

Co-payments and charges in the NHS

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 others¹, acknowledge the inconsistencies of the current system of charging, but given the broader question about access

¹ 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)

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 population².

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 tests³, 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.

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

² For example, the latest British Social Attitudes Survey for 2004 show that nearly eight out of ten 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 J and Alvarez A, (2005) '*Public responses to the NHS reforms*' In British Social Attitudes, 22nd Report (Eds: Park A et al), Sage, London, 2005

³ There is some irony in the fact that dentistry and ophthalmic services were most in demand on the inception of the NHS.

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 proportion⁴ 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 care⁵.

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 Hitiris⁶, 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).

⁴ For prescriptions, this may in fact exceed 100% if the actual cost of the prescribed item is less than the charge.

⁵ 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)

⁶ Hitiris T (2000) Prescription charges in the UK: A critical review. Discussion paper 2000/04. Department of Economics, University of York.

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.

Moreover, charges unrelated to ability to pay disproportionately burden the poor⁷ - for whom there is no reason to suppose have a greater tendency to ‘frivolous’ demand than the rich, and impact on clinically needed care⁸. 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

⁷ 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).

⁸ 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

a limited NHS budget, therefore, it is equally hard to make a case for the free provision of such clinically-peripheral services⁹.

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 voucher¹⁰.

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.

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'¹¹, 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 benefits¹². Although research has been proposed into the impact of the phased abolition of prescription charges in Wales¹³, in general there is little or

⁹ However, there remains a question concerning the reasonableness and consistency of charges for such services across the NHS.

¹⁰ Government Statistical Service (2003) Optical Voucher Survey, July 2001.
(<http://www.dh.gov.uk/assetRoot/04/06/09/92/04060992.pdf>)

¹¹ SMF Health Commission (2004) *User charges for health care*. SMF, London

¹² 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).

¹³ 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.

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.

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