

Charging for health

Executive summary

- i. The NHS Plan¹ has set out an agenda for a fundamental modernisation of the NHS. The first of the ten core principles spelled out in the Preface to the Plan is that “*The NHS will provide a universal service based on clinical need, not ability to pay*”. But despite this clear statement, the Plan does not include any assessment of the impact of health charges for items such as prescriptions, dental and optical treatment. A key question is whether such charges are a barrier to treatment and contribute to inequalities in health. Yet with the exception of Wales, such debate as has taken place about NHS charges within Government and Parliament, has been about the case for introducing **additional** charges for healthcare, rather than reviewing those already in existence.
- ii. The CAB Service believes that the NHS Plan provides a real opportunity to review existing health charges. Such a review should be a central part of the strategy to improve access to health care for people on low incomes, and would contribute to the Government’s objectives of reducing health inequalities and ensuring fair access to services. The purpose of this report is to examine CAB evidence on the extent to which current charges for prescriptions, dental and optical care are impeding access to health care. The report is based on evidence submitted by Citizens Advice Bureaux throughout England and Wales between February 1999 and April 2001, and the findings of a survey carried out in November 2000, of 1602 CAB clients in England and Wales who had paid prescription or dental charges in the previous year.

Prescription charges

- iii. In April 2001, the basic prescription charge was increased to £6.10 per item in England. Significantly the Welsh Assembly decided to freeze the charge at the April 2000 rate of £6. Many people are exempt from prescription charges, for example children, people aged 60 and over, nursing and expectant mothers, people suffering from a few specified medical conditions and people on the lowest incomes. In addition, from April 2001, exemptions have been extended to 18 to 25 year olds in Wales. According to Government figures, exemptions cover about 85% of all prescriptions. **However 80% of people aged between 18 and 60 have to pay for their prescriptions.**
- iv. Prescriptions can quickly become unaffordable for people on low incomes, particularly where multiple items are prescribed and repeat prescriptions are necessary. There is no help with the cost on low income grounds as soon as incomes rise above income support levels. This creates a severe poverty trap. Many people on incapacity benefit, who by definition have health problems and are therefore likely to be heavy prescription users,

¹ NHS Plan, July 2000, Cm 4818-1

are particularly affected because their incapacity benefit is paid at rates only slightly above income support.

- v. Key findings from the CAB survey are that 50% of clients who had paid prescription charges reported difficulties in affording the charge. And 28% had failed to get all or part of a prescription dispensed during the previous year because of the cost. By extrapolating from the sample, NACAB estimates that at least 100,000 CAB clients may be failing to get all or part of a prescription dispensed every year. People with long term health problems were particularly affected.
- vi. The wider extent of the problem is demonstrated by recent MORI² research which asked a similar question about the extent of non-dispensing of prescriptions because of the cost. They found that of those who have to pay each time they have a prescription dispensed, 7% had failed to get all or part of a prescription dispensed due to the cost. MORI estimate that this represents around three-quarters of a million people in England and Wales.
- vii. The impact on people's health of this failure to afford the necessary medication is clearly illustrated. CAB evidence demonstrates that, for some people, prescription charges can be damaging to their health. People with asthma were choosing to take some rather than all of their prescribed items, others were restricting dosages of medication below the level prescribed by their GP. People with mental health problems were faced with the choice of living below the poverty line or not getting prescriptions dispensed for medication which was essential to their ability to cope in the community.
- viii. This must be of concern on a number of grounds. Firstly it cannot be cost-effective for overall NHS expenditure, since failure to afford medication could make the need for more expensive in-patient treatment more likely. But there are also wider implications in terms of the Government's objectives to reduce health inequalities and to tackle social exclusion. The burden of prescription charges falls unequally, with people on lower incomes and with chronic health problems bearing the heaviest load.
- ix. As the Government takes stronger measures to crack down on prescription fraud, with penalty charges of up to £100 where patients are found to have falsely claimed exemption from prescription charges, it will be increasingly important to ensure that there is adequate help for those who genuinely cannot afford to pay.
- x. Some help is available with budgeting for the costs of prescription charges in the shape of the pre-payment certificate or "season ticket". Rather than paying for prescriptions as they are issued, anyone can purchase a prepayment certificate at a cost of £87.60 (£86.20 in Wales) for 12 months or £31.90 (£31.40 in Wales) for four months, which then covers all

² A representative quota sample of 1,052 adults aged 16+ was interviewed by MORI in 150 sampling points in Great Britain from 6-10 April 2001.

prescription charges in the period of the certificate. This can be helpful for heavy prescription users as it effectively caps the cost. However as it requires lump sum payment in advance, it is not a system which is designed to meet the needs of people managing on limited budgets. Only 5% of CAB survey respondents who had paid for prescriptions in the past year had purchased pre-payment prescription certificates. Amongst those who had difficulty in affording prescription charges, 27% said they had not bought a pre-payment prescription certificate because they could not afford it.

Dental and optical charges

- xi. People not entitled to free or reduced cost NHS dental treatment pay 80% of the cost of a course of NHS treatment up to a maximum of £360 (£354 in Wales). This is a significantly greater figure than for any other NHS charge.
- xii. Amongst the respondents in the CAB survey who had paid dental charges in the last year, nearly half had paid charges of over £50. One in five respondents had paid over £100.
- xiii. Overall, 44% of respondents said that they had found dental charges difficult to afford. Single people under pensionable age were more likely to report difficulties in paying charges (54%), as were single parents (55%). Not surprisingly there was a positive correlation with the size of charges: 75% of the 67 respondents charged over £200 reported difficulty in paying the charge.
- xiv. Help with optical charges for spectacles and lenses is provided by means of vouchers. However many CAB clients find that even if they are on income support and entitled to a full voucher, there is a shortfall between the value of the vouchers and the cost of the cheapest glasses available.

Travel costs

- xv. Where patients require health care which is not available within the local area, the cost of travel can be a major barrier for people on low incomes. In addition to local patient transport services, some help with the cost of travel to hospital is provided through the health benefits scheme, but CAB evidence demonstrates a range of failings both in terms of the complexity of the scheme and of the situations in which help is available.
- xvi. CAB evidence indicates that people often miss out on the help to which they are entitled because of poor information provision, difficulties in obtaining the relevant claim forms and low knowledge by health professionals, resulting in misinformation to patients.
- xvii. The health benefits scheme is also inadequate because it is only available for travel to hospitals, and not to other health outlets to which the GP may refer the patient.

- xviii. A further problem is the lack of help with travel costs for relatives visiting patients in hospital, despite the undisputed benefit to patients of family visits. The only help available is from the social fund but this is limited to claimants in receipt of income support and income-based jobseekers allowance, and even then there is no guarantee that a grant will be made as it is a budget-limited provision.

Recommendations

- The Government should conduct a fundamental review of NHS charges including a consideration of the case for extending the existing exemptions from charges. The review should also examine the case for abolishing all charges, as their continuation is arguably contrary to the fundamental principle of the NHS to provide a service on the basis of need and not ability to pay. NHS charges also conflict with the Government's wider policy agenda to reduce health inequalities and to tackle social exclusion. From the perspective of CAB clients, there is a strong case for abolition. (para 5.4)

However, whilst NHS charges remain, the following are priorities for reform:

Prescription charges

- Help with paying prescription charges should be extended to people with incomes above the exempt levels. This could be done most simply by pricing the pre-payment certificate on a sliding scale, depending on a person's income. (para 2.43)
- The Department of Health should take steps to promote take-up of pre-payment prescription certificates. (para 2.32)
- The CAB Service recommends that the Department of Health introduce measures to make the purchase of pre-payment certificates more affordable, for example by allowing the purchase of pre-payment certificates on a monthly basis at one twelfth of the annual cost. (para 2.33)

Dental charges

- There should be a significant reduction in the maximum (currently £360 in England, £356 in Wales) and in the percentage (currently 80%) of NHS dental charges which people may be liable to pay. (para 3.15)
- All patients should be entitled to regular free dental check-ups. (para 3.10)
- The Department of Health should commission research into the extent to which the current level of dental charges is causing

hardship or preventing people seeking the treatment they need. (para 3.16)

- The Department of Health should take steps to end the practice whereby some dentists make a refundable charge for an initial consultation before deciding whether they will accept a patient for NHS treatment. (para 3.19)
- The British Dental Association should draw up good practice guidance on cancellation charges, to include both the level of charges and the circumstances in which they might or might not be appropriate. (para 3.21)

Optical charges

- Glasses within the value of NHS vouchers must be available from all opticians providing NHS treatment. (para 3.25)
- The Department of Health should collect data from opticians on the availability of glasses within the voucher values and make this information available to the public by means of NHS Direct. (para 3.26)
- Registered blind and partially sighted people should be entitled to full vouchers, regardless of their income. (para 3.30)

Travel costs

- The take-up of the hospital travel costs scheme should be publicised in all GP surgeries and hospitals. The proposed Patients Advocacy Liaison Service should have the co-ordination of this promotion as a specific function. (para 4.8)
- The scope of the hospital travel costs scheme should be extended to include easier access to payment in advance, help with non-hospital travel, overnight costs where necessary, and visiting costs for family members. (para 4.17)

General

- The Department of Health should regularly review of the level of non-take-up of the low income scheme and in particular of the help available with optical charges. (para 3.29)
- The health poverty index currently being developed as outlined in the NHS Plan, should take account of the proportion of household income spent on health charges within the definition of health poverty, and set clear targets for eliminating health poverty over time. (para 5.5)

1. Introduction

Background

- 1.1 A fundamental contradiction at the heart of the National Health Service is the existence of charges for essential items such as prescriptions, dental and optical treatment, within a service which claims to provide health care free at the point of delivery. Moreover these are among the most frequently used NHS services as the NHS Plan itself points out:

“On a typical day in the NHS:

- 130,000 people go to their dentist for a check up
- 1.5 million prescriptions are delivered ...”³

- 1.2 This contradiction is not new - charges have existed almost since the start of the National Health Service, being first imposed in 1952 for prescriptions and dental treatment as part of a range of post-war revenue raising initiatives. However in recent years charges have been increased significantly. Between 1979 and 2001 prescription charges rose from 20p to £6.10 per item in England, – an increase of over thirty fold in cash terms and a five fold increase in real terms. Indeed if prescription charge increases had been limited to the rate of inflation since 1979, then by 1998/9 they would have been 66p per item rather than £5.80. (Hansard, 19.3.98, col 704)
- 1.3 The maximum dental charge underwent a twelve fold increase between 1980 and 2001 – from £30 to £360 in England. And optical charges doubled between 1976 and 1985, when they were replaced with the voucher system.
- 1.4 Successive Governments have sought to mitigate the impact of these charges through the health benefits scheme, the stated purpose of which is to focus help on those that need it most. Thus certain groups are exempt from charges, and help with charges is available to people on low incomes. However the low income scheme is highly complex and riddled with inconsistencies and has long been a source of concern to the CAB Service. This concern led NACAB to publish a report in 1991⁴ which detailed the failures of the scheme in terms of complexity, inadequacy, inaccessibility and inequity.
- 1.5 The 1991 report made a number of recommendations including the abolition of the low income scheme and its replacement by an extension of existing exemptions from charges to anyone in receipt of a means tested benefit (including housing benefit) or a disability benefit, or who is above pensionable age.

³ *NHS Plan*, July 2000, Cm 4818-1, page 23

⁴ NACAB (1991) *Health Warning: low income groups and health benefits*

- 1.6 Following the publication of NACAB's report, the Government announced an immediate review of the low income scheme. Whilst this review resulted in some useful administrative improvements, no major changes were made to the scope of the scheme, with the Minister arguing that "*no options for change had been identified within what can be afforded*" (letter from Dr. Mawhinney to NACAB, 4 March 1994). During the 1990s CABx continued to report clients on low incomes facing difficulty in accessing health care because of the costs involved.

Current situation

- 1.7 The present Government inherited a highly complex system of charges, exemptions and relief for NHS items such as prescriptions, dentistry and optical care, with little internal consistency. For example:
- People aged 60 and over get free prescriptions and (since April 1999) free eye tests but must pay for dentistry and optical appliances unless they qualify under the low income rules
 - Pregnant and post natal women get free prescriptions and dentistry but must pay travel costs for what may be frequent visits to hospital unless they qualify under the low income scheme
- 1.8 Yet apart from the welcome decision to abolish eye test charges for people aged 60 and over from April 1999, the present Government has continued with the existing system of charges.⁵ With the exception of the Welsh Assembly's decision to reduce health charges from April 2001, such debate as there has been about charges has focussed on the arguments for and against introducing additional charges for healthcare, rather than reviewing those already in existence.
- 1.9 Increases since 1998 have, however, been limited to the rate of inflation, whereas in previous years they had frequently exceeded inflation.
- 1.10 The Government's continuation of charges does not sit easily with its acknowledgement of the clear links between poverty and ill health, its commitments to tackle poverty and health inequalities and the recognition of fair access to health services as a high level indicator in the measurement of NHS performance.
- 1.11 The NHS Plan published in July 2000 sets out an agenda for a fundamental modernisation of the NHS, accompanied by significant additional resources. The proposals are intended to deliver a genuinely patient-orientated NHS. The first of the ten core principles spelled out in the Preface is "*The NHS will provide a universal service based on clinical need, not ability to pay*". Yet the issue of health charges is not even mentioned in the Plan. There does not appear to have been any

⁵ Significantly, the Welsh Assembly has decided to freeze prescription and dental charges at the April 2000 rate, and to extend free prescriptions and dental check ups to all those aged under 25, or 60 and over. The Health and Social Services Committee is also looking at the scope for extending exemptions further.

assessment made of the impact of current health charges, to establish whether they contribute to poverty and to existing health inequalities, or whether the failure to take up health care because of charges leads to greater cost to the NHS in the longer term. Nor has there been any assessment of the adequacy of the health benefits scheme despite its crucial role in enabling people on low incomes to afford the health care they need.

1.12 This is despite the fact that the arguments against charging are clearly set out in the NHS Plan, albeit in the context of a case against additional user charges:

- The Plan makes reference to the RAND health insurance experiment carried out in the US in the 1970s, and undoubtedly the most exhaustive study to date. Over 7,000 people took part in the experiment which was carried out over a number of years, during which participants were assigned to one of 15 different health insurance plans, which varied in the extent to which they required user charges. The findings showed that user charges are a blunt instrument in reducing demand in that they resulted in reduced use of both effective and ineffective treatments. In addition, they impacted disproportionately on low income and vulnerable groups. Offering full or partial exemptions in order to reduce inequities proved complex and expensive to administer.
- The NHS Plan notes that charges are inequitable because they *“increase the proportion of funding from the unhealthy, old and poor compared with the healthy, young and wealthy”*.
- The NHS Plan also comments that *“exempting low income families from user charges can create inequities for those just above the threshold”*.

Time for review

1.13 The above points are precisely the ones which are demonstrated repeatedly by CAB evidence in relation to existing charges. The NHS Plan therefore provides a real opportunity to review existing health charges in order to improve access to health care for people on low incomes. Given the overall context of increased investment in the NHS of one third in real terms in five years, it is regrettable that no steps have yet been taken to reduce, let alone abolish health charges.

1.14 This report examines the impact of charges on people on low incomes who are nevertheless not protected by the health benefits scheme, and challenges the assumption under which successive Governments have operated, that *“these arrangements ensure that no-one need be deterred from obtaining necessary medication for financial reasons”* (John Denham MP, Minister for Health, Hansard, 11.5.99, col 132). We do not

look at the detail of the health benefits scheme, although many of the concerns raised in our 1991 report remain.

- 1.15 This report is based on evidence submitted by 190 CABx in England and Wales between February 1999 and April 2001. CABx are in a good position to report on the impact of health costs on people on low incomes because of their day to day work combating poverty through benefit take-up and debt advice. Moreover, in recent years there has been a significant increase in the number of CABx operating in health settings such as GP surgeries and hospitals. Over 200 CABx now provide services specially targeted at people with health needs including 76 mental health projects, and 77 in-hospital services. 119 CABx run services within GP surgeries. These services are growing rapidly – funding has recently been obtained to provide an additional 20 such advice projects in Wales, in partnership with the Welsh National Assembly.
- 1.16 These outreach services have been shown to attract a different profile of clients, many of whom have chronic health conditions. In 1999 – 2000, CABx in England, Wales and Northern Ireland dealt with over 90,000 health-related problems, and the evidence from this case work indicates that problems with paying health charges was one of the most common concerns.

CAB survey

- 1.17 In addition to evidence from CAB case work, a client survey was undertaken during one week in November 2000 to examine the extent of difficulties clients faced in paying charges in two key areas: prescriptions and dental charges. A stratified 20% sample of CABx throughout England and Wales was drawn up, and the 128 CABx selected were asked to complete a questionnaire with every client who contacted them during the survey week who had needed to pay for prescription or dental charges during the previous year. It should be stressed that the survey was not restricted to those who had come to the CABx with concerns over paying health charges. Whatever the problem which had brought them to the CAB, people were asked to take part in the survey if they had needed to pay prescription or dental charges in the previous year.
- 1.18 Questionnaires were returned from 84 CABx, giving a CAB response rate of 66%. As Table 1 illustrates, a total of 4263 clients were approached to take part in the survey. Of these, 51% were excluded at the preliminary stage because they had not paid prescription or dental charges in the last year (either because they were entitled to free provision or because they had not needed or had not sought prescription or dental treatment in the last year). 12% refused to take part in the survey.

Table 1 Composition of sample

	Number of clients
Refusals	12% (508)
Not relevant (no health charges paid)	51% (2153)
Prescription and/or dental charge paid	38% (1602)
Total	100% ⁶ (4263)

- 1.19 The remaining 1602 clients – nearly two in five of all the CAB clients contacted – said they had faced prescription and/or dental charges in the last year. 1029 of these clients had paid prescription charges on an item by item basis and 56 had paid by means of a pre-payment certificate. 1001 of these clients had paid dental charges.⁷ Advisers completed questionnaires with these clients, to establish whether they had found the charges difficult to afford or had failed to make use of prescriptions or dental treatment during the last year because of the cost involved.
- 1.20 Appendix 1 provides details of the gender, race and household composition of the 1602 respondents. Respondents were also asked if they had any long term health problems and as many as 36% said that they had.
- 1.21 Income data were not collected for all respondents. However it should be remembered that those on lowest incomes were not included in the survey as they would not have had to pay prescription or NHS dental charges.
- 1.22 The findings of the survey and CAB case evidence are detailed in the following chapters. Section 2 focuses on prescription charges, Section 3 discusses dental and optical charges and Section 4 examines the problems people faced in affording travel costs to obtain health care.

⁶ Percentages in the tables may not add up to 100% because of rounding.

⁷ The totals for these subgroups add up to more than 1602 because 484 respondents paid both prescription and dental charges.

2. Prescription charges

- 2.1 From April 2001, the basic prescription charge is £6.10 per item in England (£6 in Wales). Where a prescription contains more than one item, each attracts the full charge. It is possible to buy a pre-payment certificate at a cost of £87.60 (£86.20 in Wales) for twelve months or £31.90 (£31.40 in Wales) for four months, which covers any prescription charge within the period.
- 2.2 Many people are exempt from prescription charges, notably 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, and people suffering from one of a limited number of specified medical conditions. From April 2001, exemptions have been extended to 18 to 25 year olds in Wales. There is also some relief on income grounds - for example 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.
- 2.3 The exempt groups are likely to be the heaviest prescription users, which explains the Government estimate that around 85% of all prescription items are dispensed free of charge (Hansard, 7.2.2001, col 571). However amongst the 18 to 60 year old population, only 20% do not have to pay prescription charges (Hansard, 7.2.2001, col 571). **The remaining 80% must pay the full cost of any prescriptions used and it is within this group that problems of affordability arise.**
- 2.4 Help with prescription charges differs from help with other health charges under the low income scheme in one important respect, because there is no tapered help with the cost as incomes rise above exemption levels. Thus whilst people with income at income support level get their prescriptions free, anyone with an income just a few pence above that level immediately faces the full cost of prescriptions, however many items are required. The effect of this absolute cut off point is to create a significant poverty trap, so that people on low incomes and in poor health can find themselves with a choice between living below income support levels or not cashing their prescriptions.
- 2.5 A total of 1029 respondents in the CAB survey - that is almost 1 in 4 of all clients contacted - had paid prescription charges in the previous year on an item by item basis. When these respondents were asked whether they had found it difficult to afford the cost of prescriptions, 50% said that they had (Table 2). Not surprisingly people with long term health problems, and therefore likely to be heavier prescription users, were more likely to report such difficulties.

Table 2 In the last year have you found it difficult to afford the cost of a prescription charge?

Payment difficulties	Total	Long term health problems	No long term health problems	No response
Yes	50% (518)	65% (241)	43% (261)	32% (16)
No	42% (436)	29% (107)	50% (305)	48% (24)
Not stated	7% (75)	6% (21)	7% (44)	20% (10)
Total	100% (1029)	100% (369)	100% (610)	100% (50)

Incapacity benefit

- 2.6 Twenty per cent of those who reported difficulties in affording prescription costs were on incapacity benefit or other disability and sickness benefits. People on incapacity benefit may be particularly affected by the absence of a taper on help with paying prescription charges, because that benefit is paid at rates only slightly above income support. Claimants can find the higher amount of benefit is more than wiped out by the cost of prescription charges. This is one of the most serious failure of the health benefits scheme and one which requires urgent attention.

A CAB 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 £2 above her income support applicable amount. As a result she had to pay the full cost of prescription charges.

A CAB in Surrey reported a couple who both suffered from multiple health problems. They applied for help with NHS costs but were told their income was £2.08 over the limit for help with prescriptions.

A CAB in Greater Manchester reported a client whose incapacity benefit was increased by £2.30 per week. As a result his income was 7p above his income support applicable amount and he was left with meeting the full costs of his regular medication.

- 2.7 The extent of this problem is also affected by the relative rate at which means tested and non-means tested benefits are uprated each April. When means-tested benefits are uprated by a lower percentage than non-means tested benefits, many people are 'floated off' income support and thus lose entitlement to free prescriptions. This was the case in April 2001 when means tested benefits were uprated by 1.6% whereas non-means tested benefits such as incapacity benefit were uprated by 3.3%. For people who need prescriptions, the marginally higher benefit rate that results is more than counteracted by the extra costs of prescriptions over the year.

A CAB in Cornwall reported a couple who were both in receipt of incapacity benefit. The wife also received higher rate mobility and middle rate care disability living allowance. Previously they had been entitled to income support and therefore received free prescriptions but when they reapplied in 2001 they were told they no longer qualified. They were spending about £100 per month between them on prescriptions.

- 2.8 The group of people worst affected are those whose incapacity for work began before the age of 45 and who may therefore have long periods of ill health ahead of them. The age addition in incapacity benefit is likely to mean they are not entitled to income support, and so receive no help with prescription costs. Indeed single non-pensioners whose incapacity for work began between the age of 35 and 44 and whose only income is long term incapacity benefit, will have found themselves also entitled to income support and therefore free prescriptions in four of the seven years between 1995/6 and 2001/2, and not entitled in the last three years. Table 3 provides a comparison of the relevant benefit rates in the period.

Table 3 Relative weekly value of income support and incapacity benefit, 1995-2002

Year	IS plus disability premium	Long term incapacity benefit plus lower age addition
1995/6	£66.30	£65.05
1996/7	£68.30	£67.60
1997/8	£70.10	£69.05
1998/9	£71.80	£71.50
1999/2000	£73.30	£73.80
2000/2001	£74.45	£74.60
2001/2002	£75.65	£77.10

- 2.9 But people in low paid work can also face difficulties, particularly if they do not have children and therefore cannot benefit from working families tax credit:

A CAB in Wales reported a woman earning £125 per week who had a number of long-term health problems, which meant having time off work. She was struggling with a number of debts and having difficulty affording repayments to her priority creditors as well as prescription charges for several different types of medication.

- 2.10 A further problem with the current rules is that in certain circumstances people can lose entitlement to free prescriptions just when their health deteriorates and their income drops, if they move from a means-tested tax credit to a contributory benefit:

A CAB 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 therefore entitled to free prescriptions. However her condition worsened and she was forced to give up work. As a result her income dropped as she was 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.

Multiple prescriptions

- 2.11 The extent of the problem is also influenced by whether the client's medical condition requires multiple prescriptions. Many chronic conditions may require a combination of drugs to be administered, each of which gives rise to a prescription charge:

A CAB in Leicestershire reported a woman suffering from asthma and arthritis who also needed hormone replacement therapy. As a result she needed four repeat prescriptions per month. She was not entitled to free prescriptions because her incapacity benefit exceeded the income limit by 15 pence.

A CAB in Tyne and Wear reported a client who had survived three heart attacks and cancer. He required six prescription items per month at a cost of £36, which he could not afford on his incapacity benefit of £78.64 per week. Nor could he afford a pre-payment certificate. He was being threatened with court action for non-payment of £17.70 prescription charges and was prepared to write a letter defending his action.

A CAB in West Yorkshire reported a woman suffering from multiple sclerosis which required a great deal of medication costing her between £30 and £42 per month. Her income was 15 pence above the level at which she would have been entitled to free prescriptions. In the previous month she had not had some of her medication dispensed because she could not afford it.

- 2.12 Given the well established link between poverty and ill health, there must be a likelihood that poorer people will disproportionately require multiple prescriptions and therefore be faced with the highest prescription costs, unless they are protected by the health benefits scheme.

Prescription duration

- 2.13 Where a patient suffers from a chronic condition which requires long term medication, the cost to the patient is also significantly affected by the length for which a drug is prescribed. This period is a matter for the GP's clinical judgement, and where the patient requires long-term medication there is no requirement on the GP to limit a prescription to one month's supply. Nevertheless CAB evidence suggests that many do so, thus significantly increasing the costs to the patient.

A CAB in East Sussex reported a woman suffering from a life-threatening heart condition. She had been provided with the medication – for which she had to pay – on a three-month basis. This was then reduced to one month per prescription, resulting in significant additional costs and effort for her. The bureau checked with the surgery which told them that practice had changed following a visit from the health authority. Other types of prescriptions such as hormone replacement therapy and contraceptive pills were however still being issued on a three months' basis.

The same CAB reported a couple on income support where the wife suffered from chronic complaints requiring three different drugs. She had been receiving these on a three-month prescription. Recently the man had become entitled to retirement pension which had the effect of lifting them just above the limit for income support entitlement. At the same time, the wife's prescription regime had been changed from a three to a one monthly duration. As a result they were significantly worse off as they had to find an additional £18 per month for prescription charges.

- 2.14 In some cases there may be sound clinical reasons for issuing medication in small quantities. However, this clinical decision can have significant financial repercussions on the patient, and the costs of frequent prescriptions may even result in patients not using the medication prescribed:

A CAB in Derbyshire reported two clients with mental health problems who were being prescribed medication on a one week basis because of the risk of self harm. One client had suffered a mental breakdown and was advised by her community psychiatric nurse that the medication would aid her recovery. However she was unable to afford the cost out of her statutory sick pay of £60.20 per week.

The second client was suffering from depression and was in low paid work and had been prescribed three items totalling £18 on a one week basis.

A CAB in Cumbria reported a young woman in low paid work who was on anti-depressants. Her GP would only prescribe one week's supply at a time. As a result she could not always afford to cash her prescription.

- 2.15 Issues around prescription duration bring into focus the tension over who pays for prescription costs – the NHS or the patient. The Department of Health is understandably determined to limit unnecessary expenditure on drugs, and whilst it accepts that the length of prescription is primarily a matter for the GP's clinical judgement, a strong steer is given towards the merits of writing prescriptions for one month only. Thus a recent issue of **Connect** – the official newsletter for health authority and primary care prescribing advisers – featured this issue on its front page, commenting:

“The Department is determined that best practice...will be shared across the NHS. Many prescribers already routinely write prescriptions for one calendar month...” (Connect, Issue 20, March 2000)

- 2.16 But what does not appear to be given consideration is the prescription charge itself and therefore the financial impact on the patient of such 'best practice'. Certainly the issue looks very different from the perspective of prescription users on long term medication, who can suddenly find that the 'price' they pay for their essential medication increases three fold if the GP moves from a three month to a one month prescription routine. Patients can find that £6.10 pays for anything between one week and three months' supply of a single item.

Failure to get prescriptions dispensed

- 2.17 The impact of prescription charges is not only to drive people into poverty. Inevitably some people will feel unable to afford the cost of their prescriptions and will simply go without, despite the serious health consequences. Indeed according to the National Pharmaceutical Association, “*what can I leave out?*” is a common question asked of local pharmacists (NPA press release, 2 March, 1998). More recently, a poll by **Doctor** – a GP specialist newspaper, found that eight out of ten doctors said that they had patients who missed out on drugs because they could not afford to pay for their prescriptions.⁸ Following the most recent rise in charges, the British Medical Association has called on the Government to initiate a fundamental review of the whole system of prescription charges and exemption categories, because of growing concerns that patients are unable to afford to get their prescriptions dispensed.⁹

⁸ Doctor, 5 April, 2001

⁹ BMA briefing paper, April 2001

- 2.18 Researchers from the School of Pharmacy and Pharmaceutical Sciences at the University of Manchester have been investigating the influence of prescription charges on both patient and GP behaviour. In one study¹⁰ investigating the reasons for non-dispensing of prescriptions, the researchers examined data on 598 prescription items which were requested not to be dispensed by 520 pharmacy customers. Amongst the 329 patients who were not exempt, the cost of the prescription charge was by far the most common reason for non-dispensing. Even though a number of items were substituted by equivalent products that were available to buy without a prescription, the researchers found that 62 items (10%) were not dispensed, or substituted, solely because of the cost.
- 2.19 Another study based on focus groups with 51 GPs showed the extent to which prescribing patterns are influenced by GPs' efforts to minimise the impact of prescription charges¹¹. Strategies reported included recommending cheaper over the counter drugs, increasing the quantity prescribed, timing repeat prescriptions to coincide just prior to the expiry of a pre-payment certificate, prescribing instead for an exempt family member, limiting the number of items prescribed, prescribing more expensive medicines rather than trying a cheaper option first and, most controversially, supplying medicines returned by other patients.
- 2.20 The impact of prescription charges is confirmed by the findings of the CAB survey. Respondents were asked whether they had failed to get all or part of a prescription dispensed during the previous year, because of the cost involved. Of those who had paid prescription charges in the last year, 12% said they had failed to get all of a prescription and further 16% had failed to get part of a prescription dispensed, making a total of 28% who had not got all their prescribed medicine dispensed because of the cost (Table 4). Analysis by household composition showed that this figure rose to 38% among single parent households.
- 2.21 People with long term health problems were also particularly affected, with 37% failing to get all or part of their prescriptions dispensed.

¹⁰ Schafheutle EI, Hassell K, Seston EM, Nicolson M, Noyce PR. (2001) *Non-dispensing of NHS prescriptions in community pharmacies*, 7th Health Services Research and Pharmacy Practice Conference Abstracts; 2001, University of Nottingham.

¹¹ Weiss M, Hassell K, Schafheutle EI, Noyce PR, (2001) *Strategies used by general practitioners to minimise the impact of the prescription charge*, European Journal of General Practice, Vol 7, pages 23-26

Table 4 In the last year have you NOT cashed all or part of a prescription because of the cost involved?

	Total	Long term health problems	No long term health problems	No response
Not cashed all	12% (128)	13% (49)	12% (74)	10% (5)
Not cashed part	16% (165)	24% (89)	12% (71)	10% (5)
Cashed all	64% (656)	57% (209)	68% (414)	66% (33)
Not stated	8% (80)	6% (22)	8% (51)	14% (7)
Total	100% (1029)	100% (369)	100% (610)	100% (50)

2.22 Sixteen percent of those CAB survey respondents who failed to get all or part of their prescriptions dispensed were on incapacity or other disability and sickness benefits and thus likely to have long term requirements for medication.

2.23 But being in work was no guarantee against hardship. 62% of those clients who had failed to get all or part of a prescription dispensed were in receipt of income from work.

A CAB in Cumbria reported a single man who had injured his knee at work. He was given prescriptions for dressings, bandages, anti-biotics and pain-killers which would have cost £24 to dispense. He only got the item for bandages dispensed and felt unable to afford the rest.

A CAB in Essex reported a family with young children where both parents were in work. Despite this they could not always afford to get their prescriptions dispensed.

Impact on health

2.24 The impact on people's health of this failure to afford the necessary medication, is clearly illustrated in CAB evidence:

A CAB in Wales reported a single mother who was suffering from glaucoma and registered blind. She had no sight in one eye and very limited sight in the other. She had been told that she would lose what sight she had left unless she used the prescribed drops. However she could not afford the eight items prescribed each month, nor could she afford to purchase a pre-payment certificate.

A CAB in Hampshire reported a client in receipt of incapacity benefit who was due to have major surgery. However he cancelled the operation because he knew he would not be able to afford the five different post-operative drugs required.

Another CAB in Hampshire reported a woman in low paid work with debts of around £6,000. She had several prescriptions for asthma which she had been unable to afford to get dispensed.

A CAB in Humberside reported a client who needed regular drugs to ease the pain of osteo-arthritis. She could not always afford to renew her prescriptions and at the time she came into the CAB she was experiencing severe discomfort.

2.25 In some cases people are putting their health at risk by altering the dosage or the way they take the medication, in order to reduce the cost:

A CAB in Lincolnshire reported a client who was prescribed Prozac. The GP advised the client to reduce the dose gradually over several weeks in order to avoid a relapse or side effects. However the client was reducing the dosage at a faster rate in order to save on prescription costs.

A CAB in Surrey reported a client in low paid work who could not afford to get the necessary prescription dispensed to control his asthma. He had decided instead to reduce the use of his inhaler and to manage with one less prescription.

A CAB in Worcestershire reported a woman in low paid work with four children. She had been prescribed two inhalers but could not afford to get them dispensed immediately. In the meantime she was using her daughter's inhalers.

2.26 For people with mental health problems, their well-being in the community may be threatened if they are unable to afford regular medication, thus undermining the Government's policy to promote care in the community. This is particularly serious in view of Government proposals to make the rights of some patients to remain in the community conditional on their taking prescribed medication.

A CAB in Northumberland reported a client with severe mental health problems who required three prescription items per month to control his condition. However his income from incapacity benefit left him only 5 pence above the level at which he would have been entitled to free prescriptions. He could not afford the £18 per month prescription bill and therefore went without his drugs – a situation which concerned him and was detrimental to his health.

A CAB in Berkshire reported a client with a severe mental illness and recurring suicidal tendencies whose illness was controlled by a high dosage of multiple medication. She reported having to pay for six items every two weeks, at a cost of £36. She stated that she was having to constantly choose between paying

essential bills and eating or paying her prescription charges. She was not aware of the availability of pre-payment certificates.

A CAB in Essex which runs a mental health project reported a client on incapacity benefit who required regular medication of two prescriptions per month in order to manage her mental condition. She was entitled to partial help with dental and optical costs but she got no help with prescriptions because her income was £1.10 per week above the level for free prescriptions.

The same bureau reported another client with a serious mental illness who needed five prescriptions per month. The CAB commented that there must surely be a strong case for including some mental illnesses such as schizophrenia as conditions for which prescription charges are exempt.

- 2.27 Clearly people's health is likely to be put at risk if they fail to take medication prescribed to control a chronic condition. This must be of concern on a number of grounds. It cannot be cost-effective for overall NHS expenditure, since failure to afford medication could make the need for in-patient treatment more likely. The impact of high prescription charges is disproportionately felt by people on low incomes and with long term health problems. There are also wider implications for the Government's objectives to reduce health inequalities and to tackle social exclusion.

Pre-payment prescriptions

- 2.28 Some help with budgeting for the costs of prescription charges is available in the form of the pre-payment certificate or 'season ticket' at a cost of £87.60 (£86.20 in Wales) for 12 months or £31.90 (£31.40 in Wales) for four months. Rather than paying for prescriptions as they are issued, anyone can purchase a pre-payment certificate, which then covers all prescription charges in the period of the certificate.
- 2.29 Pre-payment certificates can be helpful for heavy prescription users as they effectively cap the cost of prescriptions. However it is not a system which is designed to meet the needs of people managing on limited budgets and indeed the Department of Health has made no estimates of the income profile of people who purchase pre-payment certificates (Hansard, 7.2.2001, col 571). A system which requires a lump sum payment in advance is of no help to someone living just above income support levels who is finding it difficult to pay even the single charge.

A CAB in Dorset reported a client in receipt of incapacity benefit whose income was £1.43 above the level that would have entitled her to free prescriptions. She was prescribed six different drugs. The CAB pointed out that even if she could have spread the cost of the season ticket, at £1.66 per week

over 12 months it would still have left her living below income support rates.

In practice she did not get the prescriptions for pain killers dispensed but instead got pills from her mother and a friend, who both qualified for free prescriptions and did not use all the pills which the doctor prescribed.

2.30 Evidence from the CAB survey suggests that use of pre-payment certificates is not widespread. Of the 1085 respondents who had had to pay for prescriptions in the last year, only 56 (5%) used a pre-payment certificate. The 518 people who had reported difficulty in affording prescription charges were asked whether they had considered purchasing a pre-payment certificate. As many as 71% said they had not considered it, indicating that pre-payment certificates play at best a minor role in addressing prescription affordability. People with long term health problems, who would most benefit from pre-payment certificates, were more likely to have considered purchase but even so the majority had not done so (Table 5).

Table 5 Have you considered buying a pre-payment certificate?

	Total	Long term health problems	No long term health problems	No response
Yes	21% (107)	32% (77)	9% (24)	38% (6)
No	71% (366)	59% (142)	83% (216)	50% (8)
Don't know/no answer	9% (45)	9% (22)	9% (21)	13% (2)
Total	100% (518)	100% (241)	100% (261)	100% (16)

2.31 The 366 people who had not considered buying a pre-payment certificate were asked why they had not done so (Table 6). The most common response (42%) was that they did not make sufficient use of prescriptions to make it worthwhile, reflecting the fact that pre-payment certificates are primarily designed to help heavy users cap their costs. However 27% said that the reason they had not considered a pre-payment certificate was that they could not afford it, and disturbingly this figure rose to 39% among people with long term health problems who would most benefit from having a pre-payment certificate. Another 27% said they did not know about pre-payment certificates, indicating the need for more information about pre-payment certificates and how they can be purchased. Single people were particularly likely to say they did not know about pre-payment certificates (37%).

Table 6 Why have you not considered buying a pre-payment certificate?

	Total	Long term health problems	No long term health problems	No response
Can't afford it	27% (98)	39% (56)	19% (40)	25% (2)
Did not know about it	27% (98)	27% (38)	27% (58)	25% (2)
Low prescription use	42% (153)	30% (43)	50% (108)	25% (2)
Other/not stated	5% (17)	3% (5)	4% (10)	25% (2)
Total	100% (366)	100% (142)	100% (216)	100% (8)

2.32. In 1999/2000 around 550,000 4 month and 330,000 12 month pre-payment certificates were issued. However no information is available on the percentage take-up of prescription pre-payment certificates by patients who would benefit financially from doing so (Hansard, 15.3.01, col 719). **The CAB Service recommends that the Department of Health take steps to promote take-up of pre-payment prescription certificates.** This could include encouraging GPs to take an active role by providing information, displaying posters in waiting rooms and holding a supply of the claim forms.

A CAB in the Midlands reported a disabled client who was long term sick and in receipt of incapacity benefit. She was spending £72 per month on inhalers plus 11 other prescriptions. She had never been advised by her GP that she could apply for a pre-payment certificate.

A CAB in Essex reported a client who suffered from Crohn's Disease and asthma, and who required five prescriptions per month. She could not always afford to get them all dispensed, but no-one had ever suggested to her that she purchase a pre-payment prescription.

2.33. **The CAB Service also recommends that the Department of Health introduce measures to make the purchase of pre-payment certificates more affordable, for example by allowing the purchase of pre-payment certificates on a monthly basis at one twelfth of the annual cost.** This would be particularly appropriate as so many items are prescribed on a monthly basis.

A CAB in North Yorkshire reported a single client who was in low paid work who had a serious heart condition requiring seven different items of medication. She tried to budget by getting one dispensed each week, but sometimes went without what she considered to be the less critical ones. Because of her low

income, she was unable to save the money to buy even a four month pre-payment prescription.

Conclusion

- 2.34. The CAB survey and case evidence shows clearly that, despite the current exemptions, the cost of prescriptions is causing severe problems for many people on low incomes. People with long term health problems who are likely to have heavier prescription use are particularly at risk. The problem is compounded by the fact that incapacity benefit is often paid at a rate only a few pounds above income support, yet people in receipt of this benefit have no entitlement to free prescriptions and many are unable to afford pre-payment certificates.
- 2.35. Significant numbers of CAB clients are failing to cash their prescriptions because they cannot afford to do so. On the basis of this sample, NACAB has estimated that at least 100,000 CAB clients are failing to make full use of their prescriptions because of financial difficulties, every year.
- 2.36. An indication of the wider extent of the problem is provided by recent MORI¹² research which asked a similar question about the extent of non-dispensing of prescriptions because of the cost. They found that 68% of respondents had been given a prescription in the last year. Of these, 62% were exempt from prescription charges, 3% paid by pre-payment certificates and 35% were liable to pay for each item as it was prescribed. Of this latter group, 1 in 20 had failed to get all of a prescription dispensed and a further 1 in 50 had failed to get part dispensed, because of the cost. **MORI estimates that this represents about three-quarters of a million people in England and Wales who are failing to get all or part of their prescriptions dispensed because of the cost.**
- 2.37. The Institute of Fiscal Studies has calculated that a similar number of people - some 757,000 in England and Wales aged 18 to 60 - have weekly incomes within £20 of the income levels at which prescription exemption applies¹³. This suggests that the levels of income within which help with prescription charges should apply, might need to be raised by around £20 per week if the problem of prescription affordability is to be tackled. In practice there will be other people who because of their individual financial commitments or their exceptionally high prescription use, are unable to afford to get their prescriptions dispensed despite higher levels of incomes.

¹² A nationally representative quota sample of 1,052 adults aged 16+ was interviewed by MORI in 150 sampling points in Great Britain from 6-10 April 2001.

¹³ The analysis was carried out by the Institute of Fiscal Studies using the IFS tax and benefit microsimulation model TAXBEN, with data from the Family Resources Survey, 1998/99 and using the grossing factors supplied by ONS to estimate the total numbers of families affected. NACAB are very grateful to IFS for this work.

- 2.38. The absence of tapered help with prescription charges as incomes rise above exemption levels dates back to the time when such charges were relatively nominal. **However this is clearly no longer the case. Each prescribed item now costs the patient £6.10 in England, many conditions require more than one item, and there is official encouragement to GPs to reduce prescribing periods, which increases the number of prescriptions issued to individuals.**
- 2.39. Indeed recent research comparing cost-sharing arrangements for prescribed medicines across a sample of EU countries demonstrated that the UK 's flat rate charge is fixed at a relatively high rate. In this study¹⁴, the cost to the patient of 10 different prescription scenarios was compared across 7 EU countries. Apart from three of the scenarios in which the UK patient would have been exempt, the study showed that the UK patient consistently paid amongst the highest charges. The only exception was a scenario in which a three month supply of the drug was prescribed, where the cost to the UK patient then ranked third lowest out of the seven countries. But as discussed above, the trend in the UK is to move away from longer period prescriptions.
- 2.40. The fact that prescription charges are now included as insurable items in some policies is further indication that they are a significant cost which even has value for marketing insurance products.
- 2.41. As the Government takes stronger measures to crack down on prescription fraud (from December 2000 in England and Scotland, and April 2001 in Wales, penalty charges of up to £100 may be imposed, where patients are found to have falsely claimed exemption from prescription charges), it will be increasingly important to ensure that there is adequate help for those who genuinely cannot afford to pay.

A CAB in West Yorkshire reported a client who had been in receipt of income-based jobseekers' allowance and therefore was exempt from prescription charges. However he then became ill and as a result transferred onto incapacity benefit, thus losing his entitlement to free prescriptions. He suffered from breathing difficulties and had been given a prescription with four items which he urgently needed. However on a weekly income of £50.90 he was unable to afford the £24 required, and commented to the CAB that he saw fraud as his only option.

- 2.42 The CAB Service recommends that the Government should conduct a fundamental review of prescription charges and examine the case for abolition.** Certainly CAB evidence demonstrates that for some people, prescription charges can be damaging to health.

¹⁴ Noyce, Peter R. et al, (2000) *The cost of prescription medicines to patients*, Health Policy Vol 52, pages 129-145

2.43 However, if charges are to remain, it is essential that the scheme is reformed to provide tapered help for people with incomes just above the exempt levels. One option would be to apply the low-income scheme taper to the £6.10 prescription charge itself. Alternatively a simpler way to provide the necessary help would be to bring the pre-payment certificate within the low-income scheme so that patients on low incomes could purchase pre-payment certificates at a discounted rate. Tapering its price as patients' incomes rise would be a relatively simple way of addressing the affordability problem. It would also ensure that heavy prescription users on low incomes could share the advantages of the cap on total prescription expenditure currently enjoyed by the better off. **The CAB Service recommends that help with paying prescription charges should be extended to people with incomes above the exempt levels, by pricing the pre-payment certificate on a sliding scale, depending on a person's income.**

3. Dental and optical charges

Dental charges

- 3.1 Many people (for example children and pregnant women) are entitled to free NHS dentistry although, unlike in the case of prescriptions, those over 60 are not automatically exempt¹⁵. There is also relief on income grounds - for example 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, unlike prescription charges, there is tapered help through the low income scheme as incomes rise above the exempt level. **Even so, three quarters of adults receive no help with the cost of NHS dental treatment and this figure increases to 82% amongst adults aged 60 years and over** (Hansard, 9.2.01 col 714).
- 3.2 People not entitled to free or reduced cost NHS dental treatment pay 80% of the cost of a course of NHS treatment up to a maximum of £360 (£354 in Wales). This is a significantly greater figure than for any other NHS charge. It is also high in comparison with some other European countries. For example in Germany basic and preventative dental care is free and operative treatments attract a charge of between 30% and 50%; in France patients pay 30% of the cost of preventative care and treatment, but 80% for dentures.¹⁶
- 3.3 However the main focus of public concern about NHS dentistry over the last decade has been the difficulty in accessing NHS dental treatment at all in many parts of the country, rather than the cost of NHS charges. This followed the implementation of a new contract with dentists in 1990, following which many dentists decided to reduce the amount of time they devoted to NHS dentistry and increase their private practice. The impact of this loss of NHS dentistry has been particularly borne 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.
- 3.4 The extent of CAB concern about this issue was evidenced in the responses to the survey questions which sought to explore the cost of NHS dentistry and whether the charges had resulted in financial difficulties. Some CABx commented that these questions were irrelevant as their clients could not find NHS dentists and so were having to pay higher private charges for dental treatment. One CAB in Kent was so concerned that they inserted additional questions to the questionnaire to probe this area. Another CAB in Shropshire commented that of their 33 survey clients who had not paid charges in the last year, seven had not paid because there was no NHS dentist available in the area.

¹⁵ From April 2001, people in Wales aged under 25 or 60 and over are entitled to free dental check ups.

¹⁶ Robinson, R. *User Charges for Health Care* in *Funding Health Care Options for Europe*, E.Mossialos, A.Dixon and J.Figuerras (eds) OU Press, 2001.

- 3.5 Whilst some dentists have ceased to offer NHS treatment altogether, others have continued it only for exempt groups such as children and those on lowest incomes. Access to NHS treatment has therefore been particularly difficult for those adults who would be liable to pay the full NHS charge. Figures from the Dental Practice Board show a steady decline in the number of adult patients registered with the General Dental Service in England, falling from 21.9 million in 1994 to 17.1 in 2000. This decline in the numbers of those potentially liable to pay full charges may be one reason why there has not been more concern expressed over the high ceiling for NHS charges. But the issue of charges may be expected to take on a higher profile if the Government is successful in its recently launched strategy to breathe new life into NHS dentistry¹⁷. **Modernising NHS Dentistry – implementing the NHS Plan** proposes a range of alternative models of service delivery, supported by additional funding of £100 million, aimed at delivering the Government's pledge that by September 2001, everyone will be able to access NHS dentistry.
- 3.6 The average charge for a course of treatment for adults liable to pay the full cost in 1999/2000 was £21.82, with patients aged 60 and over paying an average of £22.22. (Hansard, 9.2.2001 col 715). One in 1000 patients pays the maximum charge. (Hansard, 17.2.2000 col 666). Table 7 shows the profile of treatment costs in 1999/2000. Whilst the vast majority of courses cost under £100, 171,400 courses of treatment cost over £300.

Table 7 Dental charges for General Dental Service treatment by cost of treatment, 1999/2000

Patient charge	Numbers of courses of treatment (thousands)
Under £100	24,036.2
£100 to £199	1,544.1
£200 to £299	306.7
£300 or more	171.4

(Hansard, 20.3.2001, col 138)

- 3.7 **Modernising NHS Dentistry** - the dentistry document relating to the NHS Plan – does not address the question of whether the extent of NHS dental charges is causing hardship to patients or is actually deterring people from seeking treatment, with a consequent impact on health. The CAB survey included a number of questions aimed at exploring whether NHS charges were causing financial difficulties to patients. The figures are however likely to be an underestimate of the full scale of the problem, as only those who had paid some prescription or NHS dental charge in the last year were questioned. People who had been put off seeking any dental treatment because of the cost were not included.

¹⁷ *Modernising NHS Dentistry – Implementing the NHS Plan*, Dept of Health, Sept 2000

Affordability of dental charges

- 3.8 In the CAB survey seventy one per cent of the sample (1132 respondents) said they were registered with an NHS dentist. This figure rose to 82% among pensioners. Of those who were registered, 86% said they had had a check-up in the last year. Again pensioners were particularly likely to have had check-ups (94%).
- 3.9 14% (156 patients) had not had a check-up in the last year and Table 8 shows the reasons given for not having done so. This shows clearly that affordability is the major factor, with 43% of this group stating that they could not afford the cost. At the time of the survey, the basic NHS check-up cost £4.92 although in practice this is often accompanied by a scale and polish which cost £7.76, bringing the total charge to £12.68.¹⁸ In addition patients on low incomes may be concerned that the check-up may reveal the need for additional work which would raise treatment costs still further.

Table 8 Reasons given for not having a dental check-up in the last year

Could not afford the cost	43% (67)
Did not want/need one	34% (53)
Other	17% (27)
Not stated	6% (9)
Total	100% (156)

- 3.10 It must be of concern if some patients are failing to have regular check ups because of the cost. The dental check up has a valuable preventative role to play in identifying decay at an early stage, enabling cheaper and more effective treatment to take place. It can also perform a vital role in detecting underlying medical conditions such as oral cancer. Whilst the appropriate review period for check-ups may itself be an issue for debate, **the CAB Service recommends that all patients should be entitled to regular free dental check-ups.** This would encourage people to take a preventative approach to the use of dental services, rather than waiting until they have a problem before seeking treatment. The extension of free check-ups to people aged under 25 and those aged 60 and over in Wales is therefore welcome.
- 3.11 In the last year, 1001 respondents had paid NHS dental charges. As Table 9 shows,¹⁹ nearly half the respondents had paid charges of over £50. One in five respondents had paid over £100.

¹⁸ From April 2001, charges in England have been increased to £5.12 for the basic examination and £8.08 for a scale and polish - totalling £13.20.

¹⁹ These figures suggest that the survey respondents had paid higher charges than might be predicted from the figures in Table 7. It is however worth noting that the two sets of figures are not strictly comparable as Table 9 refers to **total** charges paid in the twelve months prior to November 2000 whereas Table 7 refers to charges **per course of treatment** between April 1999 and April 2000.

Table 9 Approximate amount of dental charges paid

Up to £50	57% (570)
£50-£100	18% (182)
£100-£200	13% (126)
£200-£300	4% (39)
£300 and over	3% (28)
Not stated	6% (56)
Total	100% (1001)

3.12 Respondents were asked whether they had had difficulty in affording the dental charge. Forty four per cent said that they had found the charges difficult to afford. Single people under pensionable age (54%) and single parents (55%) were particularly likely to report difficulty. Not surprisingly there was a positive correlation with the size of charges: 75% of those charged over £200 reported difficulty in paying the charge.

3.13 The potential impact of high dental charges is illustrated by the following case:

A CAB in Hampshire reported a client who had to have four teeth removed. The bill came to £354 and the amount he had to pay was reduced to £298.44 because of his low income. He paid £100 and then continued to pay the remainder in small amounts when he could afford to. The dentist would not however provide him with his replacement teeth until the full bill was paid. When he visited the CAB two months after the extraction, he complained that he was not able to eat properly.

3.14 In 1998 the British Dental Association published research commissioned from York University's Centre for Dental Services Studies which included an examination of the public's views of the General Dental Service.²⁰ This found that many people were not aware that patients paid 80% of the NHS cost. When they were informed of this there was a widespread perception that this was unfair. Many felt that a 50/50 split or a reversal of the current ratio to a 20% patient contribution was preferable. There was also widespread concern about the ceiling (then £340) and some suggestions that it should be reduced, perhaps to £200.

3.15 It is clear that with the launch of the **Modernising NHS Dentistry**, the Government is keen to give a more positive profile and commitment to NHS Dentistry. As part of this revival, **the CAB Service recommends that if dental charges are to remain, there should be a significant reduction in the maximum and percentage of charges which people may be liable to pay.** A maximum charge of £100 would still be significantly above the average charge paid but would increase equity by providing greater protection for the minority who need the most

²⁰ Land, T, and Herring L, *User priorities for General Dental Services*, York Health Economics Consortium, 1998

expensive treatment. Similarly a reduction in the percentage paid by the patient from 80% to 50% of the cost would go some way to indicate that, if charges are to remain, NHS dentistry is a cost which is shared more equally between the state and the individual patient. The cost of reducing the maximum charge to £100 has been estimated at £35 million, whilst implementing both measures would cost £170 million (Hansard, 20.3.2001, col 137).

- 3.16 Arguably the CAB survey underestimates the full scale of the problem since it only included people who had actually paid charges in the last year. The wider question must be how many people are deterred from seeking dental care altogether because of the cost. **The CAB Service recommends that the Department of Health commissions research into the extent to which the current level of charges are causing hardship, or preventing people seeking the treatment they need.**
- 3.17 As well as addressing access issues, **Modernising NHS Dentistry** aims to introduce greater clarity into the area of charges. Patients will be given a clear statement of the charges for the course of treatment at the outset. There will also be procedures to ensure clearer boundaries between NHS and private treatment. The CAB Service welcomes this reform, which should address the often-reported problem of patients only finding out at the end of their treatment that they had unintentionally received more costly private treatment.

Other dentistry-related charges

- 3.18 It is not only the treatment charges which are of concern to the CAB Service. Bureaux report that some dentists are in effect charging for access to NHS treatment. Because 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:

A CAB in Cambridgeshire reported a single parent with three children who was in receipt of income support. The dentist would only provide NHS dental treatment if patients paid a £25 charge which was refundable only after the treatment was completed. The client could not afford to pay the charge for herself and each of her children and therefore was excluded from access to what should be free NHS treatment.

A CAB in Hampshire reported a woman who was suffering from diabetes and mental health problems and living on the reduced rate of income support whilst appealing a refusal of incapacity benefit. She would therefore have been entitled to free NHS dental care. She needed urgent dental treatment and her GP recommended a dentist in the same Health Centre. However the dentist required a £20 refundable charge before beginning

treatment which she could not afford. She telephoned several other dental practices and found they made the same upfront charge. The CAB telephoned the Health Authority which confirmed that such charges were lawful and were common.

- 3.19 It is surely contrary to the principles of the National Health Service to impose a charge for accessing NHS treatment, as it effectively excludes the poorest people who would be eligible for free treatment under the NHS. **The CAB Service recommends that the Department of Health takes steps to end the practice whereby dentists effectively impose a charge for access to NHS treatment.**
- 3.20 A second area where large charges are increasingly being reported is for broken appointments with dentists. Whilst it is understandable that practitioners wish to impose some sanction to prevent casual abuse of the system, it is clear that some dentists are imposing charges for broken appointments with no regard either for the reason the patient did not attend or for the patient's ability to pay:

A CAB in Wiltshire reported a single parent in low paid work who was entitled to free treatment, who was charged £30 for cancelling an appointment at short notice. The reason for the cancellation was that her child was sick and she could not find anyone to mind the child. The dentist was unwilling for her to bring the child to the surgery.

A CAB in Wales reported a single parent in low paid work who was entitled to free dental care. She missed an appointment although she claimed she let the dentist know in advance. The dentist then refused to treat her daughter until she paid a £15 charge for a missed appointment.

- 3.21 It seems likely that the root cause of this problem lies in the terms of the GDS contract, with its emphasis on remuneration on the basis of items of service. We hope that it will be possible to address this and other similar problems through a review of the contractual arrangements. However whilst the existing system remains, **the CAB Service recommends that the British Dental Association draws up good practice guidance on cancellation charges, to include both the level of charges, and the circumstances in which they may or may not be appropriate.**

Optical charges

- 3.22 The problems which arise with optical charges are different from those of prescription and dental charges, because of the way the service is provided. Rather than the charge itself being reduced for people on low incomes, help is provided by means of vouchers which can be used to offset the optician's charge. However the vouchers are for pre-set amounts which are dependant on the type of lens required and the assessment of patients' financial circumstances, rather than on the

actual bill which the patient has to pay because none are available within the value of the voucher.

- 3.23 The issue therefore is the shortfall between the NHS help which is provided for people on low incomes and the charge made by the private optician. Whilst the cost of eye tests and glasses will vary depending on the supplier, the help available through the health benefits scheme is for fixed amounts, depending on the type of lens required. It is left to the person seeking treatment to shop around for the best deal, and, where necessary, to meet any shortfall. As a result, even people on income support and entitled to full vouchers may find themselves having to pay towards the cost of glasses:

A CAB in Bedfordshire reported a pensioner on income support who needed new glasses. His voucher was for £50 but the cost of the cheapest glasses was £90. He could not afford the £40 shortfall from his weekly income support of £131.05 for himself and his wife.

A CAB 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 which would supply glasses within the value of his £64 voucher. Most charged around £90.

A CAB in London reported a retired man on income support who was left with a bill for £159.49 for bifocals, after deducting the value of the voucher. He had no savings to draw on.

A CAB in Hertfordshire reported a client in receipt of incapacity benefit who needed new glasses because her prescription had changed. She was entitled to a voucher but could not afford to pay the difference between the voucher and the total cost. The CAB had to help her apply to a charity.

- 3.24 The Department of Health carries out regular surveys which examine the percentage of vouchers redeemed within the value of the voucher. This has in past years shown an inexorable fall in the percentage of prescriptions redeemed within voucher values. In the 1996 survey, regional variations were examined.²¹ The survey found that whilst in the North and South East 19.3% and 16.4% of vouchers were redeemed within voucher values, the figures were much lower in the South West (0.9%) and Wales (2.4%), both predominantly rural areas where many people may not have easy access to a large town and therefore the benefits of competition in this market.
- 3.25 It is clearly important that, in setting the value of the vouchers, the Government ensures that they reasonably reflect the costs which the industry faces. But beyond that, if patients are to be ensured equality of access to optical care, then **the CAB Service must repeat the**

²¹ *Voucher survey 1996*, NHS Executive, Government Statistical Service, May 1997.

recommendation made in its 1991 report that glasses within the value of NHS vouchers must be available from all opticians providing NHS treatment. At the same time, it will be important to safeguard the network of optician outlets, to ensure ease of access to NHS optical care.

- 3.26 In addition, user awareness could be increased by using NHS Direct in a similar way to its planned use in relation to access to NHS dentistry. From September 2001 the Government has given a clear commitment that people seeking to access NHS dentistry will be able to get the information they need by telephoning NHS Direct. This service will have full details of NHS dentistry provision at the local level and will therefore be able to direct people towards their nearest provider. The database will also enable the NHS to map provision and take steps to put in place additional services in areas without local access. **The CAB Service recommends that the Department of Health establish a similar information provision for optical care, by collecting data from opticians on the availability of glasses within the voucher values and making this information available to the public by means of NHS Direct.** This data base would also enable the Department of Health to monitor the extent to which the value of vouchers was keeping pace with charges, and to take steps to ensure that affordable provision and choice was available in all parts of the country.
- 3.27 A related problem is that of benefit take-up. Whilst the health benefits low income scheme itself is highly complex, involving a claim form with 49 questions running to 15 pages, the voucher scheme is arguably the most complex part of the scheme. There are no estimates of levels of take-up available, but it is noteworthy that whereas the welcome extension of eligibility to NHS eye tests to people aged 60 and over since April 1999 led to a 34% increase in NHS sight tests in the following year, there was in fact a 3% decrease in the number of vouchers redeemed compared to the previous year.²² This is despite the low incomes of many pensioners, and would suggest that take up of the low income scheme amongst this group may be poor.
- 3.28 Research commissioned by RNIB also indicated that some people aged 60 and over were put off having eye tests because they were worried about the cost of glasses.²³ Although the survey was carried out in 1996, before free eye tests were introduced, the survey found that, amongst those who had not had an eye test within the previous two years, 12% gave as a reason that glasses were too expensive – almost as many as were put off by the cost of the eye test (15%).
- 3.29 In 1999/2000, 528,000 certificates were issued for full help (HC2) under the low income scheme and 293,000 for limited help (HC3) (Hansard, 15.3.2001, col 720). However there is no information available about the

²² *General Ophthalmic Services Activity Statistics 1999/2000*, National Statistics, Dept of Health

²³ Grindley S. and Winyard S., *Losing sight of blindness*, RNIB, 1997. NACAB would like to acknowledge the support of RNIB in the preparation of this section of the report.

level of non-take-up of the health benefits low income scheme. **The CAB Service recommends that the Department of Health regularly reviews the level of non-take-up of the low income scheme and in particular of the help available with optical charges.**

- 3.30 For people who are registered blind or partially sighted, glasses are a critical aid to independence, in the same way that wheel chairs are for people unable to walk, or hearing aids are for deaf people. **The CAB Service therefore recommends that this group should be entitled to full vouchers, regardless of their income.**

4. Travel costs

- 4.1 Where patients require health care which is not available within the local area, the costs of travel in order to access it can also be a major barrier for people on low incomes. Indeed even within the local area, clients in poor health may be unable to travel any distance without help. In addition to local patient transport services, some help with the cost of travel to hospital is provided through the health benefits system for people on means-tested benefits. However CAB evidence demonstrates a range of failings both in terms of the complexity of the scheme and in terms of the situations in which help is available.

Complex procedure

- 4.2 The normal procedure is for patients who qualify for help to pay the cost of travel themselves and then seek reimbursement at the hospital. However CAB evidence indicates that people miss out on the help to which they are entitled because
- there is often little or no information given to patients about the help which is available
 - there can be difficulties in obtaining the relevant claim forms
 - there is low knowledge by health professionals, resulting in misinformation to patients.
- 4.3 This complexity is vividly conveyed in the following CAB cases:

A CAB in Hampshire reported a client attending an eye clinic at the local hospital who correctly produced his HC3 certificate in order to obtain a reimbursement for travel expenses. He was told that he needed a letter from his doctor. He went to the doctor who referred him to the CAB who established that he should have been reimbursed at the hospital. The CAB then had to help him claim a refund instead.

A CAB in Surrey reported a client entitled to help with travel costs who tried to claim at the hospital but found that the Finance Office was closed. She was instead referred to the Benefits Agency office. They informed her that she needed to claim a refund on form HC5 but that they did not stock these. Neither the Post Office nor the CAB stocked the form either. On enquiring from the Health Information Service, the CAB was told that the forms are very difficult to obtain. This is despite the fact that applications for refunds have to be made within three months of incurring the cost. The client was very angry at the wasted time and money in trying to obtain reimbursement.

A CAB in the West Midlands reported a woman who was making regular bus journeys to hospital for chemotherapy treatment for cancer. Her sister accompanied her as she always felt ill on the way home. She was in receipt of income support so should have been entitled to a full reimbursement of the fares, but could find no-one at the hospital who had any information about how to claim. She was referred to DSS who also were unable to help. The CAB explained where to claim at the hospital and advised that she should enquire about payment for her sister and the authorisation for taxi fares because of the effects of the chemotherapy.

A CAB in Bedfordshire reported a disabled man on income support who needed an urgent operation to remove a kidney stone. He was given an appointment for 10.30 am and told he would be discharged the same day but would need to be accompanied home because of the effect of the anaesthetic. He had no way of getting to and from the hospital. The Patients Affairs Manager had never heard of sending money in advance and advised the client to ask the GP for access to the voluntary drivers scheme but there was no such scheme. The local Red Cross needed a fortnight's warning and the WRVS scheme would cost £33 because the driver lived a distance away. A return taxi would cost £35. There was a bus leaving at 7am but the client would not be fit to return by bus.

A CAB in Hertfordshire reported a client on income support who had been making regular journeys to hospital for nearly two years without realising he could claim help with travel expenses. Now that he is aware of the scheme, he finds it difficult to use. Because his income support is paid direct into his bank account, he needs a letter from DSS each time he attends, confirming receipt of income support. He has to give DSS a week's notice each time.

- 4.4 The problems experienced by the last case above could become more widespread as the DSS moves towards paying all benefits direct into bank accounts.
- 4.5 Problems are compounded where the NHS makes contracts for patients to receive treatment in non-NHS hospitals. In these cases the patient has to claim a refund under the health benefits scheme rather than a reimbursement at the hospital. Payment is only made following communication between the Health Benefits Unit, the non-NHS hospital and the relevant health authority or trust. Not surprisingly, this process can be lengthy and time consuming and too often appears to be unfamiliar to the agencies involved:

A CAB in Nottinghamshire reported a claimant whose son was referred to a private London hospital for NHS treatment. Initially the claim was incorrectly refused as not being NHS treatment. The client, who was in receipt of family credit, was forced to pay over £500 in travel costs. It took over eight months to receive the refund, by which time she had incurred interest charges on her credit card.

A CAB in Surrey reported a client on income support who was referred by his GP to a private physiotherapy clinic for NHS treatment. He correctly completed the refund form (HC5) but this was then passed from the Health Benefits Unit to the clinic and the Primary Care Group, both of whom denied responsibility. Four months later, after the client had completed the HC5 for the third time, payment was made.

- 4.6 Under the new concordat between NHS and the private sector whereby NHS patients will be treated in private hospitals in order to reduce waiting times, the frequency with which this type of problem occurs is likely to increase. Bupa, the private health insurance provider, recorded a three-fold increase in the number of NHS patients treated in its hospitals in the last three months of 2000, compared with the same period in the previous year.²⁴
- 4.7 One of the key objectives of the Government's NHS Plan is to make the NHS a more patient-centred service. The area of help with travel costs is one which clearly demonstrates that need. Even the siting of the reimbursement office can create its own barriers to claiming back travel costs if it is at the far end of a large hospital, away from out-patient clinics. But good practice does exist. For example Hope Hospital CAB reports that at their hospital, all out-patient appointment letters include a booklet outlining who can claim travel expenses and where the office is situated in the hospital.
- 4.8 The NHS Plan proposes that every health trust – both hospitals and primary care - should have a Patients Advocacy Liaison Service, to help patients navigate the NHS. Such a service could play a key role in giving the travel costs scheme a higher profile, through staff training, through developing a promotion and publicity strategy targeted both at GP surgeries and also at hospital out patients and accident and emergency departments, and through providing an information point for patients' queries. **The CAB recommends that the take-up of the hospital travel costs scheme should be publicised in all GP surgeries and hospitals. The proposed Patients Advocacy Liaison Service should have the co-ordination of this promotion as a specific function.**

²⁴ Independent, 19.2.2001

Limited scope

- 4.9 The travel costs scheme is also flawed in that it fails to provide help in many circumstances where patients and their families face travel costs in order to access health care²⁵. Firstly the scheme is limited to travel to **hospital**. If the GP refers a patient to a clinic for treatment rather than to a hospital, there is no help with travel costs available:

A CAB in Hampshire reported a single parent with two sons, struggling to cope on income support. Both children required orthodontic treatment and she was given the choice of a referral to Southampton hospital or to an alternative consultant who was nearer to her home. She therefore chose the latter because of the shorter travel time, which would also mean less time lost from schoolwork. She did not realise that this choice would mean that she could claim no help with the travel costs, which she was finding very difficult to afford.

A CAB in Wales reported a client in receipt of income support whose child was referred by a hospital to a dental clinic in Cardiff – some ten miles away. After treatment the child was unable to use public transport and a taxi had to be taken. The client claimed for help but was refused as the clinic was not classed as a hospital.

- 4.10 Nor is there any recognition of the fact that people with the greatest health or mobility needs may have difficulty in travelling to access GP or dental surgeries. Age Concern London has recently highlighted the extent of such problems amongst older people.²⁶ They found that, even in London, older people's health was suffering because of the difficulties they faced in travelling to health care. Over half of those travelling to hospitals and dentists and a third of those using GP services or health centres reported difficulty in getting there.
- 4.11 Travel problems are likely to raise even greater difficulties in rural areas where journeys may be longer and public transport less frequent. Many CABx have reported the difficulties faced by more vulnerable clients as a result of the disappearance of the local NHS dentist.

A CAB in Wales reported a pensioner client who suffered from Crohns Disease. Her nearest dentist involved a 48-mile round trip and she could not get there by public transport as it was not a direct service and she needed frequent access to a toilet. Although there was help available for hospital out-patient appointments, there was no help for travel to dentists although she needed regular treatment to keep her free from pain. She

²⁵ For more details on the operations of the travel costs scheme, see NACAB's 1991 report - *Health Warning: low income groups and health benefits*

²⁶ Age Concern London, *A helicopter would be nice*, London, 2001

was tired of having to rely on friends and neighbours for help with transport.

- 4.12 Other changes in the health service may compound the problem. For example CABx increasingly report GPs are reluctant to provide home visits, and some hospital trusts under budgetary pressure are reducing the scope of their transport services.

A CAB in Lancashire reported a client who was disturbed to receive a message on the duty doctor's telephone stating that it would not be normal policy to visit patients at home. The client was told to visit a health centre five miles away in order to see a doctor. The message also stated that it was the patient's responsibility to arrange transport and that the centre staff would not be able to assist.

- 4.13 A further problem is the lack of help with the travel costs for relatives to visit patients in hospital, despite the fact that the health benefit to patients from family visits is not disputed. The only help available is from the social fund. But this is limited to claimants in receipt of income support and even then there is no guarantee that a grant will be made as it is a budget-limited provision.

A CAB in Kent reported a client on income support whose daughter was being treated in a hospital in Sussex because there were no beds available in local hospitals. He was finding it difficult to afford the fares to visit, but was not eligible for social fund help as he had over £500 savings.

A CAB in Devon reported a couple with four children in receipt of working families tax credit whose 14 year old daughter was admitted to a hospital in Bristol for open heart surgery. They had an old car but could not afford the £20 petrol costs to visit her.

A CAB in Cleveland reported a client whose daughter had severe physical disabilities which required frequent lengthy hospital admissions. She would get very agitated if she did not see her mother on a daily basis. The hospital was 2 hours journey away, requiring two bus rides with a very intermittent service. The client therefore took taxis at a cost of £20 per journey. This caused the family significant financial difficulties.

- 4.14 For couples in receipt of social security benefits, the difficulty in affording travel costs is made worse by the rules which reduce benefits after a set period in hospital:

A CAB in Wales reported a woman in her 70's whose husband had been in hospital for over six weeks. She made 40 mile round trips most days to visit him. She had rung the CAB very

distressed by a letter from the Benefits Agency informing her that her husband's retirement pension would be reduced by £12 per week. This would make it even more difficult for her to afford to visit him.

- 4.15 In some cases the combined impact of lengthy journeys and poor health can mean that people have to arrange overnight accommodation in order to attend for out-patient treatment. There is no help for the costs of such overnight stays:

A CAB in Wales reported a pensioner client who had to travel to West Yorkshire periodically for treatment, requiring overnight stays of two or three nights. His travel costs were reimbursed but he received no help with the accommodation costs which he found difficult to afford.

- 4.16 CAB evidence indicates that clients in rural areas are particularly affected by the inadequacies of the help with travel costs. The CAB Service therefore welcomes the proposals in the Government's Rural White Paper²⁷, which are aimed at improving public transport and also at bringing more public services to people rather than expecting them to travel. Initiatives aimed specifically at reducing the costs of travel through promoting concessionary fare schemes and funding small scale transport projects may make some impact on the problems outlined above.
- 4.17 However if equality of access to health care regardless of means is to be guaranteed then **the CAB Service recommends that the scope of current provision should be extended to include easier access to payment in advance, help with non-hospital travel, overnight costs where necessary, and visiting costs for family members.**

²⁷ DETR, *Our Countryside the future*, Nov 2000

5. Conclusions

- 5.1 This report has clearly demonstrated that many people face financial difficulty in accessing the NHS care they need. This is despite the exemptions and help for people on low incomes provided by the health benefit scheme. CABx working in health projects in particular report that they often come across clients who have not had their teeth or eyes checked for years because of anxiety about charges. Moreover in a significant number of cases, people on low incomes are failing to get their prescriptions dispensed because they cannot afford the charge, thereby putting their health at risk. The burden of prescription charges falls unequally, with people on lower incomes and with chronic health problems bearing the heaviest load.
- 5.2 We believe this evidence seriously challenges the assumption made by this and previous Governments, that the health benefits scheme ensures that no one need be deterred by financial reasons from accessing health care. Moreover, this Government has raised the stakes significantly by its welcome acknowledgement of the links between health and poverty and its commitment to

“undertake the biggest assault our country has ever seen on health disadvantage...to tackle health inequalities by improving the health of our nation overall, and deliberately and determinedly raising the health of the poorest fastest”. (Alan Milburn MP, Secretary of State for Health, speech at Long-term Medical Alliance Conference, 28 February 2001)

- 5.3 The CAB Service believes there is a strong case for the abolition of all charges for health care. The main arguments against charging are well known²⁸:
- They are inequitable because, for those above the ‘low income levels’ (which are set at a very low level), the charges impact most on the worst off and on those who have most need of treatment
 - They may be cost ineffective to the health service if they result in deferred treatment
 - They involve significant administrative costs in terms of collection, anti-fraud measures, and the promotion and administration of full and partial exemption schemes
 - They are not required in order to prevent unnecessary use of health resources since access to these is already controlled by health professionals.

5.4 The CAB Service therefore recommends that the Government should conduct a fundamental review of NHS charges including a consideration of the case for extending the existing exemptions

²⁸ See for example Eversley, J. and Sheppard, C., *Thinking the Unthinkable: the case against charges in primary health care*, Health Matters, 1998

from charges. The review should also examine the case for abolishing all charges, as their continuation is arguably contrary to the fundamental principle of the NHS to provide a service on the basis of need and not ability to pay. NHS charges also conflict with the Government's wider policy agenda to reduce health inequalities and to tackle social exclusion.

- 5.5 However whilst charges remain, the priority must be to ensure that no-one fails to access health care because of financial difficulties. In this context, we welcome the fact that the NHS Plan proposes the development of a health poverty index to underpin work on health inequalities.²⁹ A similar approach has been adopted in relation to fuel poverty, which has resulted in the Government setting a clear definition of fuel poverty as being when a household needs to spend more than 10% of its income on energy to maintain an adequate standard of warmth. It has also set targets to end fuel poverty.³⁰ **The CAB Service recommends that the health poverty index currently being developed should include expenditure on health charges within the definition of health poverty, and set clear targets for eliminating health poverty.**
- 5.6 This report has set out a number of recommendations which we believe would reduce some of the most acute problems. These include extending help with prescription costs to people on low incomes, significant reductions in dental charges, ensuring people on low incomes are able to access optical care within the value of the vouchers provided under the health benefits scheme, and broadening the scope of help with the costs of travel to access health care.
- 5.7 Without such reforms, the CAB Service believes that the Government's high level objectives of ensuring fair access to health care and reducing health inequalities will not be achieved.

²⁹ *NHS Plan*, July 2000, CM4818-1, page107

³⁰ DETR press release 099, *Government seeks to end fuel poverty*, 23.3.01

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Appendix 1: Profile of CAB clients in CAB health charges survey, November 2000

Gender

Female	57% (909)
Male	39% (625)
Not stated	4% (68)
Total	100% (1602)

Race

White	91% (1452)
Black Caribbean	1% (11)
Black African	- (7)
Black other	- (2)
Indian	1% (11)
Pakistani	-(6)
Bangladeshi	-(5)
Chinese	-(6)
Other	1% (21)
Not stated	5% (81)
Total	100% (1602)

Household composition

Single non-pensioner	17% (267)
Couple non-pensioners	12% (197)
Single pensioner	6% (92)
Couple pensioners	7% (120)
Single parent	8% (124)
Couple with children	33% (534)
Other	11% (179)
Not stated	6% (89)
Total	100% (1602)

Long term health problems

Yes	36% (583)
No	59% (940)
Not stated	5% (79)
Total	100% (1602)

Appendix 2: CABx which submitted evidence between February 1999 and April 2001 and/or participated in the health costs survey.

EAST REGION

Amersham
 Aylesbury
 Billericay
 Bishop's Stortford District
 Bletchley
 Buckingham, Winslow & District
 Bury St Edmunds
 Cambridge
 Castle Point
 Chelmsford
 East Northants
 Elstree & Borehamwood
 Epping
 Fenland (Main)
 Great Yarmouth
 Harlow
 Hemel Hempstead
 Hertford
 Ipswich & District
 Kings Lynn & District
 Leighton Linlade
 Leiston & Saxmundham
 Loughton
 Luton
 Mid-Suffolk
 Milton Keynes (Bletchley)
 Norwich & District
 Peterborough
 Potters Bar
 Royston
 Stevenage
 Uttlesford (Saffron Walden)
 Waltham Abbey
 Watford
 Witham
 Wymondham & District

MIDLANDS REGION

Ashfield
 Bassetlaw (Retford)
 Bedworth & District
 Beeston
 Biddulph

Bilston
 Birmingham District Health Project
 Boston
 Bridgnorth
 Bromsgrove & District
 Coalville & District
 Cradley Heath (Sandwell District)
 Eastwood & District
 Handsworth
 Harborough District
 Kings Heath
 Kings Standing
 Leicester
 Mansfield & District
 Nottingham & District
 Redditch
 Rugeley
 Rutland
 Shrewsbury
 Sleaford
 Smethwick (Sandwell District)
 Solihull
 South Derbyshire
 South Holland
 Stafford
 Stamford & District
 Staveley
 Stoke-On-Trent (District)
 Stourbridge
 Telford Town Centre
 Warwick District
 Wellington
 Worcester

NORTH WEST REGION

Altrincham
 Atherton
 Barrow-in-Furness
 Bebington
 Birkenhead
 Blackburn
 Blackpool
 Bolton & District
 Bury
 Chester

Crew
 Crosby
 Ellesmere Port
 Formby
 Garston
 Harpurhey (Collyhurst)
 Hazel Grove
 Hope Hospital
 Knowsley South
 Lancaster
 Leigh & District
 Liverpool City Centre
 Lytham St. Annes
 Millom & District
 Morcambe & Heysham
 Nantwich
 Oldham District
 Pendle
 Sale
 Stockport
 Ulverston & North Lonsdale
 Warrington
 Whitehaven
 Wilmslow
 Winsford
 Withington
 Workington

LONDON REGION

Barking & Dagenham
 Beddington & Wallington
 Bexleyheath
 Brent
 Bromley Town
 City of London
 Dalston
 Eltham
 Feltham
 Harrow
 Hillingdon - Uxbridge
 Kensington
 Kentish Town
 Pimlico
 Sheen
 Sutton
 Thornton Heath
 Twickenham

NORTH REGION

Blyth Valley
 Boothferry
 Bransholme
 East Yorkshire
 Gateshead
 Holderness
 Hull
 Hulme
 Leeds
 Middlesbrough
 Otley
 Pitsmoore
 Pontefract
 Redcar & Cleveland (Guisborough)
 Rochdale
 Ryedale
 Selby District
 South Elmsall
 South Kirklees
 Thorne
 Tynedale
 Wakefield District
 York

SOUTH REGION

Alton
 Andover
 Bognor Regis
 Bracknell
 Bridport
 Brighton & Hove
 Camberley
 Canterbury
 Crawley
 Dorchester & District
 Dorking
 Dover
 Epsom & Ewell
 Farnborough
 Farnham
 Faversham & District
 Gosport
 Guildford
 Haslemere
 Hastings & Rother
 Haywards Heath
 Herne Bay

Horsham
 Lewes (Peacehaven)
 Lymington
 Maidenhead
 New Milton & District
 Petersfield
 Poole
 Portsmouth
 Reading
 Redhill (Reigate & Banstead)
 Ringwood & Fordingbridge
 Romsey & District
 Runnymede
 Seaford
 Sevenoaks
 Sherborne
 Sittingbourne
 Southampton
 Thanet
 Tonbridge
 Tunbridge Wells
 Winchester
 Woking
 Wokingham
 Worthing & District

WALES

Abergavenny
 Ammanford
 Barry
 Brecon
 Caernarfon
 Cardiff City Centre
 Carmarthen
 Cowbridge
 Cynon Valley
 Denbigh
 Flint (Delyn & Deeside District)
 Machynlleth & District
 Merthyr Tydfil
 Montgomeryshire District
 Neath
 Penarth
 Pontypridd
 Radnor
 Wrexham & District
 Ynys Mon

WEST REGION

Abingdon
 Bath & District
 Bristol
 Brixham
 Bude, Holsworthy & District
 Camborne (Kerrier)
 Devonport
 Didcot & District
 Exeter
 Frome & District
 Henley & District
 Ilfracombe
 Kingswood & District
 Liskeard (Caradon)
 Newquay
 North Cornwall
 North East Somerset
 North Wilkshire
 Plymouth City Centre
 Salisbury & District
 Stroud
 Tavistock
 Taunton
 Thame
 Truro (Carrick)
 West Wiltshire
 Witney