

creeping charges

NHS prescription, dental & optical charges – an urgent case for treatment

by Saranjit K Sihota

everyday essentials:

meeting basic needs

About the National Consumer Council

The National Consumer Council is an independent consumer expert, championing the consumer interest to bring about change for the benefit of all consumers. We do this by working with people and organisations that can make change happen – governments, regulators, businesses and people and organisations who speak on behalf of consumers.

We are independent of government and all other interests.

We conduct rigorous research and policy analysis and draw on the experiences of consumers and other consumer organisations. We publish. We campaign. We help people to come together to advance the consumer cause.

Issues of disadvantage are at the heart of our work, as often the most vulnerable people find it hardest to be heard.

We have linked organisations in England, Scotland and Wales, and a close relationship with colleagues in Northern Ireland. And we work with consumer organisations in Europe and worldwide to influence European and global governments and institutions.

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

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National Consumer Council
20 Grosvenor Gardens
London SW1W 0DH
Telephone 020 7730 3469
Facsimile 020 7730 0191

www.ncc.org.uk
www.epolitix.com/forum/ncc

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Our Everyday Essentials project tackles three key questions:

- What are consumers' basic needs?
- What problems do consumers have obtaining the goods and services essential to meeting their basic needs?
- How can those basic needs be met?

The project's objective is to provide solutions to the problems of social exclusion by tackling the barriers that put goods and services out of reach. Of particular concern to the NCC are those goods and services essential to meeting consumers' basic needs.

We have published a range of reports as part of the project, including:

- *Consumers' views on what is essential* (a background paper), May 2002.
- *Funding universal access to essential goods and services*, November 2002.
- *Everyday essentials: meeting basic needs – research into accessing essential goods and services*, January 2003.
- *Who pays for essential goods and services: roundtable discussion on how to fund universal access to essential goods and services*, January 2003.
- *Everyday essentials: meeting basic financial needs – consumer perspectives on the government's universal banking services and the Saving Gateway*, March 2003.

The NCC also runs the Everyday Essentials forum to promote dialogue between consumer bodies and other organisations about consumers' difficulties in accessing essential goods and services. The forum also looks at the measures which can be taken at UK, European and international level to alleviate this disadvantage.

Please note: Information about prescription charging in this report relates to England only. There are currently moves to change arrangements in Scotland and Wales.

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Summary and recommendations

The National Consumer Council (NCC) has a special brief to represent the interests of disadvantaged consumers – those who, for various reasons, are excluded from adequate provision of the goods and services necessary for meeting basic physical and social needs. In healthcare, this group can include people on low incomes, living in deprived areas, with long-term medical conditions, learning difficulties or physical disabilities, mental health problems, some older people, minority ethnic groups, homeless people.

This report briefly covers the range of problems that low-income and disadvantaged groups of people have in accessing healthcare. We focus specifically on charges (prescription, dental, optical) for healthcare services. Because there is no systematic approach or well defined core NHS services, charges can quietly creep in as annually increased prescription costs, extra costs caused by unnecessary or inappropriate treatments. Being removed from an NHS list for GP or dental care forces patients into private healthcare at an increased cost. Charges can act as a barrier to access, perversely increasing the burden of ill-health for many rather than reducing it. We outline government policy on providing a universal service, and provide recommendations to address the increased inequalities imposed by healthcare charges.

This report is also informed by research the NCC undertook with disadvantaged groups of people as part of our ‘Everyday Essentials’ project that looked at access to everyday goods and services, including healthcare. In all our work, the NCC uses consumer principles to test whether markets and public services are meeting consumers’ expectations. In our analysis of healthcare provision, we use criteria developed as part of the ‘Everyday Essentials’ project – transparency; equity; effectiveness; and efficiency.

Health services

Good health is an essential requirement for people to be able to work and earn a living, and to enjoy a reasonable quality of life – free, as far as possible, from pain and suffering. Where there are ailments, diseases, and chronic conditions we look to healthcare services for cure or for help in managing the conditions to restore our quality of life, ability to work and participate in our preferred social activities.

The NHS as a universal service is a manifestation of the importance of health to individuals and society. It is underpinned by a set of principles, two of which are key:

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Since its inception, the NHS has evolved with many anomalies and contradictions. What is essential or not, and what should or should not be comprehensively available in the NHS, has never been clear. The accessibility and availability of services has always been patchy, posing a particularly severe hurdle for the disadvantaged and vulnerable groups in society. It is widely acknowledged that disadvantaged groups fall victim to the inverse care law – the groups in the greatest need are least likely to receive the health services they require.

The Labour government has introduced a number of initiatives – such as Sure Start and Health Action Zones – intended to improve the lives of low-income and disadvantaged groups. However, many of the health goods and services that consumers would probably consider essential are not comprehensively covered under the NHS. For example, spectacles and contact lenses are a private transaction for many people, as increasingly is the provision of dental care. Take-up of services can cause consumers financial hardship and therefore limit their access and benefit from them. Also, medicines prescribed by a doctor incur a charge.

Healthcare charges

Charges can be a deterrent to seeking treatment. For example, it is estimated that around 750,000 people in England and Wales fail to get their prescription dispensed because of the cost (1). Also, three-quarters of adults receive no help with the cost of NHS dental treatment and this figure increases to 82 per cent among adults aged 60 years and over.

While there are arrangements for certain sections of the population to be exempt from prescription, dental and optical charges, the eligibility threshold is so low that many do not meet it. They are squeezed beyond their means from accessing and affording the health services they need, inevitably compounding their ill-health.

There also are inconsistencies in how the charges are applied. For example, people over 60 are not automatically exempt from dental care costs as they are for prescription charges.

Because charging can exacerbate disadvantage, it raises the question: ‘are charges an effective way of raising or saving money for the NHS?’ The NCC sees that charges are more likely to discourage use of services altogether among people on low

incomes, and do little to change the behaviour of those who can easily afford the payments.

Deterring demand for services among those in need creates inefficiencies in the system by discouraging early diagnosis and treatment. Instead, treatment is diverted to more costly parts of the system, or delayed to a point at which it is more expensive.

Creeping charges

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. The absence of a rationale for charging has meant that, over the years, crab-like shifts in charging have been taking place. For instance, the Royal National Institute of the Blind (RNIB) claims that the NHS eye test is being eroded, with opticians narrowly defining what constitutes an eye test so that they can make supplementary charges (2).

Some dentists are, in effect, charging for access to NHS treatment. As dentists are able to choose whether or not to accept a patient, some are insisting on a private consultation, for which a refundable deposit is charged, before they decide whether to accept a patient. Where patients are on low incomes and would be entitled to free NHS treatment, this can prevent access to an NHS service. For example, it is reported that as many as one in four people paying for private dental treatment is forced to do so because they cannot find an NHS dentist (3).

If dental and optical services are essential then it is necessary to be clear about what aspects the NHS will provide, and remunerate dentists and opticians accordingly. Without this clarity there is no incentive for independent contractors (who are trying to run a business) to carry out NHS work properly. Instead it encourages ways of imposing new charges to the detriment of consumers by hindering their access.

Therefore, two fundamental questions emerge:

- what is the purpose of charging in a system funded by taxpayers, based on clinical need and not ability to pay?
- if there is a purpose, how can charges be made fair?

In this report, the NCC makes a number of recommendations, aimed at the government and the Department of Health.

Recommendations

Review

- There needs to be clarity on what is core NHS provision, and therefore what will be universally available. Core services should be properly funded so that practitioners are properly remunerated. We recommend a Core Services Commission, to run over a three-year period, with public consultation.
- A fundamental, ‘root and branch’ review of NHS charges and the system of exemptions is required. This will aid understanding of the impact of charges on the NHS principle of services based on clinical need and not ability to pay.
- There should be transparency about the revenue generated by NHS charges and how it contributes to NHS resources. There should also be an assessment of whether revenue could be better raised by other means.
- The rationale behind charges and arrangements for exemptions should be visible to consumers. Clarity is also required on when charges may apply and how much they will cost.
- While charges remain, consideration should be given to whether exemptions should be extended to certain groups currently paying charges – specifically, those whose income falls just outside the eligibility threshold. An examination of those chronic conditions that appear on the list of specified medical conditions should take place and be updated.
- In dentistry we support the Audit Commission’s recommendation that the current payment system should be replaced by one that emphasises prevention, treatment based on evidence of cost-effectiveness, and that addresses health needs.
- We also support the Royal National Institute of the Blind’s recommendation that the NHS eye test should be properly funded so that optometrists are paid to conduct a full eye test, and not a partial one that lacks essential eye health checks.

Information

- While charges remain, the Department of Health and all health service providers should ensure that they take responsibility to provide consumers with information about charges.
- The priority must be to ensure that no one fails to access healthcare because of financial difficulties. Therefore, the Department of Health should take responsibility for advertising the NHS Low Income Scheme and all types of exemptions to raise awareness among low-income consumers. The Department of Health should also regularly monitor the take-up of the scheme.
- The onus should not only be on consumers to find out, but also be on the service-provider to tell consumers when charges and exemptions apply. Service-providers should advise consumers when they can buy health services more cheaply by purchasing them privately, particularly for prescriptions.
- Pre-payment prescription certificates that cover all costs for a set four-month or 12-month period, should be more widely advertised. GPs and pharmacists should have a duty to inform patients about the certificate at the time their need for multiple prescriptions is first recognised.

Flexibility

- While charges remain, flexibility in payment arrangements should be introduced to allow low-income consumers access to healthcare services.
- The purchase of pre-payment certificates should be made more affordable. There could be a mix of ways – for instance, as Citizens Advice suggest, they could be purchased on a monthly basis at one-twelfth of the annual cost. For some low-income consumers, weekly payments would be more appropriate. Alternatively, as they do in other European countries, some patients could pay individual prescription charges until they reach a ceiling – the same cost as the pre-payment certificate.
- Help with paying prescription charges should be extended to people with incomes above the exempt levels. Therefore, we support the Citizens Advice recommendation of pricing the pre-payment certificate on a sliding scale, depending on a person's income, possibly linked to other means-tested benefits.
- Arrangements should also be made available for consumers to spread the cost of charges for items such as dental treatment or glasses and contact lenses.

Affordability

- While charges remain they must reflect consumers' ability to pay, so as not to prevent access to basic healthcare.
- To become equitable with other NHS charges, the maximum amount people have to pay for dentistry should be reduced.
- The Department of Health and the General Dental Council should work together to stop some dentists charging indirectly for NHS treatment.
- We support the recommendations of the Office of Fair Trading that the professional guidance issued by the General Dental Council is monitored and enforced to ensure there is transparency in charging and consumers know if they are being charged for NHS or private treatment. We also recommend that the professional guidance be clear on the application of cancellation charges, in terms of the level of charges and the circumstances in which they may or may not be appropriate.
- We support the recommendations of Citizens Advice that NHS vouchers for the purchase of glasses should meet the full cost of glasses.

1. Access to healthcare

Waiting times are a universally experienced problem in accessing healthcare. But this is not the only problem, and attention to improving waiting lists can often detract from a range of other problems that consumers face in accessing services. For instance it is widely acknowledged that groups in the greatest need are least likely to receive the health services that they require.

Therefore, the purpose of this chapter is solely to illustrate the experience of healthcare provision by disadvantaged groups, as background for understanding the impact of charges on their lives and their health. It is beyond the scope of this report to conduct a thorough examination of access difficulties and make appropriate recommendations.

Waiting lists

Users of the NHS are often blighted by waiting lists and lengthy waits for care at every stage of the healthcare pathway. The consequences include people waiting in pain (4) prolonged anxiety about a suspected diagnosis, and deterioration in an individual's health status (5). While progress has been made in cutting waiting times for out-patient appointments and in-patient treatment (6) some consumers are better served than others. Londoners, for example, suffer poorer access to healthcare than people in other parts of the country, with longer waiting times for both GP services and hospital care (7). Consumers also continue to face long delays in accident and emergency departments (8).

Government policy has focused heavily on this universal problem with high-profile initiatives to improve access such as NHS Direct and walk-in centres, and plans to treat NHS patients in private hospitals or overseas. The desire for good access to services is repeatedly expressed in terms of shorter waits for treatment (9) but it also reflects a desire for more flexible healthcare – including extended opening hours for GP services and hospitals (10) new responsibilities for some health service staff (11) and looking beyond traditional methods of providing healthcare – for example, three out of five internet users would seek help for mental health problems on the internet (12).

Access by disadvantaged groups

There is a long and well established link between poverty and ill-health. In 1997, the health gap between rich and poor was equivalent to nine years of life. A boy born into the poorest social group was likely to live for 68.2 years, compared with 77.7 for a boy in the richest social group. For women the gap was 6.4 years. This gap had widened over the previous 20 years, by four years for men and 1.1 years for women (13).

The sectors of the population hardest hit by problems of access include people on low incomes, those living in deprived areas, those with long-term medical conditions, learning difficulties, physical disabilities or with mental health problems. Others include older people, some minority ethnic groups and homeless people. The principle barriers to access vary across these different groups and according to the area of health service provision. However, these people can often fall into more than one marginalised group and the impact of disadvantage becomes cumulative.

These groups also tend to represent the heaviest users of services. Older people, for example, are the biggest consumers of healthcare – while they comprise around 16 per cent of the UK population, as a group they consume over 40 per cent of healthcare resources (14). In general, people living in deprived areas tend to be more frequent users of GP services and slightly more frequent users of NHS hospitals than those in other areas (15).

As part of its ‘Everyday essentials’ project, the NCC conducted its own research into the needs of disadvantaged groups – those on low income, minority ethnic groups, and families with young children. The results revealed specific problems, some of which are illustrated in this report, that service-providers need to take into consideration for improving access to healthcare (16).

Primary care services

GPs

It is important to note that fewer GPs tend to serve the most disadvantaged communities. In October 2000, full-time GPs numbered around 45 per 100,000 weighted population in Sunderland, compared with 69 per 100,000 in North Yorkshire (17). Registering with a GP can be particularly difficult in deprived areas where there are fewer GPs and practice staff per capita. Similarly, consumers can find themselves denied care altogether if their GP decides to remove them from the list, forcing them to register with a new, possibly less-convenient practice.

Some people can end up with a succession of temporary registrations if no GP is prepared to take them on permanently (18). For example, homeless people can find it difficult to register with a GP altogether because they tend to move frequently; this makes some GPs reluctant to provide them with permanent registration (19).

Dentists

Difficulties in accessing NHS dentistry are widely reported in many parts of the country. Following the implementation of a new contract with dentists in 1990, many dentists decided to reduce the amount of time they spent on NHS dentistry and

increase their private practice. The impact of this loss of NHS dentistry has been borne particularly by people living in rural areas and those on lowest incomes who would have been entitled to free or reduced-cost NHS dental treatment. They have faced either the cost of lengthy and expensive journeys to access their nearest NHS dentist, or have gone without treatment altogether.

Access to dentistry

The NCC's research revealed that many people had difficulty find an NHS dentist. Some were also concerned about the lack of provision during emergency situations. One consumer with a young family spoke of the fact that her young son had woken up each night for the last week with toothache, yet she didn't really know where to take him or what to do about it (20).

The Audit Commission reports that, in deprived areas, fewer people are registered with a dentist. Dental health tends to be worse in these areas, with children's decay levels in some places as bad as they were 15 years ago (21). Difficulty registering with a dentist as an NHS patient is one of the key barriers to NHS dental care, with large numbers unregistered (22) and many dental surgeries reportedly not taking on new NHS patients (23). Forty per cent of dental practices are not accepting children or adults for registration of NHS continuing, preventive care. And, in some places, no dentists will accept adult NHS patients (24).

Those lucky enough to register with a dentist for NHS treatment can fall victim to the rules that limit registration to a specified time period, or to changes in the services provided by the health professional they register with. Some patients drop off their dentist's list without realising (25). Attending a dental practice within the 15-month period is no guarantee of remaining on the list if a dentist decides to no longer provide NHS care (26).

Secondary care services

A study in the Thames region, exploring the relationship between social deprivation and mode of hospital admission for the three most common cancers (lung, colorectal and female breast cancer), concluded that deprivation strongly influenced the mode and type of admission, and odds of surgical treatment. People from the most deprived areas with these three cancers were less likely to receive therapeutic or palliative treatment, and more likely to be admitted as emergencies, rather than as planned day cases (27).

Research has shown that the death rate for Coronary Heart Disease (CHD) is three times higher among unskilled manual men of working age than among professional men. The death rate is over three times higher for people under 65 in Manchester than in Kingston and Richmond: 69.3 and 20.6 per 100,000 respectively in 1998-

2000 (28). Yet rates of hospital admissions for procedures such as coronary artery bypass grafts and coronary angioplasty are not higher in areas with the highest CHD mortality.

The lack of early intervention not only reduces the survival rates of individuals, but also demonstrates ineffectiveness and inefficiency in the delivery of healthcare resources to people in the greatest need.

Specialist services

There are marked inequalities in care, and long waiting lists for specialist services, such as eye surgery. High proportions of people who have cataracts or glaucoma are reported to have had no contact with eye specialists. There are wide variations in the availability of low vision services around the country, and only some areas have community-based rehabilitation officers.

Availability of specialist services for older people with long-term conditions is patchy (29), as well as for specialist mental health services, and cochlear implant services for deaf people (30). It is claimed that adults with a learning disability have very limited access to speech and language therapy and physiotherapy, and that responsibility for providing specialist learning disability healthcare services is unclear (31).

Preventive care

The take-up of preventive care, such as immunisations and screening, is reported to be lower in deprived communities (32). Analysis of the fourth *National Survey of Morbidity in General Practice* showed that the rates of consultation for preventive care were 37 per cent lower in men aged 16–24 years from the poorest social groups than for those in the richest social groups. For men aged 25–39 years, preventive care consultation rates were 31 per cent lower (33).

Children with a learning disability are less likely than children in the general population to have had a dental check in the last year. And women with a learning disability are reported to often miss out on cervical and breast cancer screening (34). Also, women of Bangladeshi origin are less than half as likely as those in the general population to take up invitations for cervical cancer screening (35).

Access to pharmacy services

In January 2003, the Office of Fair Trading (OFT) published its report on its investigation into the control of entry regulation in the community pharmacy sector. It concluded that:

...control of entry regulations should be lifted. They inhibit price competition. They stifle efficiency improvements and innovation. They limit the availability of pharmacy services. And they impose substantial regulatory burdens.

The report argues that local access will improve with deregulation, because it will bring expansion of pharmacies that offer consumers lower prices, more convenient opening times, and innovative services. However, others argue that removal of the control of entry regulations will encourage the expansion of supermarket pharmacies, driving out community-based pharmacies, therefore reducing access, particularly amongst deprived neighbourhoods.

The OFT believes that the present control of entry regulation does not encourage pharmacies to open up in areas of greatest need. Local health authorities have the power to grant or refuse an application; they do not have the power to force a pharmacy to open up in a poorly served area. The OFT cites work by the Social Exclusion Unit that gave cause for concern over the lack of access to pharmacies in some of the most deprived areas. The OFT's own work showed that eleven per cent of respondents did not feel that the pharmacy was easy to get to from their home. And 14 per cent did not think it was easy to get to a pharmacy from their GP's surgery (36).

The OFT believes that overall deregulation will be beneficial to consumers. Where pocket of access difficulties exist, they say there is a ready-made solution – the Essential Small Pharmacies Scheme (ESPS).

The ESPS

The ESPS gives financial assistance to pharmacies that are not economically viable because of their location, but are vital to the provision of pharmaceutical services for the local community. There are 340 pharmacies in the UK at present receiving ESPS payments.

The scheme is funded from the 'global sum' – a fixed pot of money for the remuneration of the community pharmacy sector and is negotiated annually.

Clearly this scheme is a very important safeguard for consumers in deprived areas or rural areas, where essential services can be at some distance. It is crucial that, should de-regulation go ahead, the ESPS is properly resourced.

The OFT report cites the figure of a little over £4 million in England and Wales drawn as ESPS payments – less than 0.5 per cent of the ‘global sum’ (see box above). However, the report does not comment on whether the scheme is working to best effect and whether the resource allocation is sufficient.

As part of ensuring access to pharmacy services in areas of need, the eligibility criteria and resource calculations for the ESPS need to be appropriate and transparent.

Access to transport

The poor availability of transport is linked to deprivation and geographical inequalities in health. Work by the Social Exclusion Unit shows that, because people rely on limited and costly public transport, access is restricted to services that promote health, including healthcare services, food shopping, leisure and social activities, thus compounding and contributing to health inequalities (37) – see box below.

Transport problems

Those without a car:

- 27 per cent face difficulties travelling to hospital
- 13 per cent find accessing primary care difficult
- 16 per cent find access to supermarkets hard
- 9 per cent find access to leisure centres hard
- 7 per cent find accessing libraries difficult.

Poor transport also contributes to the disproportionate suffering of groups with the worst health, through higher rates of pedestrian casualties and pollution, caused by living near busy roads.

Appropriate services

Too often, healthcare services are not designed with the specific needs of its patient groups in mind. This is particularly the case for groups who fall into the ‘disadvantaged’ categories.

Part of the problem is caused by inflexibility on the part of services. For instance, it is unlikely that someone with a learning disability will be able to present their health

problems in a ten-minute consultation slot. Inflexible appointment systems and opening hours can cause difficulties for consumers with particular service needs who do not fit the template of the 'average' service user.

A lack of understanding by healthcare professionals of the needs and experiences of disadvantaged groups means these needs go unrecognised. For instance the physical health of people with severe mental illness is reportedly often overlooked while health professionals focus on managing their psychiatric symptoms – despite the knowledge that their physical health is generally worse than that of the general population (38).

A lack of understanding by medical staff of the health needs of people with a learning disability and difficulties in communication has been identified (39). Health and social care staff often do not have the necessary skills to cope with these patients – for example, one in five adults in the UK is deaf or hard-of-hearing, but it is reported that the majority of GPs have not been trained to communicate effectively with these patients (40).

Services also reflect an inability to respond to the preferences and needs of different sectors of the population. For example, some cancer clinics sent letters in English to people whose first language is not English. Also, a study of dental surgeries found that less than half had wheelchair access.

Certain groups of Asian women, for instance, tend to place importance on being able to register with a female GP (41). People from a Bangladeshi origin are most likely to consider it important to see a GP from their own ethnic group. However, people from Indian, Pakistani and Bangladeshi backgrounds are more likely to be registered with a single-handed practice, which limits their choice of GP (42).

Specific needs of disadvantaged groups

NCC research shows that consumers from black and minority ethnic groups sought doctors from their own group in order to overcome the language barrier, and because they felt that this would ensure that their needs would be most effectively met.

The research also shows that the absence of proper translation and interpreting facilities meant that children and family were often used to help book doctors appointments or to read letters from hospitals about tests, thus leaving no scope for confidentiality (43).

Discrimination can deny access to services for certain groups of people. Examples include the upper age limit for routine breast screening and for a range of hospital services and operations, including coronary care and cardiac rehabilitation units (44). Some GPs are reluctant to provide annual health checks for people over 75 years of age and sometimes view older people negatively because they are perceived to generate a disproportionate amount of work (45).

Examples of less explicit age discrimination include longer waits in accident and emergency for patients over 60 years of age and inadequate discharge arrangements that leave older people without suitable rehabilitation and long-term support (46).

People with learning disabilities are sometimes discriminated against when it comes to treatment for problems such as heart disease. Health professionals have been known to make clinical judgements based on their opinion of the quality of life of a person with a learning disability rather than their immediate medical needs. Sometimes treatment is denied because they are deemed not to be able to manage the aftercare (47).

In conclusion, this chapter has shown that there are a number of problems experienced by consumers in accessing healthcare services. These problems range from a shortage of healthcare professionals to inappropriate services and poor transport. Coupled with healthcare charges for prescriptions, dental and optical care, problems of access help to aggravate the inequality for many disadvantaged consumers and can prevent these people from seeking the treatment they need. We look at charges in the following chapter.

2. Affordability of healthcare

Government advocates that the NHS is based on clinical need and not ability to pay. However, many of the health goods and services that consumers consider essential are not comprehensively covered under the NHS. Take-up of services can cause consumers financial hardship and therefore limit their access to them. For example, spectacles and contact lenses are a private transaction for many people, as increasingly is the provision of dental care. Also, medicines prescribed by a doctor incur a charge.

While there are arrangements for certain sections of the population to be exempt from these charges, the threshold is so low that many who do not meet it are squeezed beyond their means from accessing and affording the health services they require. Inevitably this only compounds their ill-health. For instance a study by Mori for Citizens Advice estimated that around 750,000 people in England and Wales fail to get their prescription dispensed because of the cost (48). The result is that consumers choose to take some, rather than all, their prescribed items, or restrict their dosages of medication to delay getting a repeat prescription. The system of exemptions is also not consistent. For example, people over 60 are not automatically exempt from dental charges as they are from prescription charges. In addition dental charges are not always transparent and consumers can be vulnerable to exploitative practices.

This chapter looks at the policy and practice of charging and the consumer experience.

Government policy

The importance of health to individuals and society is best manifested in the establishment of the NHS – as a universal service. The NHS Plan published by the government in July 2000 (49) explains:

Ever since its creation in 1948, the NHS has been available when we've needed it and has removed the fear of paying for treatment when we are ill. Its founding principles of providing access to care to all on the basis of need, not ability to pay, remain as important today as in 1948. In an age when our lives and jobs are undergoing constant change, it is reassuring to know that the NHS is there and will take care of us in times of need.

The NHS Plan is underpinned by a set of principles, two of which are of interest for the purposes of this paper:

- **The NHS will provide a universal service for all based on clinical need, not ability to pay.** *Healthcare is a basic human right. Unlike private systems the NHS will not exclude people because of their health status or ability to pay. Access to the NHS will continue to depend upon clinical need, not ability to pay.*
- **The NHS will provide a comprehensive range of services.** *The NHS will provide access to a comprehensive range of services throughout primary and community healthcare, intermediate care and hospital based care. The NHS will also provide information services and support to individuals in relation to health promotion, disease prevention, self-care, rehabilitation and aftercare. The NHS will continue to provide clinically appropriate cost-effective services.*

However, since its inception, the NHS has evolved with many anomalies and contradictions. What is essential or not, and what should or should not be comprehensively available in the NHS has never been clear. Another problem is that the accessibility and availability of services has always been patchy, posing a particularly severe hurdle for the disadvantaged and vulnerable groups in society. Why there are charges for a limited set of clinical needs, such as prescriptions, dental and optical services, what benefit they bring and how they are set, is not clearly stipulated anywhere.

There are a range of exemptions for prescription, dental and optical charges (explained in the relevant sections below). And there is also the NHS Low Income Scheme for people who are not eligible for exemptions, but may need help with costs on low income grounds (see box below).

In the period 2001/02 the Prescription Pricing Authority which administers the NHS Low Income Scheme, received 879,000 claims. Of these, 496,000 received certificates for full help and 305,000 received certificates for partial help. There is no significant fluctuation between these figures over the years. There is also no assessment of the scheme in terms of the numbers of people eligible and the numbers of claims received.

NHS Low Income Scheme

The Prescription Pricing Authority's Health Benefits Division administers the NHS Low Income Scheme on behalf of the Department of Health. Any help a person is entitled to is also extended to their partner and dependent children where applicable. Consumers whose capital does not exceed the specified limits can make a claim. The limits are:

- £19,000 for those permanently in residential care
- £12,000 for those aged 60 or over
- £8,000 for everyone else.

The guide on the NHS Low Income Scheme explains that the scheme assessments are broadly based on Income Support arrangements to determine how much, if anything, a person should contribute towards their health costs. The scheme also allows for the inclusion of council tax and housing costs in the assessment.

People whose income is equal to or less than their requirements are entitled to *full help* with NHS charges (all charges) and are given a HC2 certificate. Others on slightly higher incomes are deemed to be entitled to *limited help* with 'certain' NHS charges and a HC3 certificate is given, which shows how much they are expected to contribute to their health costs. The certificates are usually valid for periods between six and 12 months.

The guide also explains that each claim is assessed individually, and that there is no maximum income threshold beyond which it is still possible to qualify for help, because it depends entirely on the circumstances of the individual or family. The NHS Low Income Scheme is complex, involving a claim form with 49 questions running to 15 pages. The information guide runs to 12 pages. It is extremely difficult to keep track of eligibility across all the charges as there is much inconsistency between them. Also, there are different forms for claiming assistance or refunds for any charges already incurred.

Prescription charging

The prescription charge, the benefits system and the NHS prescribing patterns all combine to reduce access to medicines and underline the question ‘What is the purpose of the charge?’

Exemptions

Although there are exemptions from prescription charges, they are complex and often written in inaccessible language – for example, people suffering from one of a limited number of specified medical conditions, are listed only in medical language:

permanent fistula requiring continuous surgical dressing or requiring an appliance, forms of hypoadrenalism for which substitution therapy is essential, diabetes insipidus and other forms of hypopituitarism, diabetes mellitus except where treatment is by diet alone, hypoparathyroidism, myasthenia gravis, myxoedema, epilepsy requiring continuous anti-convulsive therapy, or people with a continuous physical disability requiring the help of another person to go out.

Other exemptions are: children under 16 or under 19 in full time education, people aged 60 and over, expectant and nursing mothers up to 12 months after the birth. Some people are also exempt from prescription charges on the basis of income – for instance people on income support and income-based jobseekers allowance, or who have £70 or less deducted from the maximum working families tax credit or disabled persons tax credit.

The prescription charge

In April 2003 the charge for a single prescription rose from £6.20 to £6.30. Where a prescription contains more than one item, each costs the full amount. Prescription charges are expected to raise some £434 million for the NHS in England in 2002–2003 (50). While significant, this represents only a fraction of the NHS prescriptions bill, for instance in 2002 over £5.5 billion was spent on primary care prescribing.

The government estimates that around 85 per cent of all prescription items are dispensed free-of-charge. However, among the 18–60 year old population, only 20 per cent do not have to pay prescription charges. Of the 80 per cent that do have to pay, pharmacists routinely see many people who experience difficulties affording their prescriptions (51).

There is much research evidence in the United States demonstrating the problems people face in meeting prescription costs, and the numerous strategies they use to reduce them, as well as the negative impact on their long term health. However, research evidence in the UK of prescription affordability is very limited. The University of Manchester has initiated a number of studies in this area. But the most extensive work on gathering the consumer experience of affording all charges has

been done by Citizens Advice (previously National Association of Citizens Advice Bureaux). We have relied on their work for this chapter of the report (52).

In the case of prescriptions the particular concern is that people suffering from long term chronic conditions in need of regular medication find it difficult to meet the cost of prescriptions. This is reinforced by a finding from a survey by Citizens Advice. It showed that 37 per cent of respondents with long-term health problems were unable to get all or part of their prescription dispensed, and that 50 per cent of all respondents said they had found it difficult to afford the cost of prescriptions (53).

The prescription charge is regressive, being a flat rate national fee. For consumers on incomes just above exemption levels, prescriptions can quickly become unaffordable. Given that disadvantaged groups are more likely to experience ill-health, they are also more likely to be exposed to this charge. The prescription charge therefore compounds the tendency for disadvantaged groups to have poorer health, thereby setting up a cycle of detriment.

There is evidence to show that in the case of some chronic conditions it is vital that treatment is constant, in order to gain beneficial clinical outcomes. For example, studies have shown that in the case of hypertension, missing out treatment for just a few days can increase the risk of stroke (54).

How consumers cope with prescription charges

A number of strategies are employed by consumers to manage the problem of affording prescriptions. These range from not purchasing the prescription at all, to delaying the purchase, purchasing only some items, reducing the dose to make the medication last longer and where possible purchasing cheaper over-the-counter products.

The University of Manchester conducted a study with 16 community pharmacies in the north of England. Over a period of six weeks the pharmacy staff recorded the reasons for the non-dispensing of prescriptions. Out of 587 prescriptions, 308 (52.5 per cent) were not dispensed. In most of these cases (242) an over the counter product was sold. But there were also 62 cases where an item was not dispensed and nor was it substituted by an over-the-counter product. And a third of these (22 cases) were for drugs which if not taken could lead to a negative impact on the patient's health (55).

NCC research found that a low-income consumer from Liverpool had been prescribed a particular type of painkiller but had found that she could not afford to keep up paying for the prescription. She had, instead, compensated for this by buying cheaper painkiller in bulk (56).

A large-scale study in Canada of older people and people in receipt of benefit demonstrated that prescription costs led to a reduction in the purchase of essential drugs. This led to a rise in the number of adverse events, for instance, visits to accident and emergency departments, acute and long-term in-patient stays, or death (57).

Recommendation: The rationale behind charges and arrangements for exemptions should be visible to consumers. Clarity is also required on when charges may apply and how much they will cost.

Recommendation: While charges remain, the Department of Health and all health service providers should ensure that they take responsibility to provide consumers with information about charges.

Prescriptions and the benefit system

Although people with income at income support level are exempt from prescription charges, others just a few pence above that level incur the full cost. These people who may be in poor health can find themselves facing the harsh dilemma of not purchasing their prescriptions or living below income support levels. Twenty per cent of those who report difficulty in affording prescription costs are on incapacity benefit or other disability and sickness benefits (58).

People on these benefits are further disadvantaged by the lack of a taper on help with paying prescription charges.

A Citizens Advice bureau in Nottinghamshire reported a woman who had a spinal condition and was in receipt of incapacity benefit. She suffered constant pain and required extensive medication. Her incapacity benefit was only around two pounds above her income support applicable amount. As a result she had to pay the full cost of prescription charges (59).

People particularly affected by prescription charges are those whose incapacity for work began before the age of 45, and thus may have long periods of ill-health before them. The age addition in incapacity benefit is likely to mean that they are not entitled to income support and therefore not entitled to receive any help with prescription costs.

People can also find that they lose their entitlement to free prescriptions just when they need it most. For instance, their declining health can result in their income falling because they have had to move from a means-tested tax credit to a contributory benefit (60).

A Citizens Advice bureau in Lincolnshire reported a couple in low paid work who were struggling to manage multiple debts. The woman had a number of medical conditions which required three different drugs each month. She was in receipt of disabled persons tax credit and was entitled to free prescriptions. But her condition worsened and she was forced to give up work. As a result her income dropped as she was now only getting the lower rate of disability living allowance. But she also lost entitlement to free prescriptions, as she lost entitlement to disabled persons tax credit and was not in receipt of income support, because her husband was in work (61).

Prescribing patterns and consumer behaviour

Prescribing patterns can affect consumer behaviour – for example, deterring patients from taking their medication. Also, if a medical condition requires multiple prescriptions, the costs can be very steep, to the point of prohibitive.

A survey of 455 people with mental health problems found that these patients were spending an average of £37 each month on prescription drugs, with a small number running up monthly bills of £100 (62).

For patients suffering from conditions requiring long-term medication, the numbers of drugs and the duration for which they are prescribed both impact on cost. The cost factor means that patients can find that £6.30 pays for anything between one week and three months' supply of a single item. There may indeed be valid clinical reasons for prescribing small quantities. But due to the financial constraints of many low-income consumers, the costs of frequent prescriptions can result in patients not purchasing the medication prescribed at all.

The practice of prescribing on a monthly basis cannot always be deemed as good practice, as it evidently has negative consequences for some low-income consumers. Even as an endeavour to reduce waste it ultimately fails. The people most in need are least able to afford the necessary medication. This compounds their ill-health and increases the need for treatment and therefore cost to the NHS.

Increasing prescribing costs are one of the biggest concerns for GPs. To help contain costs, they try to prescribe generically. The British Generic Manufacturers Association says the average cost of a generic drug in England is £3.52, compared with £17.38 for an 'originator' drug. Up to 74 per cent of prescriptions are now written generically in the UK

The National Service Frameworks (NSFs) show the problems faced by the prescribing system (see box below).

National Service Framework (NSF) for Coronary Heart Disease

The NSF aims to reduce health inequalities by improving access to care for the most in need and currently least likely to receive it. The NSF for Coronary Heart Disease states that

resources will be targeted at those in greatest need and with the greatest potential to benefit.

The NSF has been noted as having increased the volume of cardiovascular drugs prescribed by 11.7 per cent during 2001. But interestingly, not everyone who could benefit is currently prescribed them. The key drug is statins, it helps to reduce cholesterol and other risk factors and are widely used in the primary and secondary prevention of CHD.

The Audit Commission comments that a significant proportion (39 per cent in one study) of those taking statins are not in the high-risk group as defined in the NSF, while large numbers of patients (up to 75 per cent of men who have suffered angina, and 66 per cent of men who have had heart attacks) who fit the profile of those likely to benefit from the drugs, are not receiving them. These are mainly patients who were diagnosed five to ten years ago. On the other hand, many patients (up to 75 per cent after two years) who are prescribed statins, stop taking them (63).

The problem is that until statins come off patent they are expensive, they should be coming off this year. statins cost around £30 per patient per month. What makes them expensive is the number of patients who could benefit from them, often more than ten per cent of a practices' patients.

It is questionable therefore whether the revenue generated by the prescription charge increases the availability of medicine. At the very least it raises the question: 'What does it contribute to the NHS?'

Pre-payment certificates

Pre-payment certificates which cover all prescription charges within a set period are available to purchase – £90.40 for 12 months or £32.90 for four months. Pre-payment certificates can be helpful for heavy prescription users as they cap the cost by covering all prescription charges in the period of the certificate. But the reality is that those who find paying a single prescription charge difficult, inevitably find it difficult, if not impossible, to advance the lump sum payment for the purchase of a certificate.

Do consumers use pre-payment certificates?

The Citizens Advice survey (64) shows that use of pre-payment certificates is not widespread. Of the 1085 respondents who had had to pay for prescriptions only 56 (5 per cent) used a pre-payment certificate. 27 per cent said that the reason they had not considered a certificate was because they could not afford it. This increased to 39 per cent among people with long-term conditions and who would benefit most from the certificate. Another 27 per cent said they did not know about pre-payment certificate and how they can be purchased, indicating the need for more information.

A study by the University of Manchester (65) also discovered that there:

was a surprising lack of knowledge about the existence of these certificates, even among participants who may have benefited...a number of participants pointed out that a Pre-payment Certificate is expensive and not everyone could afford such a lump sum in one go.

The study suggested that one solution is that patients could pay individual prescription charges until they reach a ceiling (the same cost as a pre-payment certificate). This would be a similar system to that already in place in some other European countries. However, this fails to address the point that some patients struggle to meet the costs of individual prescription charges in the first place.

Recommendation: While charges remain, flexibility in payment arrangements should be introduced to allow low-income consumers access to healthcare services.

Recommendation: The purchase of pre-payment certificates should be made more affordable. There could be a mix of ways – for instance, as Citizens Advice suggest, they could be purchased on a monthly basis at one-twelfth of the annual cost. For some low-income consumers, weekly payments would be more appropriate. Alternatively, as they do in other European countries, some patients could pay individual prescription charges until they reach a ceiling – the same cost as the pre-payment certificate.

Recommendation: Help with paying prescription charges should be extended to people with incomes above the exempt levels. One way of doing this could be by pricing the pre-payment certificate on a sliding scale, depending on a person's income, possibly linked to other means-tested benefits.

Recommendation: Arrangements should also be made available for consumers to spread the cost of charges for items such as dental treatment or glasses and contact lenses.

Recommendation: Pre-payment prescription certificates that cover all costs for a set four-month or 12-month period, should be more widely advertised. GPs and pharmacists should have a duty to inform patients about the certificate at the time their need for multiple prescriptions is first recognised.

Recommendation: While charges remain they must reflect consumers' ability to pay, so as not to prevent access to basic healthcare.

Dental charges

Many people (for example, children and pregnant women) are entitled to free NHS dentistry. People on income support and income-based jobseekers' allowance, or who have £70 or less deducted from the maximum working families tax credit or disabled persons tax credit, do not have to pay. In addition there is tapered help, as incomes rise above the exempt level through the NHS Low Income scheme. But, even though they are exempt from prescription costs, people over 60 are not automatically exempt from dental charges.

Three-quarters of adults receive no help with the cost of NHS dental treatment. This figure increases to 82 per cent amongst adults aged 60 years and over. People not entitled to free or reduced-cost NHS dental treatment pay 80 per cent of the cost of a course of NHS treatment up to a maximum of £366. This is a much greater figure than for any other NHS charge.

The NCC's research showed that many low-income consumers are deep in debt, with those with young families in the severest debt. The most common reason cited for this was simply the cost of paying for the upkeep of the children. The research shows that, for low-income consumers, existence is a day-to-day grind, with little or no scope for long-term financial planning and saving for essential goods and services (66).

Recommendation: To become equitable with other NHS charges, the maximum amount people have to pay for dentistry should be reduced.

Dentistry-related charges

There is a lack of transparency on charging which means consumers are vulnerable to exploitative charging practices. Information is usually not available to consumers on what services are available under the NHS, what services are only available privately, and the differing prices, penalties and quality of service offered by dentists. This lack of basic information denies consumers any ability to exercise even a small degree of choice, with those on the lowest incomes penalised the most.

Guidance issued by the General Dental Council (GDC) – the regulatory body for dentistry – states that information about treatment and costs should be given to consumers, including (67):

- ensuring that the cost of initial consultation and of probable costs of treatment are made clear before treatment (with written plans particularly for extensive or expensive treatment)
- explaining proposed treatment and any alternatives, and obtaining appropriate consent from patients
- ensuring that patients receive an itemised account of their treatment
- not giving incorrect information to persuade patients to accept private treatment and ensuring that patients know whether they are being charged under the NHS or privately.

In its market investigation of private dentistry, the Office for Fair Trading (OFT) reported that:

consultations and surveys show that compliance with the guidance is not routinely monitored, and that many dental practices are not following it (68).

Aside from treatment charges, another cause for concern is that some dentists are indirectly charging for access to NHS treatment. In order to decide whether to accept a patient, some insist on a private consultation for which they charge a refundable deposit. Charges of £20 to £25 have been cited by Citizens Advice, this can be hard to find for some people on low-incomes entitled to free NHS treatment. And can therefore prevent access to an NHS service (69).

A second area where charges are increasingly being imposed is for missed appointments, with charges up to £30 reported by Citizens Advice. Although it is understandable that dentists want to ensure their time is not wasted, the approach is not even-handed.

Some dentists are imposing charges for missed appointments without consideration for the reason the individual did not attend or for their ability to pay.

The NCC's research confirms this also -- consumers were afraid of being struck off the list by the dentist, simply because they were unable to keep an appointment. The consumers explained that failure to keep an appointment was due to having to rely on public transport and or having to cope with children (70).

Recommendation: We support the recommendations of the Office of Fair Trading that the professional guidance issued by the General Dental Council is monitored and enforced to ensure there is transparency in charging and consumers know if they are being charged for NHS or private treatment. We also recommend that the professional guidance be clear on the application of cancellation charges, in terms of the level of charges and the circumstances in which they may or may not be appropriate.

Recommendation: The Department of Health and the GDC should work together to stop some dentists charging indirectly for access to NHS treatment.

Some underlying influences on consumer charges in NHS dentistry

As many as one in four people paying for private dental treatment are forced to do so because they cannot find an NHS dentist (71). The government claims that as much as 90 per cent of the public has access to an NHS dentist via its telephone helpline NHS Direct. Yet dentists' private-sector earnings are now greater than those from their NHS fees.

The decline in NHS dentistry is in large part due to the remuneration system for NHS Dentists, which has remained largely unchanged since 1948. NHS dental care is provided through the General Dental Service scheme (GDS). The scheme works on a piecework basis. A list of activities can be carried out and paid for under the NHS (over 300 activities called 'items of service'). When a dentist carries out these activities (a check-up, taking an x-ray, filling a tooth) they complete a claim form. The forms are assessed by the Dental Practice Board to see whether they match the rules of the GDS, and if so, they pay the dentist. The fees for each activity are set, so that the dentists can make an income, and also take account of overhead costs, including costs of premises, staff, equipment and materials.

The Audit Commission explains that individual dentists need to carry out a certain level of activity in order to remain in business. It reports that dentists are increasingly angry at how hard and fast they have to work with NHS patients to earn the level of income that they need to pay for their premises and staff costs, which they have to meet themselves – they call it a treadmill.

The results of this treadmill are an increase in unnecessary treatment and also a decline in quality. The Audit Commission reported that the NHS wastes £150 million a year on unnecessary dental check-ups and treatment. It explains that 11 per cent of the dental budget is spent on scaling a polishing, although the benefits are only cosmetic in most cases. Also, most adult patients are advised to return for check-ups every six months, when, in fact, a check-up is more clinically appropriate every two or three years (72).

In 2000, the National Institute of Clinical Excellence (NICE) said that dentists should stop extracting wisdom teeth as a precautionary measure, as there was no evidence that there was any medical benefit, unless the teeth were diseased (73).

As the box above shows, the way dentists are funded can lead to charges for consumers. If there is over-treatment, then clearly it is a huge waste of public funds, without any improvement to the dental health of consumers. Therefore the remuneration system coupled with a lack of evidence base on what is clinically effective, is creating alarming inefficiencies to the detriment of consumers.

Recommendation: In dentistry we support the Audit Commission's recommendation that the current payment system should be replaced by one that emphasises prevention, treatment based on evidence of cost-effectiveness, and that addresses health needs.

Optical charges

Eye tests are available free to: people aged 60 or over; children under 16; young people in full-time education; diagnosed glaucoma patients; people 40 or over who are an immediate relative of a diagnosed glaucoma patient or who have been advised that they are at risk of the disease; people who are diabetic, registered blind or partially sighted, who need complex lenses. As for prescription charges, HC2 and HC3 certificates are also issued to those eligible for full or partial assistance under the NHS Low Income Scheme.

In order to help with the costs of glasses, contact lenses and the cost of their repair or replacement, NHS vouchers are provided to some of the eligible groups above. The voucher is valid for two years, as long as the person continues to be entitled to help with the cost of glasses or contact lenses. The vouchers are for pre-set amounts and depend on the type of lens required and an assessment of the person's financial circumstances. The vouchers are not based on the actual cost that the patient has to pay, because items are not available within the voucher value. Individuals have to ask for a voucher form when they have their sight test, or when they order glasses or contact lenses. The optician then claims back the value of the voucher from the local health authority.

Instead of the cost being reduced for low-income consumers, the vouchers are a means of payment. The cost of eye tests and glasses varies, but the assistance through the NHS Low Income Scheme is for fixed amounts, depending on the type of lens required. The individual must then hunt around for the best deal, and where necessary, meet any shortfall. Therefore, even people on income support and entitled to vouchers can end up having to pay towards the cost of glasses themselves.

A Citizens Advice bureau in Cleveland reported a retired man in receipt of income support who needed new glasses. He had visited several opticians but could not find one that would supply glasses within the value of his £64 voucher. Most charged around £90 (74).

Over the years, the Department of Health figures show a fall in the numbers and percentage of vouchers redeemed meeting the full cost of glasses. A survey in 1996 found that while in the North and South East, 19.3 per cent and 16.4 per cent of vouchers were redeemed meeting the full cost, the figures were much lower at 0.9 per cent in the South West. This may, in part, be due to the South West being a predominantly rural area, and as such people may not have easy access to a large town and the benefit of competition and choice (75).

It is interesting to note that the extension of eligibility for NHS eye tests to people aged 60 and over since April 1999 led to a 34 per cent increase in NHS sight tests in the following year, but this was followed by a 3 per cent decrease in the number of vouchers redeemed compared to the previous year. This suggests a poor take-up of the NHS Low Income Scheme amongst older people that have low-incomes.

Regardless of free NHS eye tests, it seems that some people aged 60 and over are deterred from having eye tests because they are concerned about cost of glasses. A survey by the RNIB in 1996 (before free eye tests were introduced) discovered that of those who had not had an eye test within the previous two years, 12 per cent cited the cost of glasses being too prohibitive as the reason. This is almost as many as were deterred by the cost of the eye test – 15 per cent (76). The 1989 Sight Test Regulations should be clarified, or amended so that there is a standard comprehensive NHS Eye Test.

The way optometrists are funded can also mean increased costs for consumers.

Some underlying influences on consumer charges - NHS eye tests

The Royal National Institute for the Blind (RNIB) fears that the NHS eye test is being eroded. It explains that in some areas people are being denied full NHS Eye Tests, due to inadequate funding from the government. This is leading some optometrists to charge for essential eye health checks that could detect diabetic eye disease and glaucoma early, and even to charge for first aid treatment traditionally given free. But as well as finding signs of eye disease, other conditions such as raised blood pressure and brain tumours can be picked up at a routine eye examination.

The RNIB quotes a survey by the association of its members, this reveals that so far 27per cent of optometrists are charging supplementary fees. The tests that patients may be charged for include:

- pupil dilation – essential for monitoring patients with diabetes and detecting signs of eye disease in many older people.
- repeat pressures and field tests – for patients at risk of glaucoma
- tests to detect 'lazy eye' and squint in children.

Where patients cannot pay, they are placed on a waiting list to see their Hospital Eye Service, which the RNIB claims involves a wait of anywhere between three to six months. This time loss, it argues, is critical, and could even lead to permanent loss of sight.

An eye test costs optometrists approximately £23.50, but the Department of Health pays the optometrist only £16.72, this is 70per cent of the actual cost of providing the service. The RNIB argues that the eye test is heavily subsidised by dispensing, resulting in expensive glasses and contact lenses.

Recommendation: We also support the RNIB's recommendation that the NHS eye test should be properly funded so that optometrists are paid to conduct a full eye test, and not a partial one that lacks essential eye health checks.

Recommendation: We support the recommendations of Citizens Advice that NHS vouchers for the purchase of glasses should meet the full cost of glasses.

3. The NCC's analysis of charging and exemptions

As part of the NCC's 'Everyday essentials' project, looking into access to essential goods and services, we used the following criteria to examine the system of healthcare charges and exemptions (77).

Criteria for evaluating funding universal access

Transparency

- Policy objectives and performance: is it clear why there is a need for a subsidy and what it is trying to achieve? What is it achieving?
- Roles and responsibilities: is it clear to suppliers, regulators and consumers who is providing and paying for universal access?
- Movement of funds: can we trace the direction and quantity of subsidy from those who pay through to those who receive it?

Equity

- Affordability: in meeting the costs of providing universal access, are the costs affordable to all? Is there any cross-subsidisation of one group of consumers by another justifiable?
- Accessibility: are essential goods and services available and affordable to all on an ongoing basis?

Effectiveness

- Targeting coverage: does the funding mechanism reach all of those in need?
- Maximising take up: do barriers exist preventing those in need taking advantage of access possibilities?
- Ensuring predictable, secure and reliable supply: can suppliers and consumers achieve the desired nature of supply in the short, medium and long term?
- Encouraging innovation: are there sufficient incentives to encourage the supplier and other parties to find better ways of ensuring universal access?

Efficiency

- Minimising waste of resources: could those in need be helped better through other means? Are subsidies funding access for people who are not in need?
- Minimising distortions: does the funding approach affect demand for goods and services, employment or the prices of goods and services?
- Minimising administration costs: are there opportunities to reduce duplication, bureaucracy and processing time?
- Minimising supplier/consumer costs.
- Minimising cost to taxpayers.

Transparency

Health charges and their extension have been regularly proposed and rejected by all complexions of governments and political parties since the NHS began. There is no clear rationale for their existence, but history suggests that they have been used as a means of curtailing or containing public spending, and a means of subsidising or protecting other specific areas of public expenditure.

The first initiative to introduce charges was justified by Clement Atlee, when Prime Minister, on the grounds of promoting efficiency of use and eliminating waste, rather than only as a means of raising revenue. He suggested that charges were a way of reducing excessive and, in some cases, unnecessary access to doctors and chemists. Therefore, they were a ‘deterrence against extravagance, rather than as an economy.’

When he was Health Minister, Anuerin Bevan defended his support of prescription charges in 1949, while admitting that he ‘knew charges were impracticable’, in order to save the housing building programme, for which he was also responsible. In 1951, during the passage of the bill for dental and ophthalmic charges, Marquand, Bevan’s successor, argued that they were necessary for urgently needed hospital development. The Cabinet also argued that the charges would help pay for increased pensions.

The debates about the relative merits of specific charges are linked to priority-setting in the NHS. For instance, for Bevan, free dental and ophthalmic services were considered more important than free prescriptions because they had not been available before on the NHS.

Marquand argued that dental charges were necessary to restore the dental service to ‘priority groups’. Therefore, charges for false teeth and spectacles were justified because: ‘those who required them were normally at work and in a good state of general health. It was a different matter to impose charges on the sick.’ (78).

In its report on dentistry last year (79) the Audit Commission asserted:

In 2002 patients are faced with charging levels that have more to do with history than with a modern policy, based on what level of charges can best promote good dental health and, at the same time, provide the taxpayer with appropriate value for money. There is, therefore, a strong case for the charging system, including the current exemption criteria, to be reviewed... Any review should assess the evidence that shows that some people appear not to access necessary dental healthcare because of its cost.

Creeping charges in healthcare

Since 1948 to the present day, healthcare charges do not seem to solve the problem of inappropriate or unnecessary treatment nor the problem of containing costs. By the same token, they do nothing to promote access, equity, affordability and cost effectiveness for the consumer. Instead, they entrench health inequalities.

This is not to say that charges (or co-payments, in health policy jargon) are ruled out of the NHS for services that are not central to the core goal of health, such as car parking at clinics or internet access in hospitals. Charges can extend choice for consumers and allow additional services to develop in an entrepreneurial way to meet people's preferences. The shift towards more local delivery and decision-making in the NHS is likely to lead to experimentation of this kind. Our concern is that, because the NHS has never said what is 'in' and what is 'out' in terms of core services, there will be no systematic approach and every chance that creeping charges, with unintended health effects on disadvantaged consumers, will grow.

For example, in 2002, a survey revealed that more than 550,000 patients were removed from lists for podiatry care, forcing many into the private sector at £30 a visit. This particularly affects elderly patients with foot disorders that require up to four treatments a year. A study by Northampton University found that many are unable to pay. As a consequence, the problems become so severe as to rob them of their mobility and independence (80).

In terms of creeping dental, optical and prescription charges, see box below.

Dental, optical and prescription charges

Dentists' private-sector earnings are now greater than those from their NHS fees with the number of adults registered with an NHS practitioner falling from 51 per cent of the population to 44 per cent in 2002 (81). The decline in NHS dentistry is in large part due to an inadequate remuneration system for NHS dentists. It has remained largely unchanged since 1948 which means that dentists are working on a fees-per-item basis, having to carry out a certain level of activity to remain in business. As such over the years there has been an increase in unnecessary treatment and a decline in quality. The Audit Commission reported that the NHS wastes £150 million a year on unnecessary dental check-ups and treatment (82).

In the case of optical charges the NHS eye test is being steadily eroded. The RNIB claims that by law the test should include whatever eye health examinations are clinically necessary to detect signs of injury, disease or abnormality in the eye or elsewhere. However the Association of Optometrists claims that regulations do not require them to carry out many vital checks as part of the NHS eye test, and as such they can make supplementary charges for these checks. An eye test costs optometrists approximately £23.50, but the Department of Health pays them only £16.72, this is 70 per cent of the actual cost of providing the service.

Prescription charges are expected to raise £434 million for the NHS in England in 2002/03; this is projected to increase to £446 million for 2003/04 (83). Since their re-introduction in 1968, the charges on NHS prescriptions have increased at least ten pence every year, with some yearly increases having reached as much as 50 pence (84).

Some countries, such as Canada and Singapore, define their core services with precision. Others, such as New Zealand, have found it hard to do. Although it may have been convenient to not have clarity about what constitutes core services, the National Service Frameworks and the clinical guidelines of National Institute of Clinical Excellence (NICE) present the beginnings of defining what core services should be.

There could be two ways to build on this to achieve clarity and give consumers a clear sense of their rights and their responsibilities. The first is to ask ministers to decide. The second is to use a participative public process with the kind of deliberative techniques developed by political scientists to allow ordinary people to get up to speed on issues before they decide.

The weakness of this is that special interest groups can prevail and the heroic search for consensus that characterises these models of public participation may not allow for the best set of trade-offs. We recommend a balance of the two, using a participative public approach to gather views and perspectives that would not otherwise be heard, and a ministerial taskforce, drawing on health expertise to reach decisions.

Recommendation: There needs to be clarity on what is core NHS provision, and therefore what will be universally available. Core services should be properly funded so that practitioners are properly remunerated. We recommend a Core Services Commission, to run over a three-year period, with public consultation.

Recommendation: A fundamental, ‘root and branch’ review of NHS charges and the system of exemptions is required. This will aid understanding of the impact of charges on the NHS principle of services based on clinical need and not ability to pay.

Recommendation: There should be transparency about the revenue generated by NHS charges and how it contributes to NHS resources. There should also be an assessment of whether revenue could be better raised by other means.

Roles and responsibilities

The onus is on individuals to find out whether they are exempt from health charges, or entitled to other financial assistance. Consumers are often unaware of basic rights such as these (85). And, unless they know where to check, or who to ask about their entitlement before they need treatment, they may have to pay and claim a refund later. Not only can this leave consumers out-of-pocket for some weeks, they then might find that they only qualify for limited, not full, help.

The practitioner (GP, pharmacist, dentist, optician) may or may not know the information themselves but the NHS information guide, *Are you entitled to help with health costs?* lists practitioners, along with the Social Security Offices, Benefits Agency, Post Office, Health Authority and the Health Benefits Division of the Prescription Pricing Authority as sources for the different forms, depending on the charges and exemption (86).

The time limit for claiming refunds is within three months of paying the charge, and receipts are required. In the case of prescriptions, it is up to the consumer to know to ask the pharmacist, hospital or doctor for a receipt form FP57 at the time that he or she pays. This is because it is not possible to get the form later.

Recommendation: The onus should not only be on consumers to find out, but also be on the service-provider to tell consumers when charges and exemptions apply. Service-providers should advise consumers when they can buy health services more cheaply by purchasing them privately, particularly for prescriptions.

Equity

The NHS Plan (87) devotes a chapter to “Improving health and reducing inequality”, in which the government acknowledges:

The gap between health needs and health services remains stubbornly wide. The worst health problems in our country will not be tackled without dealing with their fundamental causes. This means tackling disadvantage in all its forms – poverty, lack of educational attainment, unemployment, discrimination and social exclusion. It means recognising the specific health needs of different groups, including people with disabilities and minority ethnic groups.

Since the Labour government came into power there has been a steady flow of initiatives intended to improve the lives of low-income and disadvantaged groups – Health Improvement Plans, Health Action Zones, Healthy Living Centres, Sure Start, New Deal for Communities, Local Strategic Partnerships, Personal Medical Service Pilots, Personal Dental Service Pilots and National Service Frameworks. A Performance Assessment Framework has also been introduced.

Health improvement, including reducing health inequalities, and ‘fair access’ to health services according to need, are among the six goals defining the Performance Assessment Framework for the NHS. The framework is intended to ensure that universal standards are applied across the NHS and that low-income and socially-excluded groups and localities are not doubly disadvantaged by also having poorer

quality health services. The National Service Frameworks help to set the parameters for performance assessment.

Moreover, as a result of a review of NHS resource allocation in 1998, with the aim of contributing 'to a reduction in avoidable health inequalities', a 'Health Inequalities Adjustment' was made. This shifted the basis of allocation from securing equal opportunity of access to patients in equal need, towards positive action in favour of deprived areas.

In 2001/02, the 47 health authorities judged to have the highest rates of 'avoidable mortality' received an additional £70 million while a further £60 million went to Health Action Zones. This small addition to the £37 billion distributed to health authorities on the traditional 'equity of access' criterion might be expected to fund such NHS interventions as: increased levels of treatment for targeted populations; greater effort to secure patient compliance; and targeted health promotion measures (88).

The government has initiated a huge raft of local and neighbourhood based activities aimed at regenerating and strengthening communities, improving public services and quality of life – all which can begin to help reduce the 'health gap'. However, the King's Fund argues that much of the time government efforts have lacked definition and leadership. Moreover, it asserts that the more the government focuses on 'saving the NHS', the harder it becomes to pursue an agenda about 'health' aimed at reducing inequalities, improving health and monitoring demands on the NHS that are triggered or exacerbated by social and economic factors (89).

Therefore the King's Fund concludes that:

...health inequalities still appear to be a second order issue, liable to be elbowed out by more pressing problems presented by a massive provider of treatment and care. That is potentially bad news for health, especially for those most likely to get ill and die young. It is ultimately bad news for the NHS as well. And it could prove embarrassing for a Government that pledged to improve the health of the poorest when it took office in 1997.

However, with regard to charges, it is important to note that in looking at the 'Options for funding healthcare' in the NHS Plan the government argues that:

Charges are inequitable in two important respects. First, new charges increase the proportion of funding from the unhealthy, old and poor compared with the healthy, young and wealthy. In particular, high charges risk worsening access to healthcare

by the poor. Second, exempting low-income families from user charges can create inequities for those just above the threshold.

Yet in view of this argument, nothing has been forthcoming that specifically tackles the problems of existing healthcare charges and their severity for some. Even a review of the current system of NHS charges has not been proposed.

The Wanless Review (90) instigated by the Treasury, of the long-term trends affecting the health service took the view that:

The impact on equity of out- of- pocket payments for items, such as prescriptions, depends on how effective a safety net is in place to exempt all of those who cannot afford such payments....However the present structure of exemptions for prescription charges is not logical, nor rooted in the principles of the NHS.

Recommendation: The priority must be to ensure that no one fails to access healthcare because of financial difficulties. Therefore the Department of Health should take responsibility for advertising the NHS Low Income Scheme and all types of exemptions to raise awareness among low-income consumers. The Department of Health should also regularly monitor the take-up of the scheme.

Effectiveness of exemptions

Exemption arrangements for health charges would appear to be driven both by concerns about affordability and equity, but also about need for services. For example, free sight tests for people registered blind or partially sighted, or suffering from diabetes or glaucoma, and free prescription and dental treatment for pregnant women. However, the rationale behind the exemptions is often unclear, including why they lack consistency across the different charges, but particularly when considered next to evidence that people are deterred from getting the services they need because of the cost.

Also, the arrangements for exemptions are outdated and inappropriate. Many people with chronic conditions are not exempt from charges for life-saving medication. Many of these are more disadvantaged than some of those presently exempt (91). For example, adults with cystic fibrosis were excluded from the approved list of medical conditions drawn up in 1968 because children with the disease were not expected to live to adulthood.

The approved list remains unchanged and today approximately 1,000 adults with the disease pay prescription charges. Most are 30 years of age or under and often not earning high salaries as their condition has affected their education and employment prospects. Without prescribed drugs their condition would deteriorate rapidly (92).

Transplant patients, people with asthma, with Parkinson's disease, and certain types of epilepsy, all have to pay for prescriptions for basic medicines. Students with chronic conditions must pay for medicines (93).

Clinical explanations for these anomalies are not obvious, but financial reasons possibly are, because the exempted conditions often involve smaller numbers. It is also argued that conditions that qualify for exemption tend, in the main, to be less stigmatised than those for which no exemption is given. For instance, people with epilepsy, who need continuous anti-convulsive therapy are exempt, but not those who have schizophrenia or paranoia (94).

The anomalous nature of these arrangements is such that patients who are exempt from prescription charges because they have one of the medical conditions listed, get all their prescription items free, including for routine health problems unrelated to the condition that qualifies them as exempt. Other, seemingly more deserving, patients have to pay charges for the same drugs.

It has been argued that some of those who are exempt from health charges could easily afford to pay and are unlikely to be deterred by the level of charges (95). In particular, many patients in the age exempt categories are able to pay (96). Doctors argue that women no longer need to be exempt from prescription charges during the year following childbirth, as health hazards no longer apply for the majority (97).

Once consumers have checked their entitlement by some means, the process of actually getting free or reduced-cost health services can involve getting hold of a bewildering array of forms to demonstrate proof of entitlement. For people who cover more than one exemption, the complexity of these arrangements will be overwhelming. Exemption certificates issued by the health authority to people with a medical condition that makes them exempt from prescription charges have to be renewed every three years – even for conditions that are permanent (98).

Initiatives designed to help people on low incomes with health costs have a low take-up. As illustrated earlier for example, Citizens Advice found that only five per cent of those questioned who had paid for a prescription in the previous year had purchased a prescription pre-payment certificate (99).

Recommendation: While charges remain, consideration should be given to whether exemptions should be extended to certain groups currently paying charges – specifically, those whose income falls just outside the eligibility threshold. An examination of those chronic conditions that appear on the list of specified medical conditions should take place and be updated.

Efficiency

In his review Wanless (100) argues that:

the UK system of financing appears to be relatively efficient and equitable. It delivers strong cost control and prioritisation and minimises economic distortions and disincentives. A further key advantage...is its fairness, providing maximum separation between an individual's financial contributions and their use of healthcare.

However, for prescription, dental and optical charges, efficiency and equity are not the hallmarks of the system. An individual's capacity to make financial contributions directly impacts on their use of early healthcare intervention – it is reduced. What is clear in examining the impact of charges on consumers, and can only be repeated, is that 'charging' does not create a neat and tidy efficient system of healthcare provision and consumption. This is primarily because the charges are applied to clinical and not non-clinical services. And so, clinical needs simply pop up elsewhere in the system as treatment is delayed until absolutely necessary and even more costly to consumers or to the NHS.

There is further inefficiency in the administration of the charging system. The Prescription Pricing Authority's annual report of 2002 states an exercise carried out in 1999-2000 to estimate the level of patient charges not recovered by dispensers, this revealed that £59 million was evaded through deliberate fraud and £10 million through unintentional evasion.

In view of this situation, it is crucial that charges are brought within a transparent and coherent framework, which is underpinned by a robust rationale. A systematic approach can help to reduce inefficiencies as well as provide clarity on the scope of charging of clinical and non-clinical services.

4. Conclusion

Good health is an imperative for us to live full lives and contribute actively to society's progress. However, for a range of socio-economic factors, health inequalities persist and so does variable access to healthcare services. The government has initiated a plethora of initiatives to tackle inequalities, and these are very welcome. But health inequalities remain low on the agenda, with modernisation of the NHS taking precedence.

As such, the topic of 'charges' for a limited number of clinical areas (prescription, dental and optical) never manages to catch attention, because their impact is felt most keenly by low income and disadvantaged consumers. Yet the charges strikes at the very heart of the NHS – a service based on clinical need and not ability to pay.

As this report has sought to demonstrate, charges deny access to essential health services and work to compound the poor health of some consumers. The system is not based on any clearly laid rationale and as such charges and exemptions are applied inconsistently, and are even exploitative, as in the case of dentistry.

The absence of any rationale means that charges are able to quietly creep, as services such as NHS dentistry steadily erode to the detriment of consumers, and prescription costs continue to rise each year without increased access to the most effective medication.

In view of this situation, the NCC believes it is time to fundamentally review the case for charges in the NHS, by examining what constitutes core services and, therefore, should be universally available and properly funded. Already initiatives such as the National Institute of Clinical Excellence and National Service Frameworks have begun the process of identifying what should, or should not, be available through the NHS.

Our recommendations are aimed at addressing the burden of ill-health exacerbated by charges to consumers in essential areas for the maintenance of good health. And we will continue work in this area.

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