 a day (£2 an hour) parking there every day for five weeks—a total of £280 over a five week period.

#### AC, Breast Cancer Patient in her Forties

“Since my diagnosis in May 2001 I have spent over £500 on hospital car parking at various hospitals.”

3.1.5 Most of the patients who participated in the focus groups had opted to travel to hospital by car because of the unsuitability and unreliability of public transport and hospital transport. Patients undergoing courses of chemotherapy and radiotherapy commonly experience side effects such as extreme fatigue, nausea, diarrhoea and neutropenia (a condition which makes patients prone to infection). Consequently these patients are unable to use either public transport or non-emergency ambulances. Patients regularly complain that the non-emergency Patient Transport Service (PTS) is unreliable and involves long waits and lengthy ambulance journeys as other patients are picked up or dropped off along the way. The availability of volunteer driver services, which are better suited to the needs of cancer patients, is patchy and the capacity of such schemes can be limited due to the shortage of volunteers. The following quotes from focus group participants illustrate these problems:

“Sometimes you don’t make it to the bottom of the driveway before you throw up. I was ill. I was terrible, I was sick the whole way home, every single time. There’s no way I could have got on a train.”

“We were able to get an ambulance . . . but it takes it about 5 hours to get there and 5 hours to get back. It would have been alright to get there but no way could I have sat in it coming back because you feel so nauseous.”

“I just stood and waited on the bus. I must have stayed an hour and a half waiting on a bus and I’d just had radiotherapy.”

The Department for Transport estimates that 1.4 million people miss, turn down or simply choose not to seek medical help because of transport problems.<sup>34</sup> However, missing an appointment is not an option for cancer patients for whom treatment may literally be a matter of life and death. Charging cancer patients for parking when they have no alternative but to travel to hospital by car is effectively a tax on illness. If the NHS wants to avoid the charge that it is profiting from sick and vulnerable patients it should ensure that specific groups of patients are exempted from charges.

---

<sup>34</sup> Department for Transport (DfT), *Accessibility of local services and facilities* (2002).

Recommendation: Macmillan Recommends that Patients who Undertake Regular Visits to Hospital for Cancer Treatment should be Exempt from Parking Charges.

### 3.2 Prescription charges

3.2.1 Cancer patients who are not receiving in-patient treatment may be liable to pay for prescriptions for a wide range of drugs and treatments. The prescriptions required by cancer patients are mainly for drugs to counteract the side effects of treatment (nausea, fatigue, etc.). However, some patients who are prescribed cancer drugs such as tamoxifen or oral chemotherapy agents may also be liable for prescription charges. A list of the range of drugs and treatments for which cancer patients might incur prescription charges can be found at Appendix 1.

3.2.2 As radiotherapy and chemotherapy treatment is increasingly being delivered on an outpatient or day surgery basis, it is becoming more and more common for cancer patients to incur charges for prescriptions. Nearly one in five respondents (17%) to Macmillan's survey of the CancerVOICES network said that prescription charges were one of the extra expenses they had incurred since being diagnosed with cancer.<sup>35</sup> One in six respondents to a recent Macmillan survey of 50 breast cancer patients said that prescription charges were their single biggest expense.<sup>36</sup> Most of the patients who took part in the focus groups conducted by Opinion Leader Research for Macmillan said that the cost of multiple prescriptions was a major concern.<sup>37</sup> The following examples illustrate the costs incurred by patients:

#### LC, Breast Cancer Patient in her Fifties

She took Tamoxifen and other drugs for three years. Her bi-monthly prescription would, at the current rate (£6.50 per item for 18 prescriptions), cost £117 in total. In addition she also had to pay a monthly prescription charge for anti-depressants and for sleeping tablets.

#### DB, Breast Cancer Patient in her Fifties

During treatment DB was prescribed a number of items including steroids, relaxants, anti-sickness medication, and constipation medication. Each fortnight she was spending £24 on prescribed items and, over a period of six months she spent approximately £288 in total. When she finished treatment she was prescribed tamoxifen.

#### AC, Breast Cancer Patient in her Forties

Although AC didn't have to take Tamoxifen she took a whole host of other drugs as a result of her cancer ie painkillers, anti-depressants, anti-nausea medication, medication for constipation. She had five items each month, which at current rates would cost £32.50 each month.

#### PJ, Ovarian Cancer Patient in her Sixties

She was given prescriptions to combat the side-effects of her treatment. "It's unfair that you have to pay for medication to counteract the side-effects of your treatment, it doesn't even dawn on you that you may need to do that", she said.

Recommendation: Patients undergoing treatment for cancer should be exempt from prescription charges for life-saving cancer drugs or for drugs to control the debilitating side effects of treatment. Terminally ill patients receiving palliative care at home should also be exempt from prescription charges.

### 3.3 Television and telephone charges

3.3.1 Cancer patients who took part in the focus groups conducted by Opinion Leader Research reported a range of costs incurred by hospital in-patients, notably food and drink, magazines, TV rental and telephone calls. Several participants were "highly critical of the premium rate charged for calls into the hospital to the bedside phone".<sup>38</sup> Television rental and phone charges were among the most commonly cited costs incurred by cancer patients according to benefit advisers in our recent Access Denied report.<sup>39</sup> The

<sup>35</sup> Macmillan survey of CancerVOICES network (2003—unpublished).

<sup>36</sup> *Can you afford to have breast cancer?* Macmillan Cancer Relief press release, 26 October 2005.

<sup>37</sup> Opinion Leader Research (June 2005), *Macmillan Cancer Relief Better Deal Costs*. The findings from this study were published in Allirajah et al *Free at the Point of Delivery?* (2005).

<sup>38</sup> Opinion Leader Research (June 2005), *Macmillan Cancer Relief Better Deal Costs*. The findings from this study were published in Allirajah et al *Free at the Point of Delivery?* (2005).

<sup>39</sup> Miller S, *Access Denied: Benefits advisers' perceptions of the problems cancer patients face when claiming Disability Living Allowance and Attendance Allowance*, Macmillan Cancer Relief (2005).

study explored benefit advisers' perceptions of the problems faced by cancer patients in accessing disability benefits. In-depth interviews were conducted with 17 cancer-specialist advisers who work in Macmillan-funded advice services which provide advice and support to over 10,000 cancer patients a year.

3.3.2 The following case studies illustrate the impact of charges for phones, televisions and the Patientline communications system (which combines telephone, television, email and internet access).

#### PJ, Whose Sister had Bowel Cancer

PJ's sister was treated at St Thomas' in London. PJ spent £53 in total calling her sister on Patientline and, consequently, her monthly telephone bill more than doubled. It cost 39p a minute off peak and 49p a minute at peak rate but as she says "when someone is ill there is no peak or off peak". For patients to call out the charge was 10p a minute while TV rental cost her sister £3.50 for 24 hrs—but she would only want to watch a couple of programmes so this worked out to be very expensive. She says that her sister was in hospital for three weeks and had no choice but to use Patientline. "It's like grave robbing, they're making a profit out of other people's misery", said PJ.

#### PW, Breast Cancer Patient in her Thirties

"[Patientline] cost me a fortune, but I had to use it as I have a young daughter who I needed to keep in contact with and make arrangements for". In relation to TV charges she said "I had no choice but to pay to use the TV. I was stuck in bed, it was difficult to move, and the TV was the only entertainment. I never expected I'd have to pay for the privilege"

#### AC, Breast Cancer Patient in her Forties

She had to pay a deposit for the TV and £5 a day hire. AC said that it "added up to quite a bit but you don't really have much choice, you have to pass the time somehow".

3.3.3 Disability Living Allowance (DLA) and Attendance Allowance (AA) are the main benefits for meeting the extra costs of disability. However these benefits are withdrawn for adults after 28 days spent in hospital—either in one continuous spell or separate spells linked together by periods of less than 28 days (the so-called "linking rule"). Currently, other social security benefits are downrated after 52 weeks though, as the Chancellor announced in the March 2005 Budget, the hospital downrating rules will be scrapped altogether from April 2006 for all benefits except DLA and AA. In a 2003 parliamentary debate Maria Eagle MP, then Parliamentary Under-Secretary of State for Work and Pensions, explained the rationale behind the DLA/AA in-patient rules: "All in-patients' disability-related needs are met by the national health service. That is where the rule against overlapping provision comes in, and that is why DLA and AA are withdrawn".<sup>40</sup> However, as our evidence shows, in-patients incur a range of extra costs including charges levied by NHS hospitals for phone and television use. These are not frivolous types of expenditure but essential to ensure the emotional well-being of patients undergoing treatment for cancer.

Recommendation: The DLA and AA downrating rules should be relaxed in recognition of the additional costs, including phone and TV charges, incurred by hospital in-patients.

### 3.4 *The hidden costs of travel*

3.4.1 Although hospital travel costs may not appear to be NHS charges, Macmillan believes that these hidden treatment costs should also be regarded as co-payments. As we have explained in para 3.1.5 above, cancer patients have no alternative but to travel to hospital on a regular basis for treatment. The delivery of chemotherapy and radiotherapy on an outpatient basis means that cancer patients incur quite substantial travel costs during their course of their treatment. Patients who took part in the Opinion Leader Research focus groups spent £380 on average on travel and parking charges with costs ranging from £25 to £848.<sup>41</sup>

3.4.2 The NHS is making considerable savings by delivering treatment on an outpatient or day surgery basis. An influential NHS Modernisation Agency document which urged hospitals to make day surgery rather than in-patient treatment the norm, estimated that trusts could save £200 a day as a result.<sup>42</sup> A hospital can therefore save £6,000 by delivering a six week course of radiotherapy on an outpatient basis. Whilst we are in favour of hospitals delivering treatment in more cost-effective ways, this should not be achieved by shifting the financial burden onto patients in the form of travel and parking charges. The NHS is supposed to be free at the point of delivery and therefore we strongly believe that these hidden costs of treatment should not be borne by patients undergoing treatment for serious and life-threatening diseases like cancer. We would like to see the NHS take a more holistic approach to the issue of financial efficiency.

<sup>40</sup> House of Commons Hansard, 25 March 2003, Col 27WH.

<sup>41</sup> Opinion Leader Research (June 2005), *Macmillan Cancer Relief Better Deal Costs*. The findings from this study were published in Allirajah et al *Free at the Point of Delivery?* (2005).

<sup>42</sup> NHS Modernisation Agency, 10 *High Impact Changes for service improvement and delivery: a guide for NHS leaders* (September 2004).

If hospitals are introducing new ways of delivering treatment which free up in-patient beds, the financial implications for patients should always be considered. In the case of outpatient cancer treatment we would like to see some of the considerable savings that trusts are making reinvested into helping patients with travel costs.

**Recommendation:** All patients travelling to hospital for regular cancer treatment should have their travel costs reimbursed through the Hospital Travel Costs Scheme on a non-means tested basis.

#### 4. WHAT IS THE OPTIMAL LEVEL OF CHARGES?

4.1 As we have said earlier, Macmillan believes that parking charges and prescription charges for patients undergoing cancer treatment are morally unjustifiable.

#### 5. IS THE SYSTEM OF CHARGES SUFFICIENTLY TRANSPARENT?

5.1 Hospital car parking charges appear to be reasonably well advertised on hospital websites. However, as our *Free at the Point of Delivery?* report shows, patients are not being routinely informed about parking discounts or about the Hospital Travel Costs Scheme (HTCS) under which parking charges can be reimbursed for patients on benefits/low income (see para 7.1 below).

5.2 While prescription charges might be reasonably transparent, patients are not always warned at the start of their treatment that they might incur such expenses nor are they routinely advised about pre-payment certificates, which reduce the cost of repeat prescriptions as the following examples illustrate:

##### PW, Breast Cancer Patient in her Thirties

She hasn't ever been told about pre-payment certificates. She saw a sign in the chemist about it but doesn't think it would be cost effective for her. She never expected that she would have to pay for drugs after her treatment, she says it's "extra money from my pocket, another extra expense when cancer had already meant my income was reduced."

##### AC, Breast Cancer Patient in her Forties

Despite having to spend over £30 a month on prescriptions she was never told about pre-payment certificates—she found out about these herself. "It was really daunting to fork out all this money when I was so ill", she said. She was never told that she would have to pay for all of this medication after she finished treatment.

5.3 Although Patientline leaflets detailing the charges are available on hospital wards, relatives and carers are not always warned about the cost to the caller of phoning the patient in hospital. PW, a breast cancer patient in her thirties, told us that relatives and friends "weren't aware that the charges would be so high". PJ, whose sister had breast cancer, said that each time she called the Patientline telephone system there was an introduction of at least a minute before she could dial the patient's extension which she could not skip. Often her sister would turn her phone off as she felt too ill to speak and did not want to be disturbed but there was no way for PJ to find this out until she had got past the recorded message and dialled the number, by which time the call may have cost £1 or more.

**Recommendation:** Before Treatment Commences Patients should be Routinely Advised about the Range of Charges and Expenses they are likely to Incur during the Course of their Treatment.

#### 6. WHAT CRITERIA SHOULD DETERMINE WHO SHOULD PAY AND WHO SHOULD BE EXEMPT?

6.1 Department of Health (DH) guidance on car parking charges advises hospitals to "consider" concessions for certain patient groups but does not specify which patients should be granted concessions.<sup>43</sup> By contrast, the equivalent Scottish Executive Health Department guidance specifically suggests that "consideration should be given to providing concessions to certain categories of patient (for example "patients attending regularly for dialysis or radiotherapy)".<sup>44</sup> The consequence of the Department of Health's *laissez faire* approach to parking charges in England is a postcode lottery of charges and local concessions. A reanalysis of our hospital audit data found that only four in 10 hospitals (42%) with cancer centres provide free parking for certain cancer patients.<sup>45</sup> Appendix 2 illustrates the variations in practice.

**Recommendation:** Macmillan recommends that Department of Health guidance on parking should be more prescriptive and should instruct hospitals to offer exemptions to specified groups of patients, including cancer patients who regularly travel to hospital.

<sup>43</sup> Department of Health, *Income Generation—Car parking charges: A guide to implementation* (1996).

<sup>44</sup> Scottish Executive Health Department, *Guidance on hospital car park charging*, NHS HDL(2004) (April 2004).

<sup>45</sup> In November 2005 Macmillan re-analysed the hospital audit data and found that 18 out of 42 hospitals with cancer centres (42%) provide free parking for radiotherapy or chemotherapy patients or both.

6.2 The current system of medical exemptions from prescription charges, which was drawn up in 1968, is outdated and riddled with anomalies. 30 years ago cancer patients were much more likely to be treated in hospital and die from the disease. Consequently, prescription charges were not such a big issue for cancer patients. Today, as a result of more effective treatments, improved survival rates and the shift from inpatient to outpatient treatment, cancer patients increasingly find themselves liable for prescription charges often for long periods of time. This trend is set to continue as oral chemotherapy becomes more widely employed. Patients can purchase pre-payment certificates and may be eligible for free prescriptions if they are in receipt of certain means-tested benefits or if they satisfy the NHS Low Income Scheme means test. However, Macmillan wants cancer patients to be eligible for free prescriptions without having to undergo a means test. As we have argued earlier, cancer patients should not have to pay for cancer drugs or drugs and treatments to control symptoms.

## 7. HOW SHOULD RELEVANT PATIENTS BE MADE MORE AWARE OF THEIR ELIGIBILITY FOR EXEMPTION?

7.1 Department of Health guidance to hospital trusts specifically states that “notices about the HTCS should be displayed in all patient areas” and that “provider units should ensure that they provide details of the HTCS and of local transport and concessionary fare arrangements with appointment or admission letters”.<sup>46</sup> However our hospital audit shows that this guidance is not being implemented. We asked cancer nurses and information postholders in cancer centres/units how the HTCS and local parking concessions were promoted in their hospitals and found that:

### Promotion of HTCS

- 48% of health professionals in England either did not know how the scheme was promoted or else said it was not promoted;
- Only one in five respondents in England (19%) said that their hospital was promoting the scheme through posters, website, appointment letters or at first appointment;
- 34% of respondents in England said that patients were informed by word of mouth alone;
- Only 7% of respondents who knew if the HTCS was being promoted (UK-wide) said it was advertised in appointment letters, while 21% said it was promoted through posters.

### Promotion of Parking Discounts

- Parking concessions varied from hospital to hospital—some hospitals provided free parking for cancer patients while others offered discounted rates;
- Only 9% of hospitals promote parking discounts by leaflets and less than one in five (18%) promoted through posters. The most common method of promoting parking discounts for cancer patients was word of mouth;
- Hospitals do not always promote parking discounts. As one respondent told us “In theory there’s a service people can apply for to get parking for £3 a day, but in reality it’s not openly offered, advertised or discussed”.

7.2 A 2001 Audit Commission report found that the Hospital Travel Costs Scheme (HTCS) was not well publicised.<sup>47</sup> Four years since that report was published it is clear that little progress has been made and that some hospitals are deliberately not advertising the scheme. One respondent told us that “Transport and parking issues are not highlighted to patients because the area is too problematic”. Another said that her hospital did not promote the HTCS because too many patients would claim travel costs and the hospital did not have sufficient funds to cover this (even though Primary Care Trusts reimburse hospitals for HTCS expenditure). It is unacceptable that some hospitals, either deliberately or through omission, are not advising patients of their statutory entitlement to financial help under the HTCS.

**Recommendation:** Macmillan Believes that Compliance with Departmental Guidance on HTCS should be seen as a “Must-Do” Requirement and not an Optional Extra. All Hospital Trusts should be routinely Informing Patients about HTCS and Local Parking Concessions through Posters and Appointment Letters. We urge the Committee to ask the Department of Health to outline the Action it intends to take to ensure that Trusts Comply with this Guidance.

7.2 We would also like to know what progress the Department of Health is making in implementing the recommendations in the 2003 Social Exclusion Unit report Making the Connections.<sup>48</sup> The SEU recommended that the Department of Health should develop options to provide information and advice on getting to healthcare facilities and book transport where appropriate. One idea floated by the SEU was the

<sup>46</sup> 18 Department of Health, *The hospital travel costs scheme* (published on the DH website).

<sup>47</sup> See Audit Commission, *Going Places: Taking people to and from education, social services and healthcare (2001)* and NACAB, *Unhealthy Charges: CAB evidence on the impact of health charges (2001)*.

<sup>48</sup> Social Exclusion Unit, *Making the Connections: Final Report on Transport and Social Exclusion 2003*.

development of a “one-stop shop” service which would provide advice to patients on transport options and arrange patient transport. However, to date, we have seen no evidence that the Department has acted on this recommendation.

7.3 Macmillan wants a much more systematic approach to advising patients about the full range of concessions and benefits to which they might be entitled. The NHS is very poor at informing patients about financial concessions and benefits. A recent National Audit Office report found that 77% of cancer patients were not given information about financial benefits.<sup>49</sup> However, simply giving patients written information is not sufficient. Patients also need help to interpret complex information about benefits and concessions and support to negotiate the benefits maze.

**Recommendation:** Macmillan wants to see all Cancer Patients offered Specialist Benefit Advice at Diagnosis and at Key Points in the Patient Journey. Referral Mechanisms should be built into Care Pathways so that Patients are given Advice about the Right Benefits and Concessions at the Right Time.

## 8. SHOULD CHARGES BE ABOLISHED?

8.1 Macmillan’s primary concern is to ensure that cancer patients do not have to pay for the “privilege” of undergoing cancer treatment. Therefore we support any reform which means that cancer patients do not have to pay for travel, parking charges or prescriptions.

8.2 It could be argued that foregoing revenue from car park charges means redirecting money away from other front line hospital services. We think this argument is disingenuous. Firstly, we believe that the failure to consider the impact of charges on repeat visitors amounts to poor planning. Secondly, as we have said earlier 42% of hospitals with cancer centres provide free car parking for certain cancer patients. If these hospitals can provide front line services without having to levy parking charges on cancer patients then we can see no good reason why all other hospitals cannot do the same.

## 9. CONCLUSION

9.1. Macmillan believes that an investigation of the punitive impact of NHS charges and co-payments is long overdue. We would like to give oral evidence to the Committee. Considered in isolation each charge or co-payment may not appear particularly onerous, but when these costs are added up the financial impact of cancer on patients’ lives can be very substantial. Moreover, many patients find themselves having to meet these additional costs at precisely the same time that household income may be depleted through loss of earnings. In a recent Macmillan survey one in four breast cancer patients said they had to cut back on food shopping or bought cheaper food (28%).<sup>50</sup> A recent survey by CancerBACUP found that 39% of working age cancer patients had experienced “significant financial difficulties” as a result of cancer.<sup>51</sup> NHS charges and co-payments represent a significant component of these additional costs and it is vital that action is taken to relieve the financial burden on cancer patients.

*Duleep Allirajah*  
Senior Policy Analyst  
Macmillan Cancer Relief

*December 2005*

## APPENDIX 1

### LIST OF PRESCRIBED ITEMS FOR CANCER PATIENTS

The following list is not exhaustive and intended only to illustrate the range of drugs and treatments for which cancer patients might be liable to pay prescription charges.

*Tamoxifen.* Tamoxifen is an anti-oestrogen drug that arrests/slows the growth of breast cancer cells. It is typically prescribed to breast cancer patients for five years after surgery.

*Anti-nausea drugs.* Nausea and vomiting are common side effects of both cancer and cancer treatments. Patients are prescribed anti-nausea drugs (anti-emetics) to counteract this problem.

*Mouth care treatments.* Radiotherapy can cause dry mouths by retarding saliva production and it is common for patients to be prescribed drugs to stimulate saliva glands or else to be prescribed artificial salivas in the form of sprays, pastilles, gels, or tablets. Some chemotherapy drugs can cause mouth ulcers for which mouthwashes and other treatments can be prescribed.

*Painkillers.* Pain is a common effect of both cancer and cancer treatments and patients are commonly prescribed analgesics (painkillers) to relieve pain.

<sup>49</sup> National Audit Office, *Tackling Cancer: Improving the Patient Journey* February 2005.

<sup>50</sup> *Can you afford to have breast cancer? Macmillan Cancer Relief press release, 26 October 2005.*

<sup>51</sup> CancerBACUP, *Work and Cancer: How cancer affects working lives* (2005).

*Lymphoedema treatments.* Lymphoedema is the swelling of a limb or other body parts which can be caused by radiotherapy, surgery to remove lymph nodes, or by the cancer itself blocking the lymph nodes. Patients are typically prescribed compression sleeves/stockings or compression bandages to control the swelling.

*Oral chemotherapy.* Whilst chemotherapy is most commonly administered intravenously in hospital, it is becoming increasingly common for cancer patients to undergo courses of out-patient chemotherapy by taking prescribed tablets or capsules.

*Skin care treatments.* Radiotherapy commonly causes skin burns, soreness and itchiness for which patients may be prescribed creams or dressings. Scaly or thickened skin is also a common symptom of lymphoedema and doctors frequently prescribe moisturisers to treat this.

*Impotence drugs.* Impotence is a common side-effect of prostate cancer treatment for which patients may be prescribed drugs such as Viagra.

*Breathlessness treatments.* Breathlessness is a common symptom if someone's lungs are affected by cancer. Patients may be prescribed steroids, bronchodilators, sedatives, and oxygen to treat breathlessness.

*Filters for tracheostomy/stoma tubes.* People who have had laryngectomies have to breathe through tracheostomy or stoma tubes and may be prescribed filters to reduce the risk of infection.

*Diarrhoea and constipation drugs.* Diarrhoea and constipation are potential side effects of chemotherapy for which drugs can be prescribed. Constipation is also a side effect of anti-nausea drugs.

*Anti-depressants.* Depression is a common problem encountered by cancer patients and it is common for patients to be prescribed anti-depressants.

## APPENDIX 2

### PARKING CHARGES: EXAMPLES OF VARIABLE PRACTICE AT HOSPITALS WITH RADIOTHERAPY CENTRES<sup>52</sup>

#### Churchill Hospital, Oxford

- Radiotherapy & chemotherapy patients all get free parking permits
- Inpatients only pay £5 to park for their whole spell in hospital
- Patients told about the permits at their planning appointment before they start treatment
- This is an official scheme & the hospital writes off the lost revenue.

#### Lincoln County Hospital

- All cancer patients get their ticket stamped so they can park for free
- Patients told about the scheme in letters and appointments before they start treatment.

#### Cookridge Hospital

- Patients attending daily radiotherapy are given a parking permit from the main reception so that they or their escort can park for free
- Chemotherapy patients may qualify for a permit if they are attending all day
- Patients are told about the scheme at their planning meeting before starting treatment and it is also advertised at the information centre and on the day care ward
- The scheme is administered by the receptionist at the main reception
- The scheme is not subsidised by the department & the cost is just written off by the hospital.

#### Leicester Royal Infirmary

- Charges: 0–1 hour: £1; 1–2 hours: £1.50, 2–3 hours: £2; 3–4 hours: £3; 4–5 hours: £4, 5–6 hours £6, up to 24 hours: £10
- Two years ago cancer patients did not have to pay. Now all cancer patients have to pay.

#### Royal Surrey County Hospital

- Charges: 0–1 hours: £1; 1–2 hours: £1.50; 2–3 hours: £2.50; 3–4 hours: £3.50; 4–5 hours: £4.50; Over 5 hours: £6
- There is a small dedicated car park for the centre, but patients need to buy a ticket. Weekly concession tickets are available for £15 a week for all patients (not just cancer patients).

#### Christie Hospital, Manchester

- Charges: 0–4 hours: £1.50; 4–8 hours: £2.50; 8–24 hours £10
- A free parking permit is only offered at the discretion of staff for patients in serious financial difficulty.

<sup>52</sup> The information in this appendix is based on data from Macmillan's hospital audit which has been subsequently verified by checking hospital websites and telephoning the hospitals.

---

North Middlesex Hospital

- Charges: 0–2 hours: £3; 2–3 hours £2.50, 3–4 hours: £6p; 4–5 hours: £7.50; 5 hours and over £9
  - Radiotherapy and chemotherapy patients used to be able to get their ticket stamped so that they could park free, but not anymore. Daily visitors can obtain a ticket which allows parking for £1 a day.
- 

**Memorandum submitted by Mind (CP 19)**

1. INFORMATION ABOUT MIND

Mind is one of the leading mental health charities in England and Wales.

Mind's vision is of a society that promotes and protects good mental health for all, and that treats people with experience of mental distress fairly, positively, and with respect.

The needs and experiences of people with mental distress drive our work and we make sure their voice is heard by those who influence change.

Our independence gives us the freedom to stand up and speak out on the real issues that affect daily lives.

We provide information and support, campaign to improve policy and attitudes and, in partnership with independent local Mind associations, develop local services.

We do all this to make it possible for people who experience mental distress to live full lives, and play their full part in society.

Being informed, diversity, partnership, integrity and determination are the values underpinning Mind's work.

Mind would like to make the following comments in respect of the Committee's inquiry into co-payments and charges in the NHS.

2. ARE CHARGES FOR PRESCRIPTIONS EQUITABLE AND APPROPRIATE?

Mind believes the current system of prescription charging is out of date and does not address the health needs of the population, especially those on low incomes. It is inequitable and inappropriate as it discriminates against people who experience mental distress.

The Wanless Report (2002)<sup>53</sup> states some of the issues clearly:

“The system of free prescription in the United Kingdom is illogical, irrational and works against the principles of the National Health Service.”

In particular, the current system discriminates against people with ongoing mental health conditions who are on low incomes, but whose incomes are above the threshold for exemption.

This is compounded by the current Department of Health advice (based on cost rather than patient preference) to prescribe for periods of a maximum of one month at a time. For people who take medication long-term, and who may in the past have been prescribed this on a three-monthly basis, their costs are trebled by having to renew their prescription three times more often. This is in addition to the inconvenience to the person concerned and the costs to the NHS caused by the renewal process. In addition, some people may be prescribed medication eg antidepressants for one week at a time, meaning the costs become substantial.

Mind recommends that Department of Health advice be reviewed to recommend that the length of prescription offered should depend on the needs and wishes of the patient and the prescriber's view of what is most suitable based on clinical rather than cost factors.

3. WHAT CRITERIA SHOULD DETERMINE WHO SHOULD PAY AND WHO SHOULD BE EXEMPT?

Mind believes prescriptions should be free to all.

If this is not introduced and a system of exemptions is retained, all those on low incomes should be exempt. However, the current system means there is a cut-off point for people who are on low incomes but who have an income of a few pounds over the limit, meaning they are required to pay the full amount. The system of exempting some people receiving Child Tax Credit or Working Tax Credit is welcome, but this does not cover all those on low incomes, for example some people on Incapacity Benefit. The criteria need to be revised to ensure all those on low incomes can receive the treatment they need.

---

<sup>53</sup> Wanless, D (2002) *Securing our future health: Taking a long-term view*, London, HM Treasury.

In addition, Mind believes that all those with a long-term condition requiring medical care or treatment, including recurring conditions, should be exempt from prescription charges. The criteria for this should ensure that people experiencing mental health problems are included. However, we believe the current system of listing specific conditions for exemption results in inequality and exemptions should be based on the duration of the condition and the need for care or treatment rather than the specific diagnosis given.

### 3.1 *The importance of free prescriptions for people experiencing mental distress*

Many people take medication on a long-term basis in order to help maintain their mental health. However, mental ill-health requiring ongoing treatment is not currently listed as a condition entitling exemption from prescription charges. Treatment for mental health problems may consist of a number of different types of medication prescribed concurrently. In addition, the side-effects associated with some medication used to treat mental health problems often mean that further medication is required to counteract or mitigate these effects.

Furthermore, people with mental health problems are more likely than the general population to also have poor physical health. The Disability Rights Commission inquiry into the physical health of people with mental health problems or learning disabilities has found that people with a diagnosis of schizophrenia or bi-polar disorder are more likely to have ischaemic heart disease, stroke or hypertension than the general population<sup>54</sup>. This means that they may require a relatively high number of prescriptions for medication to maintain their mental and physical health. The National Association of Citizens Advice Bureaux's "Unhealthy Charges" report (2001)<sup>55</sup> found evidence that some people have to make choices between medications as they cannot afford the prescription charges for all the medications recommended for them.

Although pre-payment certificates are available for those currently receiving high numbers of prescriptions, the cost of these is prohibitive as many people on low incomes cannot afford the initial outlay for these, either for the four-monthly or annual certificate.

Enabling people who experience mental health problems to receive their medication free of charge will mean they can be assured of receiving the medication they need when they need it, without the anxiety of wondering whether they can afford it, or what they have to go without in order to pay for it. It would have the further benefit of helping to address the physical health inequalities experienced by people with mental health problems.

### 3.2 *Right to free aftercare under Section 117 of the Mental Health Act*

People discharged from section 3 Mental Health Act treatment are entitled to free aftercare, including exemption from prescription charges for that care, under the Act. However, there are anomalies and inconsistencies within the system as many of those eligible are not aware of this, resulting in some paying for their prescriptions while others do not. In addition, only medication which is required for the person's mental health treatment is exempt, despite the fact that the person may also need to take a number of other medications (see above). There may be confusion as to which is exempt and which is not, especially if medication is frequently changed.

People who have not been formally "sectioned" under the Mental Health Act do not receive section 117 aftercare and are not entitled to free prescriptions upon discharge. This includes people who have either accepted treatment voluntarily or who are detained in hospital as "informal" patients,—that is, they are compliant but lack capacity to consent to treatment (known as "Bournewood" patients). This anomaly needs to be addressed.

In addition, new mental health legislation will seek to limit the free aftercare currently provided by section 117 of the Mental Health Act to more narrowly specified forms of care and for the limited period of six weeks. Mind believes this period is too short to ensure a person receives adequate care and support after discharge.

### 3.3 *Non-Resident Treatment Orders under new Mental Health legislation*

The draft Mental Health Bill 2004 provides for compulsory treatment in the community under "non-resident treatment orders." Failure to take this medication could result in detention in hospital.

Mind opposes the principle of non-resident treatment orders. It is likely that the government would plan to make certain types of medication freely available to people receiving ordered treatment in the community. But in the absence of published draft regulations and codes, we do not have that assurance, and can only guess at the adequacy of prospective arrangements.

---

<sup>54</sup> Disability Rights Commission (2005), *Interim Report of a Formal Investigation into Health Inequalities*.

<sup>55</sup> National Association of Citizens Advice Bureaux (2001) *Unhealthy Charges*, London, NACAB.

The new treatment orders are likely to be relatively narrow. They may require an additional application to the Mental Health Tribunal to be changed (for instance for a change in medication). Medication or other treatment might be prescribed that promotes mental health or prevents deterioration that is not within the terms of the compulsory order.

Mind therefore seeks a firm undertaking that all the medication that could be prescribed will be contained within treatment orders or alternatively that all medication prescribed to a person under a non-resident order will be free. It would be counter to natural justice to require a person to pay for medication which a tribunal had ordered them to take, and upon which their liberty therefore depends. For all the reasons explained above and by the same token, people on compulsory treatment orders should not be obliged to make invidious choices about the amount of chargeable care or treatment that they can afford when they are vulnerable and at risk of losing their freedom.

#### 4. SHOULD PRESCRIPTION CHARGES BE ABOLISHED?

Mind believes, for the reasons we have outlined above, that prescription charges should be abolished, and that charges in other areas should be revised in order not to impact disproportionately upon people on low incomes.

#### 5. ARE OTHER NHS CHARGES FAIR AND EQUITABLE?

##### 5.1 *Car Parking*

Charges for car parking at NHS facilities are inequitable. This issue is of particular importance to people visiting a relative or friend who is in hospital over a long period of time, and is related to our comments on travel costs for visitors (see para 6.1). It is important that a person experiencing mental health problems stays in touch with their social networks, and if a friend or family member is visiting frequently and they are on a low income, the cost can become prohibitive.

A system should be established for claiming back parking charges for people who are on low incomes who are the primary visitor for someone in hospital, or if they are enabling children under 18 of the person in hospital to visit their parent, up to an agreed amount.

##### 5.2 *Televisions*

There has been a move in some trusts towards the installation of bedside communication facilities including TVs which require payment for use. Mind considers these to be completely inappropriate for mental health in-patient units. Many service users currently comment that there is very little activity available in in-patient units, and the TV lounge provides a very important source of activity and also a social focus for the unit.

If bedside facilities are provided at all in mental health units, TV channels should be free of charge.

##### 5.3 *Telephones*

In mental health units payphones are usually provided which require phone cards which are more expensive than domestic call rates. This is inequitable for people on low incomes. Trusts should not seek to make profit on phone calls made by patients, and should make phone cards available which are best value for money for patients.

All in-patient wards should therefore have a telephone which is available for patient use which accepts incoming calls.

#### 6. OTHER ISSUES: NON-NHS CHARGES INCURRED IN RELATION TO NHS TREATMENT

Mind would like to add the following comments for the Committee's attention:

##### 6.1 *Visiting expenses*

There are a range of costs incurred by those who experience mental ill-health or their carers which are levied by other agencies. This includes payment for travelling or overnight costs incurred by those visiting people who may be using mental health services a long distance from home, such as national specialist centres, regional secure or high secure hospitals. Currently, the only means of seeking funding for visiting costs is through application to the Social Fund, which is discretionary, limited and in some cases repayable.

In 2004, the ODPM Social Exclusion Unit published its report on mental health and social exclusion, stating the importance of social networks and support in promoting mental well-being and recovery. Ensuring people who are mental health in-patients can maintain contact with their families and friends

should therefore be part of their care plan, and people on low incomes should receive financial support to enable this. The Assisted Prison Visits Scheme provides a comparable system for people visiting prisoners which could be used as a model.

#### 6.2 *Paying for treatment recommended by a GP but unavailable through the NHS*

In addition, many people who experience mental distress find themselves paying for treatment which their GP or other doctor recommends, but are unable to access through the NHS such as counselling and psychotherapy.

In Mind's "Hidden Costs of Mental Health" report (2003)<sup>56</sup>, 21% of respondents had paid for counselling or therapy prescribed by their GP. These therapies are often unavailable via the NHS due to long waiting lists, lack of NHS therapists in the area and cuts in services etc. However, they are often vital to supporting people's mental health. Many people pay for these privately despite being on low incomes, because their health would otherwise deteriorate significantly. As well as the negative impact upon their lives, this would ultimately result in increased costs to the NHS and the state generally.

Failure to provide adequate free treatments for people experiencing mental distress is a false economy. There should be recognition of the high costs incurred to people on low incomes who need access to therapies in order to maintain their mental health, as a result of the lack of adequate NHS provision.

### 7. ORAL EVIDENCE

Mind would be pleased to give oral evidence to the Committee on this topic if it would be helpful to the inquiry.

*Moira Fraser*  
Mind

6 December 2005

---

### Memorandum submitted by the National Consumer Council (CP18)

#### INTRODUCTION TO THE NATIONAL CONSUMER COUNCIL

The National Consumer Council is an independent consumer expert, championing the consumer interest to make a practical difference to the lives of consumers around the UK.

We conduct rigorous research and policy analysis to investigate key consumer issues, and use this to influence organisations and people that can make change happen. We have linked organisations in England, Scotland and Wales, and a close relationship with colleagues in Northern Ireland.

We are a non-departmental body, limited by guarantee, and funded mostly by the Department of Trade and Industry.

#### EVIDENCE TO THE COMMITTEE

In July 2003, the NCC published *Creeping Charges*, which identified an urgent need to review charging in the NHS. It is striking how little clarity there is on the purpose of NHS charges. Very little government research or evidence has been collected on the efficacy of charging to the NHS or the public purse. There is no publicly stated rationale for this system of charges, discussion of what it is meant to achieve or what it would be "fair" to expect people in different circumstances to pay. We welcome this enquiry as an opportunity to discuss some of these issues in a public forum.

The absence of a rationale for charging has led the system for charging for prescriptions to develop in a manner which has disadvantaged some patients—particularly those on low incomes who are already more likely to suffer ill-health. Charges can be a deterrent to seeking treatment. A MORI survey has suggested 750,000 people in England and Wales fail to get their prescriptions dispensed because of cost.<sup>57</sup> Because charging can compound the effects of disadvantage, it raises the question: "are charges an effective way of raising or saving money for the NHS?"

Prescriptions were originally free with charges bought in shortly after the creation of the NHS to raise money. They were briefly abolished in the 1960s but reintroduced in 1968. Since 1979, there has been a substantial increase in the cost of prescriptions. Although this increase has slowed recently in percentage

---

<sup>56</sup> Mind (2003) *The Hidden Costs of Mental Health*, London, Mind.

<sup>57</sup> Citizens Advice: Unhealthy charges CAB evidence on the impact of health charges, 2001

terms, the current cost of £6.50—is high enough to discourage some people from getting the medicines they need. This has led the NHS away from its guiding principle of providing clinical services to those in need of them regardless of the ability to pay.

In recent years, some significant gaps have opened up between England, and Wales and Scotland. Charges in Wales have dropped to £4 and are expected to disappear entirely by 2007. The Scottish Executive has also said it will review payment and there has been a strong campaign in Scotland to abolish charges altogether.

Despite a complex series of exemptions and reduced payments, we remain convinced that many of those who genuinely find prescription, optical and dental charges a burden are still having to pay—or go without. We agree with criticisms made in the Wanless Review, which said “the present structure of exemptions for prescription charges is not logical, nor rooted in the principle of the NHS.”

We believe that the current system of charging is at odds with core values of the NHS—particularly the principle of services based on clinical need rather than the ability to pay. The current system throughout the NHS does not contribute towards the goals of access, equity, affordability and cost-effectiveness. Instead, it entrenches health inequalities. We recognise that the most straightforward ways to address current anomalies and inequalities in charging are ones that are likely to cost the taxpayer more. An alternative approach is a root and branch reform of charging, so that the most effective ways are found to promote health and allow for an appropriate level of cost recovery.

Either way, we believe that there is a prior question that needs to be addressed, which is where the boundary of collective provisions ends and individual responsibility, including financial contribution, begins. The NHS has never been open about what is covered by the health service and what is not—and yet, if the core services are not defined, it is impossible to state where individual rights stop and where responsibility begins. This ambiguity also stifles the potential for top-up services, for which charges can be made. For this reason, the NCC recommends the model of a “core services commission”, to fundamentally review the case for charges in the NHS by examining what constitutes core services, and should, therefore, be universally available and properly funded.

The Department of Health should take responsibility for giving consumers more information about the rationale for charges and the system of exemptions. This would both raise public awareness of the reasons for charges and increase uptake among those entitled to exemption.

For your information, I enclose the link to the report *Creeping Charges*: <http://www.ncc.org.uk/access/creeping—charges.pdf>

*Sally Hooker*

National Consumer Council

*December 2005*

---

#### **Memorandum submitted by the NHS Confederation (CP 28)**

The Confederation brings together the organisations that make up the modern NHS across the UK. Our membership comprises 92% of NHS organisations across the UK. We work with our members to transform health services and health for the better. As an independent driving force, we do this by:

- influencing policy and public debate;
- connecting health leaders through networking;
- involving our members in our work; and
- representing NHS employers.

Our evidence sets out our general views, based on feedback from a cross section of our member forums, on the current situation regarding the implementation of the proposed changes. Where appropriate, we have also included more specific comments on the questions asked.

*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?*

1. The current system of Prescription Charges is based on a mixture of medical need, social need and low income. This mixture potentially causes confusion and inequalities.
2. There are a number of anomalies relating to exemptions for particular types of patient that need to be addressed to make the system simpler and more obviously fair:
  - Conditions for which exemptions do not apply include asthma, Chronic Obstructive Pulmonary Disease and Chronic Heart Disease, which can be just as much a threat to a patient’s health as those which are exempt from charge.

- Exemptions apply to all prescriptions a patient may receive rather than being specific to a medical condition. It may be more equitable to make only the long-term medical condition for which a patient is being treated exempt rather than all the prescriptions that a patient may be issued with for un-associated acute conditions.
- The exemption from charge for medical treatment is not linked to income in the case of pregnancy, which may not necessarily present as much a risk to the mother's or infant's health as it did in the past.

3. Patient's clinical care may be affected by the associated prescription charges, as they may be put in a position whereby they are inappropriately having to restrict the treatment they are receiving on the grounds of cost.

4. Prescription charges are usually defined by each item prescribed on a prescription form. Certain multiple packs do exist which give rise to multiple charges, for example, helicobacter pylori irradiation therapy and many of the hormone replacement therapies. Although presented as a single patient pack, they represent a course of treatment consisting of a variety of different drugs, for which there is a charge for each different preparation (up to a maximum of three charges). Similar circumstances can arise from the prescribing of certain forms of equipment.

*Whether the system of charges is sufficiently transparent?*

5. Transparency is an issue. Patients are often unaware of the prescription charge until they are put in a position where they need a medical treatment. They also often associate the charge with profit being made with whoever dispenses the prescription, rather than recognise it as a usage charge similar to a tax.

*Whether charges should be abolished?*

6. Charges do generate income that would need to be replaced from other sources or, given the current state of public finances, found by reducing other types of services. The benefit of a reduction in charges may be less than the negative impact on other users of services. The effect of this on inequalities would need to be considered carefully.

7. Our members have not indicated that the costs of administering charges, verifying exemptions, collecting cash, recovering bad debts and auditing the system are a major issue for them and so, whilst there may be some savings if no charges are made, it is not clear that this would be a significant amount.

8. A significant reason why co-payment is used in other healthcare systems is to control utilisation and create a sense of responsibility to avoid the problem of inefficient over-consumption of healthcare. To do this, charges need to apply universally and be low enough not to deter appropriate use. The evidence seems to suggest that whilst charges can reduce inappropriate use, they may also deter patients from making appropriate use of services. The UK has a low rate of costs being a factor or being the main reason why patients do not fill their prescriptions.

*Anna Scott-Marshall*  
NHS Confederation

*December 2005*

---

### **Memorandum submitted by The Parkinson's Disease Society (CP 22)**

#### **1. THE PARKINSON'S DISEASE SOCIETY**

1.1 Parkinson's Disease Society was established in 1969 and now has 30,000 members, 25,000 supporters and over 300 local branches and support groups throughout the UK.

The Society provides support, advice and information to people with Parkinson's, their families and their carers; information and professional development opportunities to health and social services professionals involved in their management and care, and raises funds for research into the nature, cause and impact of the disease.

Each year the Society spends more than £2 million on funding research into the cause, cure and prevention of Parkinson's, and improvements in available treatments. The Society also develops models of good practice in service provision, such as Parkinson's Disease Nurse Specialist's community support, and campaigns for changes that will improve the lives of people affected by Parkinson's.

## 2. ABOUT PARKINSON'S DISEASE

Parkinson's Disease is a progressive neurological disorder. It affects all activities of daily living including talking, walking, communication, swallowing and writing. It is estimated that 120,000 people in the UK have idiopathic Parkinson's, which is one in 500 of the general population. Approximately 10,000 people are newly diagnosed with Parkinson's each year in the UK.

Parkinson's occurs as a result of a loss of cells that produce the neuro-transmitter dopamine. Dopamine is one of the chemical messengers that we have in the brain which enables people to perform coordinated movements. As yet it is not known why these cells die.

The three main symptoms are tremor, muscle rigidity and slowness of movement. However not everyone will experience all three. Other symptoms include a lack of facial expression, difficulties with balance, problems with an altered posture, tiredness, speech difficulties, pain and depression.

Most people are diagnosed over the age of 60, however younger people can also develop Parkinson's. One in seven people are estimated to be under the age of 50 when first diagnosed with Parkinson's disease and one in 20 are under the age of 40 when first diagnosed.<sup>58</sup>

## 3. PRESCRIPTION CHARGES

3.1 The Parkinson's Disease Society is most concerned about the charges levied on prescription items. The Society believes that the current system of prescription charges perpetuates health inequalities by discriminating against millions of people with long term illnesses deterring many of those on low incomes from getting the medication they require. They are a disproportionate levy on a limited section of the population and are in effect a regressive tax on those with long term conditions.

3.2 It is widely acknowledged that the current system is illogical, unfair and discriminatory as regulations only provide an exemption for a small number of health conditions. Millions with long term conditions aged between 18 and 60 may have to pay charges including more than 17,000 people with Parkinson's. In 2001 the National Association of Citizens Advice Bureaux surveyed 1,062 of their clients UK-wide and found that 28% did not get their prescriptions dispensed because they could not afford them. Half of those surveyed said they found the charge difficult to afford and one third of those who reported difficulty affording prescription charges said they could not afford the cost of the pre-payment certificate.

3.3 According to the British Medical Association all GPs have anecdotal evidence of patients asking which of two or more items on a prescription form are the most important as they cannot afford to pay for more than one at a time.

## 4. PARKINSON'S DISEASE, ITS MEDICATION AND THE LIST OF EXEMPTIONS

4.1 In a Parliamentary Answer on 5 May 1998 the then Secretary of State for Health stated: "The list of medical conditions exempt from prescription charges was agreed in 1968 following extensive discussions with the medical profession. These resulted in a limited list of readily identifiable, permanent, life-long conditions all of which require regular medication".

4.2 Parkinson's disease is a chronic progressive neurological condition for which there is no cure and it is one of the few neurological conditions for which specific drug treatments are available. Although they do not cure the condition or halt its underlying progression they can make a huge difference to the symptoms and greatly improve people's quality of life. For the individual with younger onset Parkinson's particularly, sustained and consistent daily medication is essential to management of the disease.

4.3 The most frequently used drug to treat Parkinson's is Levodopa, a compound one step removed from dopamine, the chemical messenger which is in short supply in Parkinson's. Once the Levodopa reaches the brain it is changed into dopamine, so making up for the shortage. These drugs are therefore a form of replacement therapy like insulin in diabetes. However, there are people who are initially given dopamine agonist drugs which stimulate the area of the brain where the dopamine works. These "agonist" drugs may not be as immediately effective against symptoms but they also do not produce as strong side effects as Levodopa and so are often given to newly diagnosed people to treat their Parkinson's and to delay using Levodopa until the symptoms have become more severe.

4.4 People with Parkinson's depend on medication to help control their symptoms and maintain their quality of life. As the condition progresses people with Parkinson's often move on to more medications to control their symptoms many of which can have powerful side effects that need to be managed with other drugs. They may also develop co-morbidities such as incontinence, sleep disturbance, depression and pain so their drug regime may increase. This can mean some people may have to pay for multiple prescriptions to treat their conditions.

<sup>58</sup> Quinn N, Parkinsonism, Balliere's Clinical Neurology, 1997.

4.5 An audit of drug treatment in people with Parkinson's showed that on average they take at least five different medicines and some are prescribed up to 15 medicines to be taken three or four times a day. This places an enormous financial burden on many people with Parkinson's below the age of 60. This may be particularly so in younger families with substantial financial commitments for whom the loss of regular income can lead to severe hardship.

4.6 Under current arrangements all older people with Parkinson's over 60 years of age do qualify for free prescriptions. However, one in seven of those diagnosed with Pd are under 50 years of age.

4.7 As people with Parkinson's are not exempt from charges this can present particular difficulties for people because the income frequently provided by (employed) partners combined with benefits paid to the person with Parkinson's can result in a gross income which is superficially high (and thus prevent any entitlement to free prescriptions) yet when financial commitments are fully accounted for, actually result in an available family income well below the perimeters by which "low income" is defined.

4.8 If people do not take their medication as prescribed their clinical condition is likely to deteriorate possibly leading to the onset of severe disability or to hospitalisation and acute care. This can have significant cost and resource implications for the NHS and society. Ensuring that people receive their medication on time to control their symptoms is critical for the effective management of Parkinson's. If a prescribed drug regime is not strictly followed symptoms will become difficult to control which may result in them requiring additional care and in a decline in the person's condition that they may be irreversible.

## 5. CONCLUSION

5.1 Exemption from prescription charge for those with long term medical conditions is the only option that will ensure those in need get the medication they require based on clinical need rather than age or ability to pay.

5.2 The exemption from prescription charges for people with long term conditions has both clinical and savings implications. Significant savings could be realised through reduced administrative costs and avoidable admissions to hospital. Abolition of charges for people with long term medical conditions would also be consistent with the Government's commitment to reducing health inequalities.

5.3 The existing list of exemptions for chronic conditions dates back to 1968 when few medicines were available; some conditions which are now treated extensively with medicines were rarely diagnosed then. Hence the continuation of these exemptions creates an arbitrary division between those who pay and those who do not.

5.4 With medical advances in the last 30 years resulting in the ability to manage long-term conditions such as Parkinson's much more effectively and long term, there is a clear basis for exempting those with Parkinson's from charges. The Society believes that including Parkinson's disease with those conditions which are exempt from prescription charges will ensure that the exemption list is equitable, consistent with coherent medical practice and fully reflects patient's clinical needs.

### *Person with Parkinson's Disease Case Study*

"I was diagnosed with Parkinson's disease at the age of 45. I was told 'There is no cure for this illness, but medication will alleviate the symptoms.' I was prescribed 1 drug which alleviated the symptoms for a short time.

Within two years, my drug regime had increased to three different drugs on a daily basis. I now need seven different drugs on a daily basis and, because of other Parkinson related health problems, I have a total of 13 items on my prescription request list.

At the age of 49, I retired on health grounds, resulting in a drastic decrease in income. Reduced income or not, I required continuous medication.

Although I was aware that a Prepayment Certificate would save money, this is not always possible to someone with a young family. Other bills are paid, new uniforms are bought and the Prepayment Certificate tends to be put off till 'next month.' False economy, but a fact of life.

At this stage of my Parkinson's, had I not had regular medication, I would probably need 24 hour care. I would not be able to function. I would need to be washed, to be dressed, to be fed, to be moved. I would probably be a burden to the 'Care In The Community Team.

Parkinson's is for life. My daily drug regime makes that life possible. Medication gives me a degree of independence".

*Robert Meadowcroft,*  
Parkinson's Disease Society of the United Kingdom.

*December 2005*

---

**Memorandum submitted by PatientLine plc (CP 21)****1. COMPANY BACKGROUND**

1.1. Patientline commenced operating in 1995 with the sole objective of addressing the absence of personal televisions and telephones at the bedside in NHS hospitals. Previously provision was typically limited to trolley- or wall-mounted coin-operated payphones for outgoing calls only and communal televisions in day rooms or bays. A few hospitals had individual televisions that were mounted at, or could be wheeled to, the bed.

1.2 The Company developed an integrated television (six inch screen), radio and telephone system. Its preference was to sell these systems to hospitals, but funding was not available.

1.3 By 2000, the system was operating in 16 hospitals on the basis that the Company funded the capital investment and operated the systems, generating revenue from charges to users. £16 million of capital expenditure had been committed but no profit had been earned. A decision was made to invest in the development of a new system that would have the capability of servicing the needs of hospitals as well as those of patients. This system, which was introduced to coincide with the Patient Power programme (see below) is effectively a full PC at the bedside with a 12 inch high definition screen. It is now in its second version, offering fully digital IPTV and VoIP.

**2. PATIENT POWER PROGRAMME**

2.1 Following research, the Government made a commitment in the NHS Plan in mid-2000 to provide a personal bedside television, radio and telephone in major English hospitals by end 2004, funded by the private sector and paid for by users.

2.2 Tenders were sought for licences to provide the service. The requirements were for provision at every bedside (irrespective of expected occupancy and/or use), with several free services for the NHS (such as patient information capability) and patients (such as free radio and free television for children), with limits on the prices charged to patients and an acceptance of high charges to incoming callers. Strong preference was expressed for more sophisticated systems that had the capability to provide a wider range of services for patients and that could offer access to clinical IT systems and provide other services to hospitals. The Licence Terms stipulate the terms of the contracts to be entered into between individual NHS trusts and licensees. During the licensing process, the NHS acknowledged that the provision of the required service was likely to involve high charges paid by incoming callers, relative to the costs of outgoing calls, taking into account the fact that no aspect of the service was to be funded by NHS trusts.

2.3 Licences have been granted to 10 companies since 2000, either provisional or full, of which only two were still installing when Ofcom announced in July 2005 an own-initiative investigation into the contracts with the NHS trusts and the level of incoming call charges. The remainder had either ceased provision, gone out of business or were not making further investments.

2.4 The programme has had notable success in disseminating these systems. Some 80,000 bedside terminals are now operational in around 150 English NHS hospitals, based on investment by the private sector of some £150 million. The hospitals with systems represent about two thirds of hospitals with 200 beds or more, leaving one third unprovided, as well as virtually all hospitals with less than 200 beds. The demands of this rapid expansion and technological development have placed great demands on service quality, but the industry is now entering a more mature and stable period.

2.5 Patientline has invested a total of £151 million, including UK hospitals outside England, funded entirely by equity raised on the London Stock Exchange and bank borrowings. It has services operating in 157 UK hospitals (see Appendix 1)<sup>59</sup> and has achieved a share of about 60% of those hospitals that have signed contracts. Regrettably it has been necessary to suspend installation at 14 hospitals where work is not finished because of the current investigation by Ofcom. Patientline has incurred losses in each year it has been operating, totalling almost £50 million. Last year's loss was £12 million on turnover of £50 million.

2.6 Between 10 and 15 million patients and relatives/friends currently make use of the systems each year. Response has been very positive, with NHS research conducted in late 2004i showing 88% of patients satisfied, 70% considering the systems an improvement over previous provision, 83% considering the systems easy to use, and 72% assessing the patient services as good value for money (with lower value ratings for incoming calls).

2.7 The economics of the service involve a capital commitment of around £1,750–2,000 per bed or almost £1 million for a typical hospital. There is a requirement for Patientline staff to be employed on site to service the systems and help patients, while Patientline also operates a 24 hours Customer Care Centre.

---

<sup>59</sup> Not printed here.

2.8 Revenue is currently derived almost entirely from charges for television (to those who pay), outgoing call charges and the principal share of charges for incoming calls. Payback of investment is slow and is substantially affected by the level of bed occupancy and the types of patients in hospital. So far, Patientline has earned no profits and no return on its investment.

2.9 The Patient Power programme is unique in the western world and has achieved the deployment of much larger numbers of sophisticated PC-based multi-user systems in a shorter time than in any other country, and without the use of NHS funds. Most other countries have personal televisions and telephones at the bedside, but these generally use conventional televisions and do not offer the wider range of patient or hospital services. Because the less sophisticated systems cost less than the UK Patient Power systems (typically less than a quarter of the capital cost), are not always provided at every bed and, in many cases, are wholly or partially funded by the hospitals, charges to patients and incoming callers are generally lower than in the UK, and in some cases television and local calls are free. This clearly results in much wider usage and greater benefit to patients.

### 3. ARE CHARGES EQUITABLE AND APPROPRIATE?

3.1 Charges need to be viewed against the financial experience of licensees described in 2.3 above and the losses incurred to date by Patientline of almost £50 million.

3.2 The terms of the NHS licence severely limit Patientline's pricing flexibility, so that it is forced to set high charges for incoming calls in order to minimise its losses, partly because its licence requires charges for outgoing calls to be kept at a lower level and partly because of the provision of free services and the facilities to enable services to be provided to NHS trusts, which have not been taken up. The associated costs have had to be passed on through incoming call charges. As already mentioned, the terms of Patientline's licence and contracts provide for no financial contribution from NHS trusts. Any reduction in charges for existing services without compensating payment by the NHS would make some or all of the remaining licensees non-viable and cause the termination of the service in many hospitals. This is evidenced by the fact that Patientline is the only licensee to have been successful in raising all of the required finance for the systems.

3.3 Nevertheless, most patients are very supportive of the systems and consider the services good value for money (see 2.6). There is a strong undercurrent of feeling that some services, such as television, should be paid for by the NHS, especially as NHS trusts derive significant benefits from the availability of the systems.

3.4 Current Patientline charges to patients are set out in Appendix 2. Within the economic constraints set by the NHS, considerable effort is made to cater for those with special needs, including free television for children 16 or under, half price television for those 60 or over and longer stay patients, and a facility for nurses to grant free television to those they judge to be in need. Outgoing call charges are restricted to 10 pence per minute for local and national calls. It is believed that these provisions go a long way to avoiding hardship and achieving equity.

3.5 Incoming call charges, which are paid by the caller, are significantly higher (39 pence per minute off-peak and 49 pence peak from UK fixed lines), the majority of which is received by Patientline and is used to finance the provision of the sophisticated integrated technology at every bed and the free services provided to the NHS and patients.

### 4. WHAT IS THE OPTIMAL LEVEL OF CHARGES?

4.1 To maximise benefit for patients and their families and friends, it would be ideal if terrestrial television channels could also be made available free to patients and charges for both outgoing and incoming call charges could be set at the level normally obtaining from fixed domestic lines. Free terrestrial television was initially proposed in establishing the framework for the Patient Power programme but was dropped by ministers because it would have required NHS funding, given the substantial expense of installing the integrated systems at every bedside. (One Patientline hospital chose to adopt this approach, but experience has shown that it is costly and not a high priority.)

4.2 Given competing demands for NHS funds, the charges currently made for television and outgoing calls could be considered a reasonable and equitable compromise, even though there are important therapeutic benefits in ensuring patients have access to entertainment, news and mental stimulation. It would clearly be desirable to develop additional revenue streams from the provision of additional services to NHS trusts so as to allow a reduction in the level of charges to incoming callers. Otherwise the costs of maintaining the necessary facilities to provide such services to NHS trusts will have to continue to be passed on to incoming callers through high incoming call charges.

## 5. WHETHER THE SYSTEM OF CHARGES IS SUFFICIENTLY TRANSPARENT?

5.1 Patientline invests considerable effort in ensuring that charges are fully displayed and apparent to users. Charges are set out in the instruction card attached to each bedside unit, in the introductory instructional video, on information screens on its current generation systems, on its website, in leaflets and, for incoming calls, in a message at the beginning of each call. Staff both in hospital and in the 24 hour Customer Care Centre also have full information on charges.

5.2 Patientline believes that these arrangements provide a high level of awareness of charges but is always interested in considering potential improvements.

## 6. WHAT CRITERIA SHOULD DETERMINE WHO SHOULD PAY AND WHO SHOULD BE EXEMPT?

6.1 In an ideal world charges would be set at a level that allowed an adequate return and did not require general exemptions.

6.2 As long as this is not possible, Patientline believes that recognition should be given to age (both children and the elderly) and a combination of ability to pay and clinical need. Only hospital staff are in a position to judge the latter factors, which need to be considered on an individual basis. As indicated in 3.4 above, Patientline operates a system whereby nurses are able to grant free television to those they judge to be in need.

## 7. HOW SHOULD THE RELEVANT PATIENTS BE MADE MORE AWARE OF THEIR ELIGIBILITY FOR EXEMPTION FROM CHARGES?

7.1 The discounts are published as described in 5.1. In addition, all patients registering on the system through the Customer Care Centre are asked whether they are 60 or over to ensure that those qualifying receive the discounted television charges. Children in children's wards are automatically given free television. Patientline believes that this approach is generally effective in making patients aware of the discounts available.

7.2 Patientline invests time in briefing nursing staff so that they are aware of the ability to grant free television.

## 8. WHETHER THE CHARGES SHOULD BE ABOLISHED?

8.1 While abolition of charges, even just for free to air television, would be advantageous to patients, it is unlikely to be a top priority for use of NHS funds, which would be required to finance the resulting shortfall in revenues.

8.2 Patientline does, however, believe that there would be considerable public benefit in reducing charges for incoming calls, which are currently the subject of an Ofcom investigation. However, as it has set out in submissions to the Department of Health and to Ofcom, this could only be achieved by an appropriate financial contribution from the NHS or the NHS trusts to reflect the facilities made available to the NHS trusts by these systems and the cost of the free services provided to patients. Such an approach would achieve considerable benefits and value for money for the NHS trusts through uses such as:

8.2.1 Access to the new electronic patient care records by clinicians at the bedside to improve the accuracy of data capture and access, increase patient involvement and save clinician time. This can be extended to electronic prescribing and drug administration at the bedside to accelerate drug delivery and reduce the number of adverse drug events.

8.2.2 Food ordering at the bedside to reduce food wastage, enhance food service and save costs.

8.2.3 Patient surveys either by the Healthcare Commission or the hospital.

8.2.4 Provision of patient educational material.

8.3 All of the above uses are currently in operation in one or more hospitals in the UK, but regrettably are now being adopted rapidly only in countries other than the UK. In the US, where hospitals compete for both patients and clinical staff, the principal motives for purchasing the systems are increased patient satisfaction and choice, better clinical outcomes and increased staff effectiveness. There is an established link between the provision of good quality entertainment and the reduced usage of painkillers as well as faster recovery.

## 9. CONCLUSION

9.1 The Patient Power programme has achieved a major improvement in conditions for patients in NHS hospitals, the majority of whom were previously deprived of the basic telephone communication facilities and entertainment that they normally enjoyed.

9.2 Abolition of charges, while desirable in principle on the basis that the service would be funded by the NHS, would not be feasible in practice.

9.3 Some change is desirable to make the services more accessible and to reduce the high charges payable by incoming callers that are currently required to finance the integrated systems, which include many free services to the NHS and patients. The options include:

9.3.1 Provision of free to air television at no charge if sufficient NHS funding were available.

9.3.2 Reduced charges for incoming calls. This could be achieved by introducing payment by the NHS for the integrated facilities that are currently provided by the licensees without receiving any revenue, including free radio and television for some patients and the capabilities of the systems to carry clinical services for hospitals.

9.4 Patientline has been pressing the Department of Health for action to encourage the wider use of these systems by the NHS trusts, both to improve the service offered by NHS acute hospitals and to permit a reduction in incoming call charges. Regrettably work on this project has been suspended by the Department of Health because of the Ofcom investigation and Health Committee enquiry, but should be resumed without delay.

9.5 Patientline believes that the introduction of a payment by the NHS for benefits that it currently receives at no cost and the wider use of the systems by the NHS offers great potential to assist the NHS while increasing benefits and value for money for patients and their relatives and friends. Patientline recommends that this approach be pursued with urgency.

9.6 Patientline would welcome the opportunity to amplify on these views by providing oral evidence.

*Derek Lewis*  
Chairman

7 December 2005

## APPENDIX 2

### CURRENT PATIENTLINE CHARGES TO PATIENTS

<i>T1—all except five sites</i>	
<b>TV</b>	
Patients aged 16 and under	Free (until 9pm)
Patients aged 60 and over	£3.50 for two days of TV (48 hours) or they can buy 2 hours of TV for £2
Patients aged 17–59	£3.50 for one day of TV (24 hours) or they can buy 2 hours of TV for £2
	TV can also be purchased in: 3 days—£10 5 days—£15 7 days—£20
All patients	All patients receive free: Half an hour when signing-up 1 hour of TV every day
<b>Telephone</b>	
Outgoing	10p a minute (minimum outgoing call charge is 20p).
	All patients receive a free 20p credit to make a call when they first sign-up.
	Calls to mobiles, international destinations and other networks may vary.
<i>T2—all sites excluding Sunderland, plus five T1 sites</i>	
<b>TV</b>	
Patients aged 16 and under	Free (until 9pm)
Patients aged 60 and over	£1.70 for one day of TV (24 hours)
Patients aged 15–59	£3.50 for one day of TV (24 hours)
All patients	All patients receive free: Half an hour when signing-up. 1 hour of TV every day.

**Telephone**

Outgoing	10p a minute (minimum outgoing call charge is 20p).
	All patients receive a free 20p credit to make a call when they first sign-up.
	Calls to mobiles, international destinations and other networks may vary.

**Internet and email**

All patients	20p per 5 minutes
--------------	-------------------

**Games**

All patients	30p per game play
--------------	-------------------

*Sunderland (non-TV as other T2 sites)***TV—channels 1–5**

All patients	Free (24 hours)
--------------	-----------------

**TV—all other channels**

Patients aged 16 and under	Free (until 9pm)
All other patients	£1.90 for one day of TV (24 hours).
All patients	All patients receive free: Half an hour when signing-up 1 hour of TV every day <sup>60</sup>

**Memorandum submitted by the Royal College of General Practitioners (CP 7)**

1. The College welcomes the opportunity to comment on House of Commons Health Committee: Inquiry into Co-Payments and charges in the NHS.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the “voice” of GPs on issues concerned with education; training; research; and clinical standards. Founded in 1952, the RCGP has over 23,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. The College supports a review of co-payments and offers the following comments for your consideration.

*Are the charges for: treatments, including prescriptions, dentistry and optical services (such as telephone and TV use and car parking) equitable and appropriate?*

4. In general the College feels that any form of co-payment or charge is likely to be more regressive than a system that is free but paid for by taxation.

5. The College is concerned that some prescription charges are not equitable. The College feels that some individual diseases gain exemption when they are no more serious or requiring of long term management than others. For example a patient who suffers from hypothyroidism will receive exemption from all prescription charges, where as a patient who suffers from hypertension will have to pay for everything.

6. Further more the College is concerned that some exemptions from prescription charging are irrational. For instance if a patient has one of the index conditions then they will receive free prescriptions for any condition. However it is only necessary for the patient to start on the index to allow life time exception. Even if treatment is stopped at some stage, treatment for all other conditions for this patient will remain free.

7. The College feels that there should be charges for telephones to take into account the cost of premium numbers. However given that mobile phones are not supposed to be used in hospitals, perhaps the NHS could investigate a system whereby NHS phone lines could be connected to a cheap (or even free) service to reduce costs to patients.

8. The College further feels that an area in the hospital where it is permissible to use mobile phones should be investigated. However for those that are bed bound this would not be an option and therefore the former option should still be investigated.

<sup>60</sup> [Source reference—NHS research].

9. In regards to hospital parking the College feels that there are cases for and against charging. For instance charging would encourage people to exercise more if they lived close by as well as cutting down on carbon emissions. It would also discourage those not on hospital businesses from parking.

10. However on the other side it would be unfair to charge those who have no option but to travel by car. The College would also be concerned that if parking charges were high it would encourage more people to ask for ambulance transport. This would mean GPs would have to make more decisions as to who should and shouldn't receive ambulance transport and this is already a difficult and unwelcome job. The College suggests that exemption for those being admitted to or attending out-patients would help to resolve this.

*What is the optimal level for charges?*

11. There is a concern that in some cases young adults and the elderly avoid eye and dental checks due to the charges.

*Is the system of charges sufficiently transparent?*

12. The College is concerned that there needs to be more transparency in co-payments and that there needs to be a greater standardisation across the country in order to ensure equality.

*What criteria determine who should pay and who should be exempt?*

13. The College is concerned and feels that exemptions from charges in the NHS are not always equitable. Exemption charges do not take into account wealth and the poor still have to pay for dental and optical treatments. Further more some people who do receive exemptions such as the over 60s may in fact be relatively wealthy in comparison to working people.

14. The College feels that consideration should be given to abolishing routine eye tests and dental examination fees for full time students over the age of 18 and possibly even to abolish prescription charges in this group as well given the level of debt that most are now incurring. Abolishing these fees may well prove to be cost effective in terms of long term benefits both for patient and NHS treatment.

I acknowledge the contributions of Dr Claire Gerada, Dr Orest Mulka, Ailsa Donnelly and Professor Nigel Sparrow towards the above comments. While contributing to this response, it cannot be assumed that those named all necessarily agree with all of the above comments.

*Dr Maureen Baker*  
Royal College of General Practitioners

*5 December 2005*

---

#### **Memorandum submitted by the Royal National Institute of the Blind (CP 30)**

There are around two million people in the UK with sight loss and every day another 100 people start to lose their sight. We are the leading charity working in the UK offering practical support, advice and information for anyone with sight loss. We are also the largest organisation of blind and partially sighted people in the UK. Eighty per cent of our Trustees and Assembly Members are blind or partially sighted and we now have a thriving individual membership scheme with over 10,000 members.

We welcome the Committee's inquiry into co-payments and charges and have comments relating to a few of the questions outlined in the Committee's press release announcing the inquiry.

#### **IS THE SYSTEM OF CHARGES SUFFICIENTLY TRANSPARENT?**

Our main concern in this area relates to the NHS voucher scheme for the Hospital Eye Services and General Ophthalmic Services (GOS). These vouchers are provided to people entitled to help, through the NHS voucher scheme, toward meeting the costs of their spectacles or contact lenses, whether provided by an optometrist in the community or in the Hospital Eye Service. Current free entitlements include people under 16, people in full time education under the age of 19 and people who get income support and a number of other benefits.

#### **ACCESSIBILITY OF VOUCHERS**

The accessibility and therefore clarity of the voucher is not often of a high standard due to the following factors:

- Vouchers can be photocopied repeatedly, therefore causing indistinct and poor quality print.
- Vouchers can in the first place be designed in small print.

These factors can make it impossible or very difficult for a visually impaired person or someone with sight loss, who are after all going to be significant users of Hospital Eye Services facilities, to access information on the voucher. We would like to see measures introduced to ensure that all information produced by the NHS, including vouchers and related information, meets best practice and is produced in at least 12 point print. Clearly this is of vital concern in relation to Hospital Eye Services vouchers, which, by definition, will need to be accessible to people with sight problems.

This is particularly relevant when taking into account the Disability Equality Duty, within the Disability Discrimination Act, 2005. This duty will require public sector to promote equality of opportunity for disabled people and tackle discrimination. The NHS needs to start looking broadly at the access barriers that it will have to cover in the Disability Equality Schemes that they may have to produce, and we believe that accessibility of printed information will be one key issue, amongst others, that will need to be addressed.

#### CONTRACTED OUT OPTOMETRIC SERVICES AND CHARGES

In some hospitals ophthalmic services are provided by private sector companies that have a contract with the PCT. We are concerned that proper auditing takes place regarding the provision of spectacles and low vision aids within this setting. This is because these companies have the ability to both prescribe and sell spectacles and low vision aids, the former being paid for by the patient with vouchers and perhaps also additional private funds, the latter being paid for by the hospital.

We believe that charges for these items by private providers must be transparent and therefore open to auditing inspection to establish that costs are similar when either a hospital or a private company is providing the same equipment to patients.

Review of guidance on “Optical Charges for Hospital Eye Service (HES) Patients” Department of Health regulations relating to the application of the NHS spectacle voucher scheme in the Hospital Eye Service were issued in the circular reference HC(89)12, which was cancelled on 1 April 1993.

The guidance is yet to be renewed and we are concerned that parity of treatment is maintained in terms of the entitlements under both Hospital Eye Service Vouchers and GOS vouchers. We do not believe that having one system of entitlements for Hospital Eye Service patients and another (under GOS) for people being treated in primary care settings would be beneficial. Therefore we hope the DoH’s review of General Ophthalmic Services will take account of the replacement for the HC(89)12 guidance when it is issued and ensure that both voucher systems retain the same entitlement structure.

*Dan Scorer*

Royal National Institute of the Blind

*December 2005*

---

### Memorandum submitted by the Royal Pharmaceutical Society of Great Britain (CP 8)

#### EXECUTIVE SUMMARY

##### INTRODUCTION

- The RPSGB is the regulatory and professional body for Britain’s pharmacists. As the only organisation that works with all pharmacists in Great Britain, the RPSGB safeguards the public and promotes the development of the pharmacy profession, whose unique knowledge and skills play a key role in the health of the nation.
- The RPSGB’s longstanding policy is that there should be no financial barrier to the use of prescribed medicines. This implies either a move to abolition or a major reform of the existing charging system in a way that could be shown to have little or no deterrent effect on use.
- Since all British governments, including the present administration and the devolved governments across the UK, have espoused the general principle that the NHS should be free at the point of use, there is a prima facie case for abolishing prescription charges.
- The Society acknowledges that the implications of abolition or radical reform are considerable and considers that no such move should be considered without a careful analysis of the consequences for patients, professionals, the pharmaceutical industry and the public purse.
- In 2005, the RPSGB published a policy paper, Prescription charges: should they be abolished?, setting out a policy framework for prescription charges and exemptions; options for alternative systems and recommending further studies that should be commissioned as next steps. This policy paper is attached to this submission.<sup>61</sup>

---

<sup>61</sup> Not printed here.

## INTRODUCTION

1. The Royal Pharmaceutical Society of Great Britain (RPSGB) is pleased to respond to the Health Committee's call for evidence for its inquiry on co-payments and charges in the NHS. The RPSGB is the regulatory and professional body for Britain's pharmacists. As the only organisation that works with all pharmacists in Great Britain, the RPSGB safeguards the public and promotes the development of the pharmacy profession, whose unique knowledge and skills play a key role in the health of the nation.

2. Given the day to day contact the pharmacy profession has with the public and their prescriptions the RPSGB has developed a clear policy position on prescription charges, and we have taken the opportunity, within this submission, to focus on this area.

3. The RPSGB's longstanding policy is that there should be no financial barrier to the use of prescribed medicines. This implies either a move to abolition or a major reform of the existing charging system in a way that could be shown to have little or no deterrent effect on use.

4. Since all British governments, including the present administration and the devolved governments across the UK, have espoused the general principle that the NHS should be free at the point of use, there is a prima facie case for abolishing prescription charges.

5. The current system of prescription charges is widely perceived as illogical and unfair and there have been widespread calls for radical reform or abolition. The Welsh Assembly has already decided to pursue abolition and the Scottish Executive is due to publish a consultation paper shortly. The Scottish Parliament is currently considering a private members' bill proposing the abolition of prescription charges and has also commissioned a review into prescription charges.

6. In 2005, the RPSGB published a policy paper, Prescription charges: should they be abolished?, setting out a policy framework for prescription charges and exemptions; options for alternative systems and recommending further studies that should be commissioned as next steps.

7. Abolition or substantial reform should not be considered without a careful analysis of the consequences for patients, professionals, the pharmaceutical industry and the public purse. Any such analysis should:

- assess what the response of users would be to the removal of the charge or to new charging structures;
- assess the impact of this response on the use of other health services eg the potential reductions in hospital admissions arising from greater compliance with medication regimes;
- identify the full financial and workload implications for pharmacists, GPs and other health service professionals;
- Consider the implications for other policies particularly those such as direct supply minor ailments schemes which develop the community pharmacy role and for the recent policy initiatives aimed at reducing the costs of providing care for chronic diseases including the promotion of self-care and alternative to medicines such as dietary modification and exercise regimes;
- consider alternative charging structures which would mitigate the weaknesses of the existing system;
- assess the possible response of the pharmaceutical industry to any changes in demand for particular products;
- review all the relevant evidence on abolition and restructuring including overseas experience of changes in charges and of the impact of different charging structures;
- assess the implications of having different charging regimes in different parts of the UK.

8. Implications of abolition or radical reform are considerable. In particular:

- any income foregone has to be replaced from other services or other sources of income or made good by savings elsewhere in the NHS;
- removal or reduction of the price barrier will lead to greater take-up of prescriptions and hence greater claims on GPs' time as well as that of other professionals;
- the balance between prescription only medicines (POM), pharmacy only (P) and over the counter (OTC) medicines will change and hence the current system for financing community pharmacy may be undermined and require modification if the current system is to continue.

9. The RPSGB acknowledges that in the light of the financial, professional and industry considerations, the relevant administrations might wish to proceed in a measured way, taking due account of the impact of phased abolition in Wales.

---

**BACKGROUND**

10. As the Committee will be aware, prescription charges were introduced in 1952 and have been in place ever since with the exception of a brief period in the 1960s. The removal of charges in 1966 coincided with a sharp rise in the number of prescriptions dispensed, which continued until their reintroduction in 1968 at a time of economic crisis. When charges were reintroduced in 1968, exemption arrangements were added and have remained more or less the same to the present time.

11. From the 1960s onwards, the real cost of prescriptions—ie the charge adjusted for inflation—rose sharply: in 1996 it was nearly eight times its level in 1956. In recent years it has remained more or less constant. However, the number of prescriptions dispensed has continued to rise. The UK average is now [2002–03 figures] 12.4 per head. Wales (16.2) and Scotland (12.9) are above this average while England (12.3) is below. Prescribing levels in the UK are low by international standards but nevertheless exceed those in Australia, Greece, Denmark, Norway, Finland and Sweden.

12. Over 85% of prescriptions are obtained free of charge. The income from charges finances less than 1% of the cost of the NHS and about 6% of the total net ingredient cost of all prescriptions dispensed. The total revenue raised by prescription charges is around £500 million per annum, which represents about 40% of all income raised from NHS charges. Nearly all OECD countries impose prescription charges but the form of charge imposed in the UK—a single nationally determined amount—is not typical. Where standard national tariffs are in place, typically these vary with the type of drug. In some countries the charge, a co-payment, is calculated as a share—which may vary between drug categories—of the cost of the medicine concerned.

13. Most countries limit the impact of charges through exemptions or maximum limit to payments in a year. The scale of such exemptions is generally lower than in the UK. The existing system of charges has been criticised by user groups, think tanks and professional bodies, other pharmacy bodies and the pharmaceutical industry.

14. The notion of extending exemptions for chronic conditions was explicitly rejected by Alan Milburn when he was Secretary of State for Health. In 2004, however, minor modifications were introduced to the low-income exemption threshold. However, using its devolved powers, the Welsh National Assembly has decided to abolish prescription charges and is currently in the process of implementing that policy in stages, with completion 1 and free prescriptions—scheduled for 2007. In Scotland, the possibility of abolishing charges is also under discussion. Following consultation an MSP (Colin Fox) has now introduced the Abolition of NHS Prescription Charges (Scotland) Bill.

15. The reluctance of the UK government to reform the existing charging regime appears inconsistent with its health policy goals. In The NHS Improvement Plan it signalled its intention to switch the emphasis of health care policy over the next four years away from waiting times for elective treatment to care for those with long-term conditions. The majority of these are highly dependent on prescription medicines and most are required to make a contribution to their cost. As we set out below, it is this group which is most likely to be deterred from taking the medicines they need by the existing charging regime.

16. At the same time, the government is making a number of other changes to make it easier for patients to access medicines: at the UK level there is the transfer of medicines from prescription to P (available in a pharmacy without prescription) or GSL/OTC (general sales list/over the counter) status, and in England measures such as the liberalisation of entry to community pharmacy, which have implications for the financial stability of existing providers. (The Welsh and Scottish governments are also pursuing measures to improve access to medicines.)

17. The question arises therefore as to whether the continuation of prescription charges in their present form is compatible with other health policies.

18. Therefore in this submission we have set out a framework for assessing the appropriate role for the use of prescription charges within a national health service in England, which seeks to ensure that access to care is based on need not willingness to pay, and hence which does not generally impose charges at the point of use. We also consider in broad terms alternatives to the present system of charges, before setting out the RPSGB's view as to what should happen next.

**THE SCOTTISH PARLIAMENT**

19. The Committee will be aware that legislation in the form of the Abolition of NHS Prescription Charges (Scotland) Bill is currently passing through the Scottish Parliament. This process has ensured that, in turn, the Welsh Assembly's decision to abandon prescription charging has been scrutinized.

20. At a Scottish Health Committee Meeting on 29 November, it became clear that more evidence was required in order to properly plot the success of the policy of abolition. However the Committee did acknowledge that the current system is no longer fit for purpose in its current form—the Partnership Agreement looked to address this through consideration of charges for people with chronic health conditions and young people in full time education or training. The Deputy Health Minister also acknowledged that the consultation would have to be wider than just these two strands and would consider the fundamentals.

21. Given the Scottish Executive is so far down the line with this legislation we hope that the UK Parliament will be given an opportunity to examine and debate the results, so that a similar policy approach can be taken forward for the rest of the UK.

#### A POLICY FRAMEWORK FOR PRESCRIPTION CHARGES AND EXEMPTIONS

22. The framework incorporates the following elements:

- Users or self-carers.
- Government in its role of financier, and as health policymaker.
- Professionals, primarily those prescribing and/or dispensing medicines.

#### USERS

23. The critical question, both from the financial and the health viewpoint, is how do users react to the existence of charges for prescription medicines?

#### *Impact on use of medicines*

24. Studies carried out in a number of countries over a substantial number of years come to the same broad conclusion, that users, particularly those on lower incomes, are deterred from seeking or taking up prescriptions by the existence of charges. This was the finding of the only research based on an experimental design, the RAND studies, carried out in the US in the 1970s [Newhouse 1993] but there is now a substantial body of evidence from a number of countries accumulated since then which confirms this result.

25. A key research project carried out in 2004 surveyed the relevant literature from a wide range of countries, including England, and come to the following broad conclusion:

“Virtually every article we reviewed supports the view that cost sharing through the use of co-payments (charges) or deductibles decreases the use of prescription medicines by the poor and the chronically ill”.

26. Studies appearing since this survey including a number from Australia and the US support this general conclusion.

27. Obviously the impact on demand depends on the level of the charge. For example, a Canadian study of the imposition of a \$2 charge, a fraction of the UK charge, found that it had little impact on access by all income groups. The UK evidence is provided by statistical analysis of the impact of changes in the level of charge introduced in the years since their original introduction, and by survey and focus group methods.

28. A review of these studies in 2000 suggests that on average, for every 1% increase in the cost of a prescription, demand falls by  $\frac{1}{3}\%$  (the estimates vary considerably). This means that overall demand is relatively inelastic (ie not very responsive) which explains why the increases in UK charges in the recent past have increased revenue. There is some evidence that elasticity has been rising over time. Given the significant increase in the real-terms level of charges, this is only to be expected since a small proportional change in the charge now represents a much larger absolute change in what users have to pay.

29. The fact that demand overall is inelastic does not mean that all users are unaffected by charges. Within the UK, the available evidence suggests that the current charge deters some of those with incomes just above the exempt income threshold and some of those with non-exempt chronic conditions, because of the large up-front cost of the pre-payment certificate, as well as ignorance of its availability. For example:

- A survey carried out by NACAB [2001] found that around 50% of those who had received a prescription in the past year (and about two-thirds of those with long-term health problems) reported they found difficulty in meeting the charges. NACAB estimates that about 100,000 of their clients fail to make full use of prescriptions because of their cost. This study also cites a MORI survey which puts the national figure at  $\frac{3}{4}$  million.
- Studies of non-take-up have found that the rate is higher for the non-exempt than for the exempt.

30. Not all studies into the impact of charges find they reduce the take-up of medicines. But where they do not, the groups concerned have generally been higher-income or the relatively healthy or, as noted above, the charge has been much lower than the UK level. But they make the important point that the impact of charges may be on the decision to consult as much as on the decision to make use of a prescription. If this is correct, then the apparent lack of response to charges among some users groups may be understated by any analysis focusing solely on the take-up of prescriptions.

31. A number of studies have established that users may respond to an increase in prescription charges by making more use of alternatives, particularly over the counter medicines (OTCs). A 1989 study found that a 1% rise in prescription charges led to 0.2% increase in the use of OTCs. A more recent study carried out in 1998 found that such substitution took place primarily for minor health problems but there was also substitution for more serious problems. Another issue, debated in the Scottish Parliament, details the

unfairness of current arrangements in that patients with one of the listed chronic diseases are exempt from all prescription charges. Therefore a patient with diabetes and asthma receives asthma inhalers without charge, whereas a patient with asthma alone has to pay.

32. In some health care systems, a distinction is drawn between branded and generic medicines. Research into the impact of such charging arrangements suggests that users are price sensitive ie they are very responsive to such differentials. Research on this issue carried out in 1999 found that an increase in prescription cost from \$10 to \$15 for branded medicines resulted in little reduction in the use of medicines but did produce a switch from brands to generics.

33. Another common form of charge derives from what is termed reference pricing. In this system, the insurer covers the cost up to the reference price and patients pay the extra if they choose a more expensive medicine within a given therapeutic category.

34. Evaluation of the impact of the introduction of such a scheme for ACE inhibitors in British Columbia [Schneeweiss et al 2004] found little impact on drug utilisation and no increase in other health care costs. But other studies have found that overall drug costs met by insurers/government were reduced by this form of charge, at least in the short run.

35. All the studies reported here have examined increases to charges or limits on reimbursement. The impact of reductions in charges does not appear to have been researched presumably because reductions are rare. The statistical studies referred to above cannot be relied upon to provide estimates of major changes to the level or structure of charges. However, in Italy charges were abolished in January 2001, and in the year that followed, spending on medicines increased by just over one third, leading to a reintroduction of charges in some regions. No detailed studies of this episode appear to be available, however.

#### *Impact on health*

36. If the use of medicines is curtailed by charges, does it matter? Only a small number of studies have addressed this question. A study in the US of mentally ill patients living in the community faced with a cap on the drug expenditures for which they would be reimbursed, found that the increase in hospital admissions led to cost increases of 17 times the drug cost saved. Another study by the same authors found that charges led to more people being institutionalised for care and also found reductions in the use of particular medicines including essential ones such as insulin, thiazides and frusemide.

37. A study in Canada on the impact of charges introduced in 1996 found that use of essential medicines decreased and hospital admissions rose. A further study of the US Medicare system found a clear link between greater availability of medicines and improved mortality rates among the elderly by studying the impact of the introduction of insurance coverage for medicines during the 1990s.

38. A study carried out in the US concluded—albeit tentatively—that while low levels of co-payment had little effect on use of medicines, the health status of elderly users (measured by a combination of two scoring systems) did appear to decline, the higher the level of payments.

#### *Are charges fair?*

39. Any system of prescription charges applied to all or most of the population may be judged to be unfair against the criterion which the NHS applies to most health services that they should be free at the point of use. More specifically, whether charges are fair as between users depends critically on their precise structure and the nature and extent of exemptions. The current UK system is inequitable in three main respects:

- The sharp “cut-off” at the lower income exemption limit means that people just above the limit may be worse off than those below it.
- It requires people with low incomes to pay while some with much higher incomes such as well-off pensioners or pregnant women do not.
- The existing list of exemptions for chronic conditions dates back to 1968 when few medicines were available; some conditions which are now treated extensively with medicines were rarely diagnosed then, and new conditions such as AIDS have emerged. Hence the exemptions create an arbitrary division between those who pay and those who do not, which is not based on any defensible medical criterion.

#### GOVERNMENT

40. From the viewpoint of HM Treasury, charges have two positive attributes: they raise revenue and reduce expenditure. Simply viewed as a tax, charges on prescription medicines are relatively inefficient ie the administration and transaction costs are higher than for most other taxes.

41. Charges reduce public expenditure if they are set, like the current prescription charges in the UK, on average, below costs—and hence are subsidised out of taxes—and if users are deterred from accessing the services on which charges are imposed and thereby the total amount of subsidy is reduced.

42. From the viewpoint of a government as a health and health-service policymaker, taxes represent a barrier to access, again provided that [some] users are deterred from taking up the services affected. Accordingly there is a direct conflict between the two viewpoints, unless there is no deterrence effect. However, the evidence set out above suggests that there is.

43. The potential scale of the conflict between the two viewpoints can be reduced by a variety of means of which the most significant are partial or total exemption of certain groups, particularly those with low incomes, from charges. The extent of exemptions means in practice that charges can never be a major source of revenue, particularly as the main users of prescription medicines, the chronically sick and the elderly are, in general, on low incomes. But the current range of exemptions is not based on any defensible principle: those over retiring age enjoy exemptions whatever the level of their income, while many of those suffering from long-term conditions requiring medications have to pay the full charge.

44. An alternative would be to reduce the charge to the level below that which would maximise tax revenues to a more or less nominal level. But to take the latter option makes charges viewed as a tax even more inefficient. Their only purpose would be to serve as a reminder to users that there is no such thing, from the viewpoint of society as a whole, as free medicine. Finance and health policy share an interest in the efficient use of public funds.

45. Charges have been justified on the grounds that they deter frivolous use and encourage more responsible use of medicines. There is no evidence to support either of these arguments. Charges may indeed reduce the seeking or cashing of prescriptions in circumstances where there is little need for medical intervention. But there is no practical way of imposing charges which distinguishes these circumstances from those in which medicines are important to health. The only way in which some degree of judgement can be exercised over what is medically important or otherwise, is through the prescribing decision itself. This is where the main emphasis of policy should be if there is concern about inappropriate use.

46. In summary: if charges are imposed they can never make a substantial contribution to financing the bulk of the costs of supplying necessary medicines. In the words of a recent OECD cross-national report on health care reform:

Increases in co-payments substantial enough to have significant effects on demand are likely to have undesirable effects on access and may have additional social costs.

47. Moreover, according to a number of studies where charges have been increased, the effect on overall spending has been temporary. The main reason is that charges are only one of several factors bearing on the use of medicines. Nevertheless the amount currently raised through charges is not negligible. Any assessment of alternative charging systems or outright abolition should either consider alternative sources of revenue or the benefits forgone by diverting funds from other beneficial uses, or estimate the further potential for reducing spending on medicines such as measures directed at prescribers.

#### PROFESSIONALS

48. The prime motive for those prescribing and dispensing medicines is to improve the health of their patients. Nevertheless professional behaviour may be influenced in a number of ways by the way in which charges are levied and the financial context in which prescribing and dispensing takes place. Research has been carried out into professional behaviour in a number of countries. The specific findings reflect the specific circumstances of each but some general points emerge:

- Prescribing behaviour may be influenced by a desire to reduce the burden of charges.
- Prescribing behaviour may also be influenced by the financial incentives bearing on the prescriber.
- The existence of charges may also pose issues at the boundary between hospital and community eg in the case of day surgery where non-exempt patients are liable for charges, but where practical considerations make it hard to impose them.

49. There are many other influences on professionals. A large number of measures have been introduced to improve prescribing in both clinical and cost-efficiency terms, including in particular medication reviews and prescribing guidelines and pressure of various sorts to increase the use of generics. Measures to improve prescribing—if successful—should reduce the force of the argument for charges based on “frivolous” use.

#### ALTERNATIVES TO THE CURRENT SYSTEM OF CHARGES AND EXEMPTIONS

50. The design of a policy framework on charging within the national health service requires a balancing of different objectives.

51. The decision taken by the Welsh National Assembly reflects the view that overwhelming weight should be given to ensuring the availability of medicines to users. In contrast, policy in England reflects a more even balancing of objectives in which the Treasury interest is given greater weight relative to the access and health objective. Other countries go even further in this direction by imposing higher charges, at least for some medicines.

52. In Great Britain, the revenue/cost-containment objective is pursued by policies such as those promoting the use of generics, the provision of cost information to prescribers, and the transfer of medicines from prescription to OTC status, all of which are intended to reduce the costs falling on the NHS/Treasury. In addition, the Pharmaceutical Price Regulation Scheme provides a measure of control over the prices the industry can charge, while at the same time recognising the industry's need to invest in R & D.

53. In considering alternatives to the present system, we can define a number of broad options:

- Abolition of charges without any compensating changes in related policy areas: this is the approach in Wales.
- Retain a revenue objective similar to the present one but redesign the charging system so as to achieve a similar level of revenue but raised in a different way. Such options include a lower charge with fewer exemptions, as proposed by the Health Select Committee in 1994, proportionate charges which may be banded according to therapeutic value, reference pricing for conditions treatable by a range of therapeutically similar medicines, a national formulary of medicines which the NHS will pay for or subsidise (which would exclude some safe but not very effective medicines), as well as modifications to the existing system of exemptions so as to include a wider range of long-term conditions and to the current season-ticket system to make pre-payment more affordable.
- Reduce the revenue "target" from charges but use other measures to compensate for the loss of revenue eg by using stronger incentives for prescribers to reduce costs through generic or other forms of substitution.

54. Possible implications from the user viewpoint could include:

- changes in take-up of prescription medicines and hence the potential for greater compliance with prescribed medicines regimes or the reverse;
- the same for medicines transferred from prescription to OTC status.

55. Possible implications from the governmental viewpoint could include:

- the overall costs to the public purse including both the immediate loss of revenue and the costs of meeting any subsequent demand effect resulting from changes in user and prescriber behaviour;
- policy options that might modify the demand effect and hence reduce the impact on NHS expenditure eg other forms of control or limit on prescribing;
- the potential for cost saving in other parts of the NHS from improved compliance with prescribing regimes;
- if a substantial change were envisaged, the Westminster government would wish to take into account the impact on the pharmaceutical industry, within the context of the PPRS and its likely response in terms of its pricing and marketing strategies;
- the relationship between prescription charges and health policy in general, and other policy objectives such as those in England to reduce emergency admissions through improvements to chronic care, and the attempts to promote changes in diet and an increase in exercise—both of which may impose costs on users which are not usually met by the NHS. Abolition of charges tilts the balance in favour of patients seeking care paid for by the NHS rather than selfcare through health-promoting activities or dietary modifications.

56. Possible implications from the professional viewpoint could include:

- the workload implications for all health professionals generated by the expected rise in take-up if charges were abolished or lowered;
- the impact on the current system for financing community pharmacy eg if users switched back to prescribed medicines from OTCs if all prescription charges were abolished;
- the impact of other policies—within pharmacy and general practice in particular—which bear on access to prescription medicines and the alternatives to them which might modify the above.

*Beverley Parkin*

Royal Pharmaceutical Society of Great Britain

*December 2005*

---

**Memorandum submitted by the Socialist Health Association (CP 9)**

The Socialist Health Association was founded in 1930 to campaign for a National Health Service and is affiliated to the Labour Party. We are a membership organisation with members who work in and use the NHS. This submission is made on behalf of the Association.

We believe the NHS should be organized in such a way as to minimize disparities in quality of service between the socially excluded and the most advantaged sections of society. Ideally it should be organized in such a way that all such disparities disappear.

We have campaigned for many years for a free health service without any charges. We are very willing to give oral evidence to the committee.

1. *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?*

As Aneurin Bevan said in the debate about the introduction of prescription charges in December 1949: “The proposal to have a charge up to 1s. creates no administrative difficulty at all. The administrative difficulties arise out of the necessity of exemption.” It is apparent from the debate at that time that charges were imposed primarily as a method to restrict demand. It is not clear to us why it is still thought necessary to restrict demand specifically for medication prescribed outside hospital, wigs and trusses, dentistry and spectacles, but only for poorer people of working age. Since we established the National Institute for Clinical Excellence there are criteria for the prescription of medication and other treatments. It is difficult to see what positive role these charges play.

“What evidence is there that user charges, known to health economists as co-payments, have the selective effects on consultation rates required to restrain over-use, even if that were a real problem? Obviously user charges discourage use, but economists have good evidence that consulting behaviour has little elasticity. Poor people will give higher spending priority to consulting a doctor than to food, if they believe medical advice is needed.<sup>62</sup> The effect of user charges is simply to reduce all consultations across the board, regardless of the nature of the problems that prompt them. The effect is selective only for those with lowest incomes, least able to afford them, but most likely to be sick.<sup>63</sup> In the early years of the African AIDS pandemic, user charges were imposed at state-funded Sexually Transmitted Disease (STD) clinics in Kenya on advice from the World Bank and as a precondition for international aid. Consultation rates fell by 60%.<sup>64</sup> Public care systems have collapsed throughout Africa: no money, no treatment.<sup>65</sup>

User charges are advocated not to promote more rational behaviour, but to shift public behaviour ‘corrupted’ by experience of a free public service back to a ‘normal’ commercial pattern.”<sup>66</sup>

2. *What is the optimal level of charges?*

In our view zero is a proper level of charge for treatment or services which are clinically required. If a treatment or service is not clinically required then we would not consider that it should be within the scope of the NHS and charges might properly be made.

3. *Whether the system of charges is sufficiently transparent?*

The Director of the SHA worked for ten years as a Welfare Rights Officer in a large teaching hospital giving advice to patients and their families. He can give evidence that the Hospital Travel Costs Scheme in particular is not understood by those who are intended to benefit from it or those who administer it. In many hospitals determined efforts are made to prevent patients from claiming the help with fares to which they are entitled. The offices concerned are hidden away in obscure parts of the hospital, there is no publicity given to the scheme and the offices are often closed at times when patients would reasonably want to access them.<sup>67</sup> Although the research upon this work was based is now dated we have reason to believe that little has changed.

There are particular problems with the cost of taxi fares. Many hospitals refuse to pay for taxis. The official guidance on this point states:

“In a few cases, where there is no alternative (for example, in cases where patients have restricted mobility, or public transport is not available for all or part of the journey), patients may have to use a taxi or volunteer car service for the whole or part of their journey.”<sup>68</sup> This does not correspond with the law, which states:

“The amount of any NHS travel expenses to which a person is entitled under these Regulations—

<sup>62</sup> Creese A User fees, *British Medical Journal* 1997;315:202–3.

<sup>63</sup> Evans RG, Barer ML. The American predicament. OECD Policy Studies No 7 *Health care systems in transition*. Paris: OECD 1990. pp 80–5.

<sup>64</sup> Moses S, Manji F, Bradley J E. Impact of user fees on attendance at a referral centre for sexually transmitted diseases in Kenya. *Lancet* 1992;340:463–6, and Editorial. Charging for health services in the third world. *Lancet* 1992;340:458–9.

<sup>65</sup> de Sardan JPO. Africa: no money, no treatment. *Le Monde Diplomatique* June 2004:15.

<sup>66</sup> Dr Julian Tudor Hart—*The Political Economy of Health Care* (in press).

<sup>67</sup> Hospital Travel Costs Scheme—Current Practice and Best Practice Guide, Manchester Health Authority 1997.

<sup>68</sup> The hospital travel costs scheme—update May 2005 page 13.

- (a) must be calculated by reference to the cost of travelling by the cheapest means of transport which is reasonable having regard to the person's age, medical condition and any other relevant circumstances;<sup>69</sup>

It seems to us perfectly reasonable that patients should attend hospital using a taxi, and indeed that they should be encouraged to use taxis, which are a form of public transport, rather than use their own vehicles for which car parking provision should be (but rarely is) made.

#### 4. *What criteria should determine who should pay and who should be exempt?*

"The present system of NHS charges is a dog's dinner lacking any basis in fairness or logic" Lord Lipsey, Social Market Foundation. In reply to this comment, made in the SMF's report in 2003 the Department of Health said it regularly reviewed its prescription policy. It is difficult, however, to discern any evidence of such reviews having any influence on the real world. The list of conditions which give exemption from prescription charges appears to have been laid down in 1950, on the basis that these were conditions where medication was then permanently required. We are not aware that there has been any subsequent change. As stated above we feel that the fairest and most efficient system would be to abolish charges altogether. We defy the Department to produce a fair and acceptable system of charges to replace the present embarrassing mess.

#### 5. *How should relevant patients be made more aware of their eligibility for exemption from charges?*

If there are no charges we will not have to worry about this matter. If there were a fair and comprehensible system of charges and exemptions it would be much easier to explain. The lack of awareness of exemptions, particularly in respect of Hospital Travel Costs, acts in practice as a system of rationing by ignorance which is perhaps the most indefensible of all rationing systems.

#### 6. *Whether charges should be abolished?*

A long series of reports have established that charges on patients are the worst possible method of financing a health service. These include both the NHS Plan,<sup>70</sup> and the Wanless Report<sup>71</sup>. The National Consumer Council in 2003 pointed out that around 750,000 people in England and Wales fail to get their prescription dispensed because of the cost and how little clarity there is on the purpose of NHS charges.<sup>72</sup> The National Association of Citizens Advice Bureaux in 2001 described how the "fundamental contradiction at the heart of the National Health Service is the existence of charges for essential items such as prescriptions, dental and optical treatment, within a service which claims to provide health care free at the point of delivery".<sup>73</sup>

Further reports have described in detail the inequitable consequences of the present system for cancer patients,<sup>74</sup> and the importance of tackling travel costs effectively.<sup>75</sup> In our view the development of a more complex system of healthcare provision such as is now proposed, requires this problem to be tackled now. Many of our members and many NHS staff have formed the view that this government intends to privatise the NHS. If the government wants to prove wrong those critics who assert that the widespread introduction of charging is next on the agenda then it would do well to sort out this mess.

"The availability of good medical care tends to vary inversely with the need for the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."<sup>76</sup>

We do not accept that it is desirable to deter the population, particularly the poorer members of it, from seeking medical attention:

"The myth that consultations for retrospectively diagnosed 'non-illness' represent over-use or abuse is refuted by evidence, but this has not deterred advocates of NHS 'reform' from using it as a weapon in argument. Bosanquet and Pollard confirmed its grip on public opinion in their survey noted on p 5. Apparently unconcerned about whether it was true, they identified it as their best entry point for eroding persistent public support for an inclusive NHS funded through social solidarity:

<sup>69</sup> The National Health Service (Travel Expenses and Remission of Charges) Regulations 2003 Reg 3(5).

<sup>70</sup> The NHS Plan: a plan for investment, a plan for reform 2000.

<sup>71</sup> Securing Our Future Health: Taking a Long-Term View 2002.

<sup>72</sup> Creeping charges by Saranjit K Sihota.

<sup>73</sup> Unhealthy Charges 2001.

<sup>74</sup> Free at the Point of Delivery Macmillan Cancer Relief 2005.

<sup>75</sup> Making the Connections: Final Report on Transport and Social Exclusion Social Exclusion Unit 2003.

<sup>76</sup> *The Lancet*: Saturday 27 February 1971 The Inverse Care Law, Julian Tudor Hart.

“... almost two-thirds say that people visit their GP when there is no real need, simply because the service is free at point of use . . . it is the public’s readiness to concede over-use . . . that points the way forward . . . With 64% saying that there is over-use, there is a strong moral as well as practical case for a charge . . .”<sup>77</sup>

There is no way that any care system can function without the number of people consulting about worries greatly exceeding the number whose worries eventually prove justified. For example, rectal bleeding is an important signal of possible bowel cancer, for which early surgery is life-saving, but it still commonly presents too late. About 20% of adults have some rectal bleeding each year, but less than 1% of them consult a GP, and the proportion referred to a hospital specialist for further investigation is ten times less even than this.<sup>78</sup> For this example alone, and there are many others, there is overwhelming evidence that patients use the NHS too little rather than too much . . .”<sup>79</sup>

We urge the Government to take a bold step by abolishing charges. If it is felt necessary to restrict demand for NHS services then let us devise a rational way of doing so which does not discriminate on the basis of personal wealth.

“The essence of a satisfactory health service is that the rich and the poor are treated alike, that poverty is not a disability, and wealth is not advantaged.”<sup>80</sup>

*Martin Rathfelder*  
Socialist Health Alliance

5 December 2005

---

### Memorandum submitted by the Social Market Foundation (CP 33)

#### INTRODUCTION

The Social Market Foundation is an independent public policy think tank established in 1989 to provide a source of innovative economic and social policy ideas. Steering an independent course between political parties the SMF has been an influential voice in recent health, education, welfare and pensions policy reform. Our current work reflects a commitment to understanding how individuals, society and the state can work together to achieve the common goal of creating a just and free society.

The Social Market Foundation set up a Health Commission in July 2002 to look at healthcare funding.<sup>81</sup> As part of its deliberations it published reports on current charges in the NHS and the potential for, and desirability of, increasing user charges in health care.<sup>82</sup> A further publication on the wider use of co-payment in public services is due to be published shortly.<sup>83</sup> Responses to the following questions mainly draw on these documents.

#### *Question 1*

(a) *Whether charges for treatments, including prescriptions, dentistry and optical services are equitable and appropriate?*

#### Prescriptions

The SMF’s Health Commission concluded that scrapping prescription charges altogether could lead to unnecessary demand for medicines which would increase the NHS bill. Moreover, the NHS would lose a substantial income of more than £400 million. It was felt however, that the current arrangements for prescription charges were illogical, unfair and inequitable for some groups, and therefore ought to be reformed.

The most obvious area of unfairness is in relation to exemptions from payment for people with certain chronic conditions. There seems to be no clear rationale for exempting people with diabetes for example from payment, while people with asthma have to pay for life-saving medication. The SMF Health

---

<sup>77</sup> Bosanquet N, Pollard S Ready for Treatment: popular expectations and the future of health care. London: Social Market Foundation, 1997:98–103.

<sup>78</sup> Fijten GH, Muris JWM, Starmans R *et al.* The incidence and outcome of rectal bleeding in general practice. *Family Practice* 1993;10:283–7.

<sup>79</sup> Dr Julian Tudor Hart—*The Political Economy of Health Care* (in press).

<sup>80</sup> Nye Bevan In Place of Fear 1952.

<sup>81</sup> The members of the SMF Health Commission included: Lord David Lipsey (Chair); Rabbi Julia Neuberger; Professor Ray Robinson; Dr Chai Patel CBE; Dr Bill Robinson; and Fergus Kee.

<sup>82</sup> See *A Fairer Prescription for NHS charges: The Social Market Foundation Health Commission Report 1* (June 2003) and *User Charges for Health Care: The Social Market Foundation Health Commission Report 2D* (September 2004).

<sup>83</sup> Charging Ahead? The use of co-payments in UK public services (forthcoming January 2005), Ed. Jessica Asato.

Commission proposed a new system for prescription charges which would link the charge to the therapeutic value of the medicine. This would mean chronic conditions that are currently not included in the list of exemptions would attract lower cost-sharing rates, even down to 0%.

Another group which is affected by prescription charges is those on low incomes just above the threshold for help. This group is hit with a double-whammy—they do not qualify for the exemptions (because they are not receiving benefits) and yet they suffer a greater likelihood of becoming ill as compared to people with higher incomes. There is evidence that people on lower incomes delay or forgo their prescription medicines. For example, a survey by NACAB suggests that around 750,000 people in England and Wales fail to take up their prescription because of cost.<sup>84</sup> This can lead to further health costs down the line as patients' conditions worsen and need more expensive treatment. The SMF Health Commission proposed the introduction of an annual limit on the amount an individual should pay on prescription charges which would replace the current season ticket arrangements. The Commission considered the need for tapered help for people on low incomes just outside the threshold for exemption, but rejected it on the grounds of increased administration costs.

The inequities in the current system of prescription charges are further compounded by exempting older people and expectant or new mothers from charges, even when they could afford to pay them. The BMA has argued, for example, that there is no need to exempt women from prescription charges in the year following childbirth, because the medical problems that used to occur in the twelve months after birth are much less common now.<sup>85</sup> 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. The SMF Health Commission proposed scrapping the automatic exemption for pregnant women, nursing mothers or older people, and that free prescriptions should be provided free to children and others only on the basis of low income.

#### Dentistry

The current system of charges for dentistry is widely considered to be confusing and inefficient. There are too many charges for NHS treatment, and a lack of awareness among patients that they are required to pay 80% of the cost. Moreover, there are concerns that the piecemeal system creates incentives to over-treat patients, wasting NHS funds. The SMF Health Commission proposed that there should be a greater focus on prevention, and that treatments that qualify for NHS funds should do so according to clinical effectiveness. Treatments that are not essential to treat a medical condition should therefore be subject to full cost recovery. The Commission's favoured approach was for the NHS to pay for everyone to have free check-ups, though at longer intervals than is currently the case. It was felt that greater use should be made of dental capitation schemes to cover the costs of treatment, and that the government should consider arrangements to cover some or all of the costs of enrolment in a capitation scheme for people on low incomes.

#### Optical charges

As with other charges, there is evidence that optical charges discourage take-up of services. However, the situation is complex, because even groups which are eligible for free eye tests (the over 60s for example) appear not to be utilising the opportunity which suggests that something else, potentially the cost of glasses, is acting as a disincentive. The optical market is complicated by the fact that it is dominated by designer brands which is not the case with other physical aids, and this can leave the consumer vulnerable. The SMF Health Commission's approach was to emphasise prevention. It proposed that sight tests should be made free to everyone to encourage early diagnosis and treatment, with the increased costs to be partially offset against the savings from preventing advanced eye disease. The Commission also proposed that vouchers for people on low incomes to pay for glasses should reflect the real costs of glasses, and that glasses within the value of NHS vouchers should be available from all optometrists participating in the scheme.

(b) *Whether charges for hospital services (such as telephone and TV use and car parking) are equitable and appropriate?*

There is much evidence that charges for car parking and travel do put people off seeking healthcare and once again there is much confusion about eligibility for reimbursements.<sup>86</sup> The SMF Health Commission proposed that help with the costs of travel should be provided on the basis of low income only. It was also suggested that people who are eligible for help with the costs of travel to hospital should also be given help with travel to other NHS services such as GP and dental surgeries.

The Commission did not believe there was a problem with charging for non-clinical services, such as for TV use, from an equity perspective, but information about such charges should be made more available to patients before their hospital stay.

<sup>84</sup> National Association of Citizens Advice Bureaux (2001), *Unhealthy Charges: CAB evidence of the impact of health charges*.

<sup>85</sup> British Medical Association (2002) *Funding—prescription charges*.

<sup>86</sup> Social Exclusion Unit, (2003), *Making the Connections: Final Report on Transport and Social Exclusion*.

*Question 2*

What is the optimal level of charges?

The optimal level of a charge depends on many factors including the purpose of the charge (eg to reduce demand on a particular service, or to increase revenue), equity considerations, and public acceptability. In general, clinical services ought to attract very few charges and those that do must have sufficient exemptions to ensure that those on low incomes are able to access services. Charges should not be relied upon to form a substantial part of health service funding. Even countries which have much higher levels of co-payment in healthcare, only raise around 10–20% of income from charges with the rest generated through taxation or social insurance. Moreover, the amount raised through a charge will always be reduced through exemptions and the costs of administering the charge. As has already been shown, some charges actually increase costs to the NHS in the long-term because they dissuade patients from accessing treatment which results in higher costs of treatment further down the line. Assumptions, therefore, that more charges will result in increased revenue must be treated with caution.

*Question 3*

Whether the system of charges is sufficiently transparent?

Most systems of charges are complex and widely disliked by patients. The illogical nature of some charges such as prescriptions means that people do not view them as fair. The flat rate of prescription charges, for example, gives no indication of the true cost, or more importantly the therapeutic value, of drugs. In some cases this can be overcome by developing a clearer rationale for the charge with exemptions based on whether the charge is unduly hindering access to the service, rather than on historical precedent. In most cases charges, along with their exemption criteria, should be better advertised to the public.

*Question 4*

What criteria should determine who should pay and who should be exempt?

Exemption criteria should be strongly linked to principles of equitable access to health services. In our opinion, this means that generally people on lower incomes and children should be exempt from charges, while everyone else should be expected to pay, including older people on higher incomes. Another important consideration is whether the charge negatively impacts on the general objective of a healthier society. We would argue that some charges (such as for eye tests) work against the preventative approach, and therefore should be abolished. Similarly, our suggestions for linking the amount that patients pay for prescriptions to the efficacy of the treatment ensures that those people who need vital medicines to treat chronic diseases will be eligible for free treatment. This will reduce costs in the longer term because more people with those conditions will take-up the treatment they need.

*Question 5*

How should relevant patients be made more aware of their eligibility for exemption from charges?

All health professionals should be more active in promoting the exemption criteria to their patients, but patient groups can also play an important role in informing their members of their rights. The Expert Patient Programme could also do more to inform patients of their right to exemptions from charges.

*Question 6*

Whether charges should be abolished?

Charges provide a necessary function in increasing health service revenue and ensuring that some health services are used efficiently by reducing demand. In the absence of direct prices, a situation of “moral hazard” may develop where patients use health care unnecessarily thereby increasing costs for the NHS. This could be compounded by “supplier induced demand” in situations where doctors or others rely directly on attracting business to generate their income. Charges help to send signals to patients about the costs of healthcare and make them consider their use of services more carefully.

Many health charges in England, however, suffer from a lack of clear rationale and in some cases work against wider health objectives. We suggest that in most cases charges need not be abolished, but should be rationalised to better help people on low incomes or with chronic conditions, to link charges to the value or benefit of the treatment or service, to encourage a preventative approach if possible, and to simplify the system of exemptions. Moreover, we would urge that issues of equity and take-up of essential care must be at the forefront of policy-maker’s minds when considering the introduction of any new charges for health services.

*Jessica Asato*  
Social Market Foundation

*12 December 2005*

---

## Memorandum submitted by Standard Life Healthcare (CP 10)

### 1.1 INTRODUCTION

1.1.1 Standard Life Healthcare is one of the UK's leading private medical insurers with around 440,000 lives covered. We provide a range of healthcare solutions focusing not only on ensuring prompt treatment when our customers are ill but also a range of tools to promote good health.

1.1.2 We have a track record of collaborative working to promote good health having been prominent in the debate on improving health at work. We also want to contribute to our debate by offering some conclusions drawn from our experience of a business centred around private payments for healthcare.

### 1.2 *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.*

1.2.1 It is Standard Life Healthcare's view that it is fundamentally appropriate to levy charges for aspects of healthcare so long as they are transparent and fair. We have heard recently that the NHS may be facing a deficit of around £620 million for 2005 and healthcare costs are increasing rapidly leading to cost pressures in both the public and private sector. In this environment it is appropriate and necessary to continue to levy charges. This is not to say that the system cannot be improved but it should not be scrapped altogether.

1.2.2 We argue that the current system of charges is inappropriate in that it is incoherent and lacking a proper framework to decide what should be provided free at the point of delivery and what should be subject to charging. This is unhelpful for patients who are uncertain about where they will have to pay charges as well as helping to prevent a proper public debate about the value of healthcare.

1.2.3 We should ask whether patients would consider charges to be more appropriate if there was greater public understanding of the costs of healthcare and the funding pressures on the NHS and other providers.

### 1.3 *Whether the system of charges is sufficiently transparent*

1.3.1 The system of charges is not at all transparent. There is no logic behind the current regime of charging. Why do we pay a prescription charge but make no contribution to the cost of drugs supplied as part of in-patient treatment? Why do we pay for car-parking but not for the hotel cost of a hospital bed? Why are optical services subject to charging but GP appointments are not? This is not to draw conclusions about any of these specific examples but to make the point that the current system of charges is confusing and incoherent. Funding pressures on health services mean that charges are inevitable but it does not serve patients to maintain the current, unclear system. We need a proper public debate about the need for co-payments in health services.

### 1.4 *Whether charges should be abolished*

1.4.1 In a perfect world we would all prefer that healthcare was provided entirely free at the point of need for patients. However soon after the foundation of the NHS it became clear that some charges were necessary to cope with the extraordinary demand for "free" health services. This is a pattern that has not altered in the decades since. Ideally charges should be abolished but in actuality this is not a realistic option.

### 1.5 *Recommendations*

1.5.1 The government should open a public consultation on charges; where they should be levied and at what level. One aim of this should be to explain to patients and the public why, with the high costs of modern healthcare, charges are necessary.

1.5.2 There should be greater recognition from government that people are willing to pay for healthcare. We see this in the booming market for health related products, particularly those focusing on diet and fitness as well as research that demonstrates that 58% of people would pay up to £1000 for medical treatment. Only 24% would not be prepared to pay for treatment. (Standard Life Healthcare Attitudes to Healthcare Survey 2004).

1.5.3 The government should encourage those who can afford to contribute more towards the cost of their healthcare by considering ideas such as Health Savings Accounts which could work along the same principles as an ISA—tax free savings hypothesized for spending on healthcare.

David Furness  
Standard Life Healthcare

December 2005

---

**Memorandum submitted by Which? (CP 17)**

**RE: CO-PAYMENTS AND CHARGES IN THE NHS**

**SUMMARY**

NHS patient charges can act as a barrier to people getting the care or treatment they need, when they need it. They can also cause people to defer treatment which can result in higher long-term costs to the NHS.

The burden of charges often falls heaviest on those who have the poorest health despite significant numbers of people being exempt from paying charges. Low income exemptions are confusing and many people do not know whether they are exempt from charges or not.

The proposed new system of NHS dental charges will bring greater simplicity and transparency, but it will not overcome all the problems associated with the current charge system. Proposed charges for bands 2 and 3 are still too high. We also suggest that the oral health assessment should be free of charge.

The growth in charges for hotel facilities and non-clinical services, including parking, is worrying. While the costs of providing such services should not be met from NHS funds, they should not be used as a source of income generation.

Travel costs, including parking charges, will be increasingly important with changes in the way healthcare is provided in the NHS. We suggest various reforms to ensure these do not act as a barrier to people seeking or receiving treatment.

A fundamental review of exemptions should be undertaken to ensure greater consistency and fairness, and to eradicate the historical anomalies between different types of NHS charges and the groups of patients that are exempt from charges. This should be based primarily on clinical considerations, and ensure that no-one is precluded from treatment because of low-income.

Abolition of all patient charges will require either significant additional investment or take money from other areas of NHS care. In the cash-limited NHS, it is questionable whether this is the best use of money. A thorough cost-benefit analysis is needed to assess whether the costs of removing NHS dental and prescription charges will be off-set by healthcare gains for individual patients and across the NHS as well as savings of administration costs. This should include assessments from the patient's perspective as well as strict economic or clinical considerations.

Other approaches may help overcome some of the problems caused by charges. For example, adopting a maximum charge payable in any one 12-month period at a level no greater than the current pre-payment certificate. In order to aid budgeting, it should be possible for people to make these payments on a monthly as well as quarterly or annual basis.

**INTRODUCTION**

1. Which?, formerly known as Consumers' Association, is an independent, not-for-profit consumer organisation with around 700,000 members. Based in the UK, it is the largest consumer organisation in Europe. Entirely independent of government and industry, we are funded through the sale of our Which? range of consumer magazines and books, and *Drug and Therapeutics Bulletin*—our publication for healthcare professionals.

2. We campaign on a wide range of issues of importance to consumers, one of which is health. Our health campaign aims to ensure all consumers have access to safe, high-quality and patient-focused healthcare whenever and wherever they need it, together with the necessary information and support to be able to make informed decisions about their healthcare. This aim is supported through consumer and health policy research.

3. In compiling this memorandum, we have drawn particularly on our work on dentistry. Which? was a member of the Department of Health working group on NHS dentistry patient charges.

*Are charges for treatments, including prescriptions, dentistry and optical services, and charges for hospital services equitable and appropriate?*

4. It is undeniable that charges for NHS treatments act as a deterrent or prevent some people getting treatment when they needed it. This is despite significant groups of people who are exempt from paying charges. Evidence from the Commonwealth Fund comparative study of five countries (including the UK)<sup>87</sup> indicates that 4% of people failed to fill a prescription or skipped a dose because of cost, rising to 6% for those with below average incomes. While these figures are much lower than for other countries in the study (probably as a result of exemptions), they still represent a worrying number of people who are unable to

---

<sup>87</sup> Commonwealth International Health Policy Survey 2004 (covering Australia, Canada, New Zealand, United Kingdom and United States) [http://www.cmfw.org/surveys/surveys\\_show.htm?doc\\_id=245240](http://www.cmfw.org/surveys/surveys_show.htm?doc_id=245240).

take required medication because of its cost. For dentistry, the figures are even more concerning. Twenty-one per cent of people had not seen a dentist even though they needed dental care because of cost, rising to 24% for people with below-average income.

5. This research confirms findings from NACAB (now known as Citizen's Advice) in its 2001 study of NHS charges, which found prescription, dental and optical charges all acted as barriers to people getting treatment.<sup>88</sup>

6. Delaying treatment or failing to seek early or preventive treatments can often result in the need for more extensive and more expensive interventions at a later date. For example, a person with asthma who chooses only to obtain the prescription for medicines that bring immediate relief for their condition, is much more likely to experience crises that require emergency intervention, and in some cases hospitalisation. Thus, for the want of £6.50, the individual patient experiences much poorer long-term management of their condition and the NHS bears significantly higher costs.

### *NHS Dental Charges*

7. In the case of dentistry, the financial burden of NHS treatment currently often falls hardest on those with the greatest needs, especially those with low-incomes, but who are above the low-income threshold for exemptions. This is particularly concerning given the close correlation between poor dental health and socio-economic status. And because people aged over 60 years are not automatically exempt from dental charges, many who fall into this group are older people living on limited, fixed incomes.

8. The current dental charge regime is extremely complex and grossly opaque, and acts as a real disincentive for many people to seeking treatment. Additionally, the actual level of charges that patients pay can be very high (80% of the cost of treatment up to a maximum of £384 for a course of treatment). Many people put off going to the dentist by the fears of what any treatment might cost.

9. Which? research conducted earlier this year shows that dental charges act as a major barrier to many consumers receiving care and treatment. Seven per cent of people who had not visited the dentist in the last year were put off by the cost of treatment and 58% of people agreed with the statement that dentistry costs too much even if it's provided by the NHS.<sup>89</sup> Additionally, many of the stories from consumers left on our website as part of our dentistry campaign, illustrated the real problems many people face meeting the costs of NHS dentistry. Our research and information from consumers paint a picture of people deferring visiting a dentist until it is unavoidable, often resulting in a failure to seek the regular preventive care that is essential to improving oral health.

10. As a member of the DH working group on NHS dental patient charges, Which? has contributed to the development of the new system of patient charges that will be introduced in England from April 2006. We believe this new system of patient charges is a significant improvement to the current charge regime. We have particularly welcomed the reduction in the maximum charge now payable for a course of NHS treatment to just less than half the current charge (from £384 to £189). Additionally, the three-band system offers much-needed simplicity and greater clarity so that patients will know in advance what they have to pay for their care. It will also be much clearer when people are receiving private treatment and when it is NHS.

11. Although the new system of NHS patient dental charges is much improved, it is not ideal. In formulating the proposals for the new system, the DH working group was required to work within the strictures of ensuring the new charge regime generated the same levels of income as is currently raised by the existing regime (£0.5–0.6 billion pa). This requirement has determined the levels at which the charges are set. It also precluded making dental check-ups or the oral health assessment free as is being done in Scotland and Wales.

12. Which? has argued that the band charges for levels 2 and 3 are too high, and Band 3 should be set at about £125–130. In our response to the DH consultation on the new system of dental patient charges, we also argued that including repair and replacement of dentures or orthodontic appliances in Band 3 would cause significant hardship, with many people, including older people on fixed incomes, paying significantly more under the new system. While inevitably some people will pay less under the new system and some more, we are pleased that the Government has responded to our concerns in its final scheme for patient dental charges.

### *Travel costs, and parking and other charges*

13. In addition to NHS prescription, dental, optical and other charges, the costs of travel, including parking charges, are becoming an increasingly important additional financial burden for patients that can seriously affect access to care. Problems are particularly acute for patients who require long courses of treatment such as physiotherapy, chemotherapy or radiotherapy, or who have low incomes. These charges

<sup>88</sup> National Association of Citizens Advice Bureau *Unhealthy Charges* (2001).

<sup>89</sup> Which? omnibus survey of interviews conducted in-home between 12–16 January 2005 with a nationally representative sample of 1,894 GB adults aged 16+.

are of increasing importance as more care is provided on an out-patient or day-care basis, and services are rationalised or centralised on single sites. Additionally, roll-out of patient choice across the NHS will mean more people are likely to travel to receive treatment.

14. As with all charges, the burden of these costs falls heaviest on those who are sickest or who have low-incomes. In our recent report *Which Choice? Health*<sup>90</sup>, we highlighted the impact of travel costs on limiting the choices of people, particularly those on low incomes or living in rural areas, and the need for assistance with travel costs to ensure they are not disadvantaged in their choice of treatment options because of the cost of getting there.

15. Help with travel costs is available for people on low-incomes but is only provided to attend a hospital or other facility for NHS treatment under the care of a consultant. As more treatment is provided outside hospital, many of these clinics or facilities are not covered by the current scheme, which can again limit access to treatment for some of the sickest and most vulnerable people. This has been a particular problem for people needing dental treatment who have to travel many miles to receive care because of the difficulties in securing NHS dental treatment locally. We suggest that the current scheme to provide financial help with travel to hospital should be extended to cover types of treatment that are provided in non-hospital settings and are not under the care of a consultant.

16. The creep of local authority controlled parking zones and introduction of the congestion charge for Central London, sometimes means the operation of parking charges is outside the control of the NHS facility where care is provided. However, these all add additional elements to the cost of being sick and getting treatment, and it should be possible to recoup under the scheme for help with travel to hospital.

17. Where such charges are levied by an NHS facility, they should not be used as a means of income generation. However, the cost of maintaining parking facilities should not take money from a trust's money for service provision.

18. Some hospitals already give exemption to parking charges for people requiring long-term, essential treatment, in addition to those who have a blue badge, disabled parking permit. We suggest that where hospitals charge for parking they should give priority to people receiving treatment at the hospital and introduce permits to allow those who need to travel by private transport, because of their health or clinical needs, to park for free while they receive treatment or attend appointments.

19. The creeping introduction of charges for other amenities such as TV and telephone use is a worrying trend. Again we suggest that such schemes should not be used as a means of income generation for trusts, however neither should their provision detract from clinical services. We note that OFCOM is undertaking an investigation of telephone charges levied by Patientline, and await the outcome of this.

#### *Exemptions from charges*

20. Although for most types of NHS patient charges there are various exemption categories intended to ensure that particularly vulnerable groups are not prevented from seeking or receiving treatment by its cost, current exemptions are rife with anomalies and inconsistencies. As such, they can be inequitable and very confusing for patients. For example:

- People aged over 60 are not automatically exempt from dental charges but are from prescription charges.
- People aged over 60 and some high risk groups receive free eye tests but not dental check-ups.
- People with diabetes are exempt from all prescription charges, irrespective of whether they are associated with managing their condition or not. However, those who suffer from cystic fibrosis are not; similarly people with asthma or who need life-long essential medication following an organ transplant are not.
- Additionally, exemptions on the basis of low-income are extremely complex and often very difficult for consumers to understand whether or not they are exempt from charges.

21. The list of those groups that are exempt from charges has evolved historically but has not kept pace with recent medical developments or population changes. For example, until fairly recently few people with cystic fibrosis survived into adulthood, but now many are paying for prescription medicines that are vital for life. Similarly, the blanket exemption for people with diabetes was made at a time when incidence of the disease was much lower than it currently is, and is forecast to be in the future. And with the planned increase in the pension age for women to 65, and the talk of increasing this still further for both men and women in the future, there is little rationale for continuance of the current exemption for prescription charges for people over 60 years.

22. *Which?* suggests the over-riding basis for exemption for any charges should be clinical need. Additionally, no-one should be prevented from receiving treatment because of low income. We recommend that there should be a systematic and radical review of the exemption categories to eradicate anomalies and inequalities and to ensure that charges do not prevent people with low incomes or significant healthcare needs seeking or accessing both preventative care and essential treatment.

<sup>90</sup> *Which Choice? Health* (July, 2005).

23. Lessons from the review of dental charges suggests that this will not be an easy task and removing exemption status from groups that already have it is likely to be unpopular. However, the growing numbers of people who likely to be eligible for free prescriptions suggests that this is likely to become an increasing burden on the NHS that takes resources from other much-needed services. More and creative ways of looking at this issue are needed, particularly if groups of patients who are not currently exempt from charges, but need life-sustaining medication are to be given exemption status. For example, should exemption from charges be limited only to those prescription items that are needed to manage the condition that grants exemption status?

24. We suggest that there should also be greater consistency between exemption categories for prescription, dental and optical charges to facilitate better consumer understanding. Particular attention should be given to the exemption categories for dental charges to afford greater consistency with prescription and optical charges. This should include examining whether there are certain groups of people who are clinically-disposed to greater risks of poor dental health.

#### *How should charges be set?*

25. Which? suggests that where NHS patient charges exist they should be based on the following principles:

- Transparency and simplicity.
- Consistency and fairness.
- Affordability, particularly for those on low incomes and with the greatest clinical needs, such that charges do not act as a barrier to care.
- Supportive of preventive care.
- Ease of administration.
- Ease of understanding for patients.

Additionally the costs of administering any low-income exemptions should not be so great as to negate the value of any charge income levied.

26. We also suggest that any annual increases in the level of charges should be limited to at most the current rate of inflation, otherwise the burden for those on fixed incomes becomes too onerous.

#### *Should charges be abolished?*

27. In an ideal world, there would be no charges within the NHS. However, this is not a realistic option given the limited pool of funding available for NHS care. Removing dental, optical and prescription charges would have significant financial implications for the NHS that would either require significant additional funding or would take money away from other aspects of service provision. For example, making all NHS dental care free would require, under current levels of activity, investment of a further £0.5–0.6 billion a year. Despite the healthcare benefits that would no doubt accrue together with significant savings in an administration costs, it is questionable whether this would be the best use of limited NHS resources.

28. In relation to prescription charges, Which? has been neutral on whether they should be abolished, arguing for the need for a proper cost-benefit analysis of the likely costs and benefits of such a scheme, both now and in the future, which takes full account of the patient's perspective as well as strict economic considerations. While over 80% are already dispensed without a charge, the costs of making all prescriptions free would be significant and likely to increase significantly in the future. The amount spent on medicines in the NHS continues to increase at a rate greater than inflation each year, and the number of average number of prescription items dispensed increases each year—13.7 in 2004 compared with 9.5 in 1994. Of particular concern is the fact that many of these medicines are never actually used.

29. There is a real danger that if NHS prescription charges were abolished, the drug bill might escalate out of control unless there are some limits on what types of medicine can be prescribed free. In some European countries, the level of prescription charges depends on the therapeutic level of the medicine (for example in Belgium and France) with some drugs requiring as little as a 15% co-payment while others require a full 100% payment for any drug that is not on the national list. Alternatively, in Sweden and Denmark, what patients pay towards the costs of medicines is determined by their overall annual levels of co-payments, with a set maximum limit in any 12 month period above which all medicines are free.

30. If NHS prescription charges are to continue, we suggest that fixing a maximum annual level of charges that patients pay would be fairer for all. This way people who are chronically ill (but are not on the exemption list) or who suffer a period of ill-health would receive help with their prescriptions. This annual limit could be set at the level no greater than the annual season ticket (pre-payment certificate) of £93.20, and people should be able to purchase this on a monthly basis as well as quarterly and annually.

31. In relation to dentistry other issues arise. We suggest there is little rationale why charges exist for dental care but not for other types of healthcare. For the consumer, there is very little difference between the pain and health implications of an ear infection and those of a dental infection, but for one there is no

charge to see the health professional and for the other there is. While we would not argue that there should be no NHS dental charges, we do suggest that the current charge for the oral health assessment (or check up) should be abolished to encourage more people into preventive care. This could be particularly important in picking up the early stages of oral cancer.

32. For the future, it is likely that the costs of providing universal healthcare under the NHS will continue to rise. This is likely to lead to increased pressure to introduce new or increase existing co-payments for NHS services. What will be important in this context is to ensure that people with equal, but different clinical, needs are treated fairly and consistently whatever type of care or treatment they need. It is also vital that the short-term gains of introducing or increasing co-payment are not allowed to obscure the longer-term benefits, both for individuals and the healthcare system as a whole, of ensuring people receive early and preventive care to deal with their condition or illness.

*Frances Blunden*  
Which?

7 December 2005

---

#### **Memorandum submitted by Ellen Schafheutle and Peter Noyce, University of Manchester (CP 25)**

Peter Noyce and Ellen Schafheutle are members of the Drug Usage and Pharmacy Practice (DUPP) group within the School of Pharmacy and Pharmaceutical Sciences, University of Manchester. Ellen Schafheutle is a Research Fellow and Pharmacist, who holds a Post Doctoral Award funded by the NHS R&D Programme and The Health Foundation, to research “Is the prescription charge a barrier to meeting primary health care goals?” Peter Noyce is Professor of Pharmacy Practice and Head of DUPP, whose mission is “to undertake research that addresses issues of importance in informing and shaping practice, governance and policy relating to medicines and pharmacy”.

A major theme of DUPP’s research is patient access to medicines: systematically exploring, over the last 10 years, how patients make choices about medicines and routes of access, the barriers to access and how they may be negotiated. Peter Noyce and Ellen Schafheutle were partners in a seven-nation EU Biomed project which addressed the impact of patient charges on medicines on patient and prescriber behaviour and investigated how the cost to patients of commonly prescribed medicines varied across Europe and could be reduced in different cost-sharing arrangements.

We submit the following evidence under the respective headings of the terms of reference of the Inquiry on Co-payments and Charges in the NHS, and will be willing to give oral evidence.

#### **WHETHER CHARGES (ON PRESCRIPTIONS) ARE EQUITABLE AND APPROPRIATE?**

Prescription charges are equitable in that:

- They are a fixed cost per prescribed item, irrespective of the cost of the medication.
- Everyone aged 16 or under, pregnant or within a year of giving birth, or 60 and over is exempt from charges on all medicines prescribed under the NHS.
- Everyone who purchases a pre-payment certificate does not incur further charges for NHS medicines prescribed under the NHS during the period covered.

Approximately 50% of the population of England pay prescription charges—for approximately 13% of items dispensed under the NHS.

The system is inequitable in that:

- If a patient suffers from one of the listed clinical conditions, eg diabetes or epilepsy, then they are exempt from charges on medicines prescribed for them under the NHS, whereas if they have cancer, schizophrenia, HIV or AIDS, hypertension, coronary heart disease, asthma, tuberculosis or require immunosuppressive therapy following transplant, then they are subject to prescription charges.
- For many patients, their ability to pay for their prescriptions changes little through the 55–65 age range, yet they are liable to pay charges on NHS prescribed medicines for the first five years, ie before 60, and receive them all free at 60 and over.
- Currently, exemption is universal, providing “blanket” exemption from charges for any medicines prescribed under the NHS for patients exempt from prescription charges. For example, people exempt due to a medical condition can obtain any prescribed medication free of charge, even if this is unrelated to the qualifying condition.
- The ceiling or cap on prescription charges offered by pre-payment certificates:
  - Is not available to those who cannot afford—as a lump sum—the advance payment.

- Is not foreseeable as beneficial for bouts of acute or episodic illness requiring intensive treatment. Asthma is an example of a chronic condition, which is episodic and unpredictable, thus people may find it difficult to anticipate whether the purchase of a pre-payment certificate would be worthwhile, and may end up paying more in individual charges.

We have published evidence that patients in England on chronic therapy, who cannot afford to pay some or all of the prescription charges, take a range of avoiding/coping measures.<sup>1-4</sup> This mirrors research in North America,<sup>5,6</sup> where further work has shown difficulties in affording medicines leads to a decrease in consumption of prescribed medicines.<sup>7</sup> This has been shown to effect an extra burden on health outcomes<sup>8-10</sup> and thus resources.<sup>11</sup>

#### APPROPRIATENESS OF THE PRESCRIPTION CHARGE

Research in progress provides valuable insights into patients' views on the appropriateness of prescription charges.<sup>12</sup> Many are very supportive of having a National Health Service and appreciate and accept that increasing costs need to be covered. Many articulate that they accept paying for their prescriptions, yet they are aware of many inconsistencies and inequities within the current system.

Many people—and interviewees are either asthmatic, have hypertension or coronary heart disease—resent the unfairness in the current system of medical prescription charge exemptions. They cannot understand why some chronic life-threatening conditions, such as diabetes, are exempt, yet they have to pay for their prescriptions. There is a clear awareness among interviewees that their conditions are long-term and taking their chronic medication helps to prevent adverse episodes such as asthma or heart attacks requiring hospital admission, or a stroke leading to long-term impaired health. All such adverse outcomes would not only mean worse health for them personally, but have implications for their use of NHS services and thus considerable resource implications. This brings many interviewees to the conclusion that conditions requiring life-long, or at least long-term, drug therapy, should either be completely exempted from charges or at least subsidised. As one patient expressed:

“It’s a false economy, if I can prevent you from getting something, then rather than getting the money off you for a prescription of six pound odd, and putting that into the NHS, if I still fall ill because I can’t afford that prescription, that six pound now as when I go into the hospital has gone up to three grand they’re spending on me. [ . . . ] As an asthmatic, why am I entitled to a free flu jab? To stop me from getting flu products, to stop me from getting more ill and so on. [ . . . ] So I can get a free flu jab to stop my illness getting worse, but I can’t get the medication that’s needed to keep that at bay long term, without having to pay for it.” (ID9)

Many interviewees comment on the level of the prescription charge, saying that it is too high. They demonstrate particular awareness of this causing serious affordability problems for those on low incomes, whose income would be above the level that would exempt them, yet below an income that made prescription charges affordable. Several interviewees suggest that a lower charge would make medicines more affordable and reduce the number of cost-related decisions or choices patients make about their medication.

#### WHAT IS THE OPTIMAL LEVEL OF CHARGES?

From a series of focus groups with GPs in the North West of England we know that they alter their prescribing in various ways to reduce the cost of medication to patients liable to pay.<sup>13</sup> They for instance minimise the changes that they make to patients' regimens—which otherwise would prove costly to patients—when the prescriber is titrating doses or drugs following a new diagnosis or commencement of a new course of treatment. We have further shown in an evaluation of the new NHS repeat dispensing scheme that GPs are writing more prescriptions for two monthly periods for chargeable patients compared with exempt patients.<sup>14</sup> This is reflected in the average net ingredient cost of chargeable prescription items in 2004 being a third higher than those in exempt items for the elderly.<sup>15</sup>

The current prescription charge, being item based, is particularly burdensome, if a patient is prescribed several medicines, either to manage a chronic condition, eg hypertension, or acute exacerbation, eg a chest infection in an asthmatic.

Despite GPs being concerned about the cost of medicines to patients,<sup>13</sup> our findings—mirrored by a more recent US study<sup>16</sup>—show patients are reluctant to raise the cost of medicines with their doctors.<sup>1,2,12</sup> Instead they wait until they go to the pharmacy before indicating that they are unable to pay for their prescribed medicines and limiting the cost of their prescription to the most important items on it.<sup>4</sup>

As recently announced, both nurses and pharmacists will soon be adopting wide prescribing responsibilities. It will be interesting to see how they deal with the challenges posed by prescription charges. Community nurse prescribers already demonstrate ambivalence in responding to exempt patients' demands for OTC medicines so that they can avoid buying them.<sup>17</sup>

Difficulty in paying for prescribed medicines has been shown to be double the problem for patients suffering from hypertension or dyspepsia in England compared with Italy.<sup>3</sup> Where possible, English patients who paid prescription charges were much more likely than their Italian counterparts to purchase over-the-counter (OTC medicine), rather than pay prescription charges. These differences in patient behaviour were largely attributed to the different levels of prescription charges in the two countries. The prescription charge in England is nearly six times that in Italy.

#### WHETHER THE SYSTEM OF CHARGES IS SUFFICIENTLY TRANSPARENT?

Our own research suggests that patients' awareness of the existence of pre-payment certificates is limited, even, and particularly, among those who may benefit.<sup>1</sup> This is supported by a survey of some 1,600 Citizens Advice Bureau clients.<sup>18</sup> Patients thus rely on health care professionals, ie mainly doctors and community pharmacists, to raise awareness of pre-payment certificates. This is also corroborated in our most recent qualitative work, which indicates that it relies on the health professional realising that the patient would benefit from a pre-payment certificate, which may not be the case if a number of single item prescriptions are presented for dispensing over a short period of time.<sup>12</sup>

#### WHAT CRITERIA SHOULD DETERMINE WHO SHOULD PAY AND WHO SHOULD BE EXEMPT?

The criteria that should determine NHS prescription charge exemption are informed by our and others' research:

- Prescription charge exemptions ought to discriminate between medicines that are essential for controlling major disease or illness, eg anti-retrovirals (in HIV), anti-psychotics; critical to maintaining public health, eg anti-tuberculosis therapy; or providing proven long-term benefits, eg anti-hypertensives; and those which are not essential, often providing symptomatic relief. A way to address this may be a national formulary or list of drugs that are exempt.
- Most European co-payment systems have age-related exemptions. In these countries they are for the young but not necessarily for the elderly, despite these being recognised as the highest users of medicines. Instead, these systems rely more on ensuring that exemptions apply to essential medicines, and low income does not act as a barrier.
- Whilst the issue of patients on low incomes having problems affording prescription charges suggests a review of the process of determining low income exemptions, the more obvious point is that it is the level of the charge that presents the challenge, particularly when two or three items are prescribed.
- Pre-payment certificates should provide a true cap on the cost of drug therapy (prescription charges). An immediate way of addressing this would be through devising a method of paying by instalments (TV licenses, for example, can be purchased by stamps—"prospective instalments"). Longer term, with community pharmacies being linked into NHS Information Technology, this cap could be equitably and consistently applied electronically, as it is in Denmark. This would address the existing barrier of not being able to afford lump-sum payments for purchasing pre-payment certificates, as well as the unpredictability of medication and cost in episodic conditions.

Currently, "blanket" exemptions from charges create inequalities, whereas these proposals ensure that essential drugs are free and prescribed medicines are more accessible through caps on total annual drug expenditure and possibly a lower charge.

#### WHETHER CHARGES SHOULD BE ABOLISHED?

Looking at the use of medicines by people currently prescription charge exempt, and how they differ from those that pay, provides valuable insights into the effect a potential abolition of prescription charges may have. The answer to this question can thus be informed by studies that have investigated the behaviour of patients who are already exempt under current conditions.

- When medicines are deregulated to OTC status, patients who are exempt from charges are more likely than those who pay, to access such products through NHS prescriptions, than purchase them as OTC medicines.<sup>19, 20</sup>
- NHS minor ailments schemes, where exempt patients can obtain listed items directly from community pharmacies at no cost, are effective in transferring the demand for the treatment of minor ailments from general practitioners to community pharmacies.<sup>21</sup>
- Patients who routinely receive prescribed medicines and are exempt from charges are more likely to request products for the relief of minor ailments on prescription than either patients who do not receive routine medication and/or are not exempt.<sup>20</sup>
- Exempt patients on repeat medication are less likely to request that an item is not dispensed, on the basis of already having an existing adequate stock, than patients who pay.<sup>4</sup>

The total revenue from prescription charges is currently about £430 million per year, and this makes up about 5% of the net ingredient cost of all dispensed prescriptions.<sup>22</sup> Taking the evidence listed above into account, it is reasonable to assume that abolition of prescription charges will not only result in a loss of this sum, but also to assume some change in behaviour for those people that would now have free access to medication. A complete abolition of prescription charges, ie exemption for all, is likely to distort demand and may unnecessarily overburden GPs.

*Professor Peter Noyce and Dr Ellen Schafheutle*  
School of Pharmacy & Pharmaceutical Sciences  
The University of Manchester

7 December 2005

#### REFERENCES

- Schafheutle, EI, Hassell, K, Noyce, PR, Weiss, MC. Access to medicines: cost as an influence on the views and behaviour of patients. *Health & Social Care in the Community* 2002; 10: 187–195.
- Schafheutle, EI, Hassell, K, Noyce, PR. Coping with prescription charges in the UK. *The International Journal of Pharmacy Practice* 2004; 12: 239–246.
- Atella, V, Schafheutle, E, Noyce, P, Hassell, K. Affordability of medicines and patients' cost reduction behaviors: empirical evidence based on SUR estimates from Italy and the UK. *Applied Health Economics & Health Policy* 2005; 4: 23–35.
- Schafheutle, EI, Hassell, K, Seston, EM, Noyce, PR. Non-dispensing of NHS prescriptions in community pharmacies. *The International Journal of Pharmacy Practice* 2002; 10: 11–15.
- Cox, ER, Jernigan, C, Joel Coons, SJ, Draugalis, JR. Medicare beneficiaries' management of capped prescription benefits. *Medical Care* 2001; 39: 296–301.
- Cox, ER, Henderson, RR. Prescription use behaviour among Medicare beneficiaries with capped prescription benefits. *Journal of Managed Care Pharmacy* 2002; 8: 360–364.
- Stuart, B, Grana, J. Ability to pay and the decision to medicate. *Medical Care* 1998; 36: 202–211.
- Tamblyn, R, Laprise, R, Hanley, JA, Abrahamowicz, M, Scott, S, Mayo, N et al. Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *Journal of the American Medical Association* 2001; 285: 421–429.
- Rice, T, Matsuoka, KY. The impact of cost-sharing on appropriate utilization and health status: a review of the literature on seniors. *Medical Care Research and Review* 2004; 61: 415–452.
- Lexchin, J, Grootendorst, P. Effects of prescription drug user fees on drug and health services use and on health status in vulnerable populations: a systematic review of the evidence. *International Journal of Health Services* 2004; 34: 101–122.
- Soumerai, SB, McLaughlin, TJ, Ross-Degnan, D, Casteris, CS, Bollini, P. Effect of limiting Medicaid drug-reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia. *New England Journal of Medicine* 1994; 331: 650–655.
- Schafheutle EI. Is the prescription charge a barrier to meeting primary health care goals? 2005. Post Doctoral Award, Funded by The Health Foundation and the NHS R&D Programme.
- Weiss, MC, Hassell, K, Schafheutle, EI, Noyce, PR. Strategies used by General Practitioners to minimise the impact of the prescription charge. *European Journal of General Practice* 2001; 7: 23–26.
- Ashcroft D, Elvey R, Bradley F, Morecroft C, Noyce P. National Evaluation of Repeat Dispensing by Community Pharmacists. Final Report. The University of Manchester, 2005.
- Department of Health. Prescriptions Dispensed in the Community. Statistics for 1994 to 2004: England. London: Health and Social Care Information Centre, 2005.
- Piette, JD, Heisler, M, Wagner, TH. Cost-related medication underuse: do patients with chronic illnesses tell their doctors? *Archives of Internal Medicine* 13-9-2004; 164: 1749–1755.
- Hall, J, Cantrill, J, Noyce, P. Influences on community nurse prescribing. *Nurse Prescriber* 2003; 1: 127–132.
- Phelps, L. Prescription charges. *Evidence* 2002; 8–9.
- Schafheutle, EI, Cantrill, JA, Nicolson, M, Noyce, PR. Insights into the choice between self-medication and a doctor's prescription: a study of hay fever sufferers. *The International Journal of Pharmacy Practice* 1996; 4: 156–161.
- Payne, K, Ryan-Woolley, BM, Noyce, PR. Role of consumer attributes in predicting the impact of medicines deregulation on National Health Service prescribing in the United Kingdom. *The International Journal of Pharmacy Practice* 1998; 6: 150–158.
- Hassell, K, Whittington, Z, Cantrill, J, Bates, F, Rogers, A, Noyce, P. Managing demand: transfer of management of self limiting conditions from general practice to community pharmacies. *British Medical Journal* 2001; 323: 146–147.
- Department of Health. Personal Communication, Statistics Division. 7-12-2005.

---

### Memorandum submitted by Professor Donald Light (CP 3)

This testimony is based on the accompanying systematic review of all qualified studies in English published between 1977 and 2002 on the effects of user fees for prescription drugs in vulnerable populations. The review looks at a variety of mechanisms for cost sharing including flat co-payments, multi-tiered co-payments, and deductibles paid by patients, as well as reimbursement limits above which patients pay the entire amount. These 25 qualifying studies document that co-payments and other charges cause clinical harm in an effort to hold down expenditures. They are penny-wise and pound-foolish.

By their nature, co-payments and charges can only save money by forcing patients to make decisions about whether or not to see a doctor, fill a prescription and then take the drugs as prescribed, or see a dentist about a problem. Changing the nature of these decisions could potentially save money but only by seriously discriminating against the most severely ill patients; the sickest 2% and 10% of patients consume 41% and 72%, respectively of all health care expenditures. 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.

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. Even small co-payments have resulted in significant reductions in use lower-income patients.

Since poorer people are more likely to be sick, and sicker people use many more drugs, user fees are an effective, well-targeted way to reduce the amount that the state spends on drugs. Studies show this reduction leads to significant increases in hospitalisation and emergency-room visits, but those costs occur on someone else's budget and thus represent false savings. The segmented budgets within the NHS assure that cost-shifting and care-shifting to other budgets will seem to save money, at least in the short run, but even greater costs occur down the road.

Co-payments and other charges increase the very inequalities that current policy aims to reduce. They remove coverage and undermine the goal of universal health care. They are an example of the Inverse Coverage Law, that in cash and private insurance, coverage varies inversely with need. Ironically, co-payments and other charges frustrate the goal of prevention which is getting patients to see their primary care provider when they think they have a problem, and using drugs that their doctors judge they need. Why are co-payments being used at all?

If co-payments and charges reflect the goals of the NHS, the system should move away from the principle of free at the point of service and towards having patients pay for their medicines. The Nobel laureate in economics, James Buchanan, pointed out in a notable report what he regarded as the "inconsistencies of the NHS"; that the cheaper something is, the more of it will be consumed, and free goods will induce infinite demand. This is basic economics, he wrote, and obvious to any thinking person. Buchanan likened the NHS principle of "free at the point of delivery" to offering free beer. The NHS is doomed to go bankrupt, he argued, if it offers free services, like free beer.

However, Buchanan overlooked several important points. First, as Robert Evans<sup>91</sup> has pointed out, health care is not like beer or other goods people buy, because health care is desirable only for its (intended) positive effect on health status; consuming health care is not inherently pleasant and there is no rational incentive for anyone to use it, unless they think it is needed because of a concern about their health. Second, as has been documented by the Canadian Health Services Research Foundation,<sup>92</sup> patients do not control most health care expenditures, because doctors are the gatekeepers and make all of the expensive decisions (eg admitting to hospital and ordering tests). Finally, it is clear globally that public one-payer systems such as the NHS or Canadian Medicare have consistently controlled costs much better than does the U.S. with its high charges and partial health care coverage. In the former, those running the system can restrain both supply and demand more effectively and more equitably. This point is still true today. Co-payments and other charges advance the current privatization of the NHS, moving it closer to the kind of system the United States has, where the provision of medical care is increasingly dependent on patients paying cash. To be consistent, doctors and dentists should also be charged, to discourage them from seeing patients or prescribing medicines!

There is one positive and evidence-based application for co-payments, applying fees to encourage patients to use the most cost-effective drug available for their condition: a system known as reference pricing. Under reference pricing, public drug coverage is automatically available for the cost of the designated reference drug within a therapeutic class. (A therapeutic class is a family of drugs, not chemically the same, used to treat the same medical condition. Independent expert review of the evidence is used to group drugs into therapeutic classes.) If patients want to use a more expensive drug in that therapeutic class, they pay the difference in cost. In cases where the reference (first-line) drug is inappropriate (for instance due to comorbidities) or causes unacceptable side effects, the physician can obtain a special authority for the patient to use a higher-cost alternative without paying the additional charge. Thus co-pays serve to keep

---

<sup>91</sup> Evans R *Strained mercy: the economics of Canadian health care*. Toronto: Butterworths, 1984.

<sup>92</sup> Canadian Health Services Research Foundation. *Myth: user fees would stop waste and ensure better use of the healthcare system*. Ottawa, Ontario: Canadian Health Services Research Foundation, 2005:1–2.

overall costs down, yet support clinically appropriate prescribing. British Columbia's Pharmacare program uses reference pricing, and it has been shown to reduce costs without leading to negative clinical outcomes.<sup>93,94</sup> Denmark and other countries operate similar schemes, with similar results. It is important to note that such a system also gives the right incentives to pharmaceutical companies, to spend less on derivative variations of existing drugs and more on clearly superior drugs. That is, after all, what patients, doctors, and society want them to do.

**Recommendation:** Eliminate current co-payments and other charges so that prevention, quality care, more equitable access by social class, and patient adherence to professional advice are increased. Consider using co-payments to enhance clinically more appropriate prescribing. Adopt reference pricing to control drug budgets while providing patients with the medications they need.

*Professor Donald Light*  
Princeton University, USA

22 November 2005

---

### Memorandum submitted by Ray Thomas (CP 15)

#### INTRODUCTION

*Why focus on dental implants?*

1. Dental implants raise a number of questions of principle in relation to co-payments and NHS charges. These include:

- (a) Ways in which co-payments and charges might take account of patient responsibility for their medical condition.
- (b) How co-payments and charges might reflect both health benefits to the individual and benefits to the NHS in reducing medical needs.
- (c) How co-payments might be used to encourage patients to take treatments outside the NHS in order to help raise standards of medical practice and encourage the exploitation of new technologies.
- (d) How loans by the NHS to patients might be appropriate to support co-payments in cases where the benefits of treatment extend over many years.

#### SUMMARY

2. Implants are potentially a very large component of dental care for a nation that notoriously suffers from bad teeth. Implants replace the need for dental bridges and dentures. The potential demand for implants in the UK is measurable in terms of millions of patients, and (to make up for existing levels of tooth loss) 10s of millions of implants.

3. It is suggested that patients should generally be expected to pay a substantial proportion of of the cost of implants. But the use of implants and the development of implantology could be encouraged by introducing a system of co-payments. A specially designed system of co-payments could make implants affordable though loans and could support patients' use of implantology services outside the National Health Service and outside the UK.

#### THE IMPLANT TECHNOLOGY

4. Implants provide a lifetime solution to tooth loss. Bone ossifies around the implant and so implants preserve bone structure. A tooth based on an implant is more durable than a natural tooth. Thus implants save future dental costs as well as providing teeth for healthy living.

5. Implants promise a reduction of the costs of dentistry. Given favourable conditions a skilled implantologist can make three or four implants in an hour. The implantologist can generally deal with abutments and insert crowns etc even more speedily. Thus the costs of implants in terms of the time of skilled dentists is lower than that necessary for the existing dental technology.

6. An implant is a more simple solution than a bridge, for example, because the construction of a bridge requires the dental work on two adjacent teeth. It can be expected that the cost of an implant will generally be below that of bridge construction. Tooth loss itself leads to recession of the bone of the jaw. The cost of

---

<sup>93</sup> British Columbia Ministry of Health. Pharmacare: Reference drug program. Vol 2005: British Columbia Ministry of Health, 2005 (July).

<sup>94</sup> Canadian Health Services Research Foundation. Reference-based drug insurance policies can cut costs without harming patients. Evidence Boost. Ottawa, Ontario: Canadian Health Services Research Foundation, 2005 (June):1–2.

implants can be set against that of the prescription, impression, etc associated with fitting a denture, and the series of prescriptions and impressions etc that are typically necessary for the refitting of dentures in response to further tooth loss and bone resorption..

7. The effectiveness and falling cost of implants are attributable mainly to the development of technology in the design and production of titanium implants. The use of new information technology has supported further developments. Computer aided design, based on information from digital photographs, is already widely used to produce crowns that are an exact fit—thus reducing the need for adjustments at fitting stages.

8. Computer aided positioning systems based on information from X-ray photographs that will identify the optimum position for implants are at an advanced stage of development. Such computer aided positioning systems can be expected to supplement the skills of the implantologist. These advances in technology contribute to the productivity of dentists as well as higher quality dental care. It is expected that such developments will in the near future make fitting an implant and a crown a routine operation that can be accomplished within, say, an hour.

#### EQUITY ISSUES

9. Dental health is in part a personal responsibility. Good dental hygiene reduces the chances of problems that can lead to tooth problems. It is equitable therefore that patients should bear a proportion of the cost of dealing with tooth problems. This principle is already recognised by the practice of charging by the NHS for nearly all dental services for adults.

10. This principle applies to tooth loss as well as to other dental problems. In the case of implants it seems equitable that patients should pay a higher proportion of the cost of treatment than for other dental services because dental implants represent a high quality and permanent solution.

11. But implants can be expected to reduce NHS costs. The cost of making an implant and new crown may already be below that of constructing a bridge. The use of implants can be expected to reduce future demand for dental services because the demand for services from patients with implants can be expected to be less than the demand for services by patients with dentures.

12. It appears appropriate therefore that the NHS should give material encouragement to patients to have implants. Sharing of the cost between the NHS and patient is appropriate. Perhaps a 50/50 sharing of cost would be just. The most equitable proportion could well depend upon more detailed examination of the issues than is appropriate in this submission. The case of implants demonstrates that where there are benefits in the way of a reduction of future demand for NHS services this could well be recognised by the co-payments system.

#### COSTS

13. One practical issue is that many patients cannot afford even 50% of the current cost of implants. But because implants are a long-term solution governmental loans to patients would be appropriate. Perhaps interest free loans over a period of say ten years could be instituted? The case of implants demonstrates that where benefits extend over a long period it would be reasonable to introduce the practice of government loans to support co-payment by individuals.

14. The major problem in encouraging the use of implants is the availability of appropriately skilled dentists. The dental profession in the UK appears to be about a generation behind that of other European countries in this matter. The use of implants is already common in many European countries including those of the former Soviet Union. But in the UK there is a severe scarcity of dentists with expertise in implantology.

15. The scarcity of skills in the UK is associated with high prices. Cost quoted in the UK are typically £2,000 per implant upward compared with about £1,000 or less in some other European countries. Costs are widely expected to fall with the development of supporting technologies. But because of the scarcity of implantologists in the UK falling costs can be expected to increase the difference between the high costs in the UK as compared with the low cost in other countries.

#### AVAILABILITY WITH THE NHS

16. The conditions under which implant services are available within the NHS are unclear. A search of the NHS website for tooth implants actually yielded information only on breast implants !

17. There are many things the NHS can do to raise knowledge and skills of implantology among its own staff. But there is no obvious way of bringing a whole generation of dentists in the UK up to standard that seems common in other European countries. Such developments go beyond the scope of this submission and the role of the Health Committee.

18. But it seems unavoidable that the best prospect for development of the quality of services available to the public in the UK requires encouragement of the use of dental services outside the NHS and outside the UK. In the short term it would be appropriate to encourage patients with a co-payment system to find service outside the NHS and in other countries.

19. The use of a co-payment system could also be used to obtain information from patients on the costs and quality of the services they use and so contribute to the development of implantology services in the UK. The availability of information on the experience of patients own experience of implants outside the NHS could provide a valuable means of furthering interest and knowledge among dentists in the UK. A system of co-payments to individuals seeking implants could contribute to that stock of knowledge and skills.

20. The case of implants provides a case where the existing system of charges and co-payments present barriers to the assimilation of advances in medical science and technology. It is hoped that this memorandum points to some ways in which these barriers might be overcome.

*Ray Thomas*  
Open University  
December 2005

---

**Memorandum submitted by Peter May (CP 32)**

Telford DGH, on a green field site, did not have CAR PARK charges in the 80's and 90's. Out of town there was no competition for our parking spaces.

When the finances became a little rocky The Trust's auditors suggested that the budget could not be accepted another year.

It was not the Board who willingly introduced Parking Charges but their Auditors—a private accountancy firm who insisted: It is therefore clearly a money raising exercise; Out of keeping, I would suggest, with the Principle “*free at the point of need*”.

Car Park charges are £1 for 24 hours.

No one is exempt.

Attendants rove the car park and £40 penalty Non-payment NOTICES are stuck on winscreens. If these are not settled Solicitors letters arrive at home threatening a Small Claims Court action, not in Shropshire, £100 and costs.

It's all very intimidatory.

Ticket machines make life impossible for the Visually and Dextrously challenged elderly, disabled or infirm. One is expected to type in ones Registration Number.

C P Plus are the company who profit out of the sick's need to park near outpatients and the visiting worried relative's need to park while visiting.

Often the elderly sick's spouse is themselves an elderly pensioner; £1 seems little but mounts up when visiting daily over three or six weeks in hospital.

FREE at the POINT of NEED and this a RICH NATION. SHAME!!

*Peter C May, MB.ChB.,LRCP,FRCS*  
Senior Consultant Orthopaedic Surgeon.  
The Shrewsbury and Telford Hospital  
9 December 2005

---

**Memorandum submitted by Mr James Halsey (CP 6)**

1. I am a lay person involved in the NHS in a number of areas and do not feel sufficiently informed to respond to all of the Terms of Reference.

2. A patient-carer journey to hospital for many starts and ends with being transported by car and parking on hospital premises is part of that journey. All should be done to ensure as far as possible that the car parking part of the journey runs smoothly, thus as far as possible reducing the already raised stress levels as patient-carer enter the hospital proper.

3. I would like to respond in some detail regarding public-carer and staff car parking at some hospitals and have outlined my concerns and suggestions under the following headings shown below.

#### 4. PUBLIC CAR PARKING

Most appropriate system is to obtain a ticket on entry and pay on exit at barrier. The public have enough to worry about whilst in hospital and have no real idea how long they will be and this system avoids the worry of being clamped or receiving a ticket. The parking charges should be fair but not punitive and the Trust could publish separate accounts detailing the monies raised from car parking charges and where it is likely to be spent. Any barrier system would need to accommodate speed of access for emergency vehicles.

#### 5. STAFF CAR PARKING

Some Hospital Trusts have staff parking spaces allocated on a priority and non-priority criteria whereby staff are asked to contribute a monthly amount taken directly from salary but with no guarantee of finding a parking place. I think this process is unreasonable, unfair and appears a revenue raising process. With the majority of NHS staff being female, working irregular hours, on shift work, sometimes living some distance from the hospital and with difficult public transport links, action is needed to address this unsatisfactory situation.

#### 6. DISABLED PARKING

A limited number of disabled parking places are normally available but problems arise when all these spaces are taken. Some Trusts allow disabled drivers to park in paying places without payment but some do not and Clear Guidance is needed.

#### 7. SUGGESTION

Taking blood tests away from Acute Hospitals and into the community would free up many parking places for use by patient-carer and staff and also may be the preferred public option but could result in a fall in revenue for the Trust.

8. Any future PFI project should give serious consideration for allowing where possible adequate parking facilities.

*James Halsey*

*4 December 2005*

---

#### **Memorandum submitted by Mrs Josephine Hyde-Hartley (CP 34)**

Charges for treatments, including prescriptions, dentistry and optical services; and hospital services (such as telephone and TV use and car parking) are neither equitable or appropriate. They should be abolished.

The original and Best founding principles of the NHS are that it should be paid for by our taxes and be free at the point of contact, for all citizens in an emergency or otherwise.

Unless "Co-payment" includes a working "voluntary" element, it becomes a preposterous and pretentious pretext designed to benefit the "interests" of those who seek to over-regulate the public, because it's what they normally do. (See 1689 Bill of rights)

For example; both employees and patients of my local NHS Trust Hospital have "no alternative" other to pay for parking, either because it is removed from their wages or because there are no free car parks on-site.

As employees, we have to write a letter to the car parking people to get them to stop removing this monthly fee. Personally I argued to get my parking fee cut down, because I work part time. Otherwise we have to find elsewhere to park off-site, with no security or run the risk of "routine" penalty.

Creeping regulations! This is a fine example of how this so-called litigation culture is creeping into our lives as free citizens. (It also sounds uncannily like Lord Turners latest idea to "encourage" us to buy extra pensions cover)

Meanwhile on the wards it is plainly unfair that some patients cannot access the TV service over their beds because they have not the immediate means. Eg patients with no money and no-one to speak up for their rights, and whose journey through the various hospital wards might be very quick.

You should find out exactly whose "best interests" are being provided for, in the case of all these "co-payments" which have crept into the NHS, of late.

I hope you will discover that we can find a better way to redress any inappropriate inequalities which you may find. I have, in my "action research (n of 1)" which is still "in process". This is without recourse to this so-called litigation culture, which is spoiling the lives and jobs of too many (equal) stakeholders in UK Health and Social care.

I am currently trying to remedy similar inequitable and inappropriate burdens associated with my NHS contract and status as a patient in the best way I can find for all equal stakeholders, through “working in partnership”.

I think I have boiled it down to a question of “honour”, for the sake of reducing costs all round, in an emergency. To recover our Rights and liberties we should harness the best spirit of “voluntarism”, to remedy ridiculous and frustrating inequalities. The “Best interests” of the public are paramount in the Public Services.

Through “honour” we should be able to complement the Best practices of Public Service with private freedoms, by “working in partnership”. Through “raising a concern” we can share the risks associated with avoiding inequitable and inappropriate burdens, thus activating our Human Rights and liberties to improve things, where others cannot help.

Accountability can be used as an instrument of peaceful new deals for equal stakeholders, and as far as I can see the “up and coming” laws, legislations, policies and systems would allow this perfectly easily. If people would only communicate more openly!

I am wondering if there is some kind of “Hybrid” Law to support such local action. I’m thinking about this at the moment, but as a “common” person it’s all a bit strange and difficult, due to cultural and institutional barriers.

However, at this point I want to thank “Parliament” and all who are involved in these wonderfully empowering IT systems, which have allowed me to learn so much about this world and our Public Services, albeit in an awkward and clumsy way.

You might want to contact my good MP Janet Anderson, for a reference.

*Mrs Josephine Hyde-Hartley*

*14 December 2005*

---