TAX ON ILLNESS?

A guide to NHS Charges

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A description of the legal basis of current NHS charges, an overview of their history, impact and cost, and recommendations for change.

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Introduction

The National Health Service was established in 1948 to provide a comprehensive service designed to improve the physical and mental health of the population of the UK. The relevant legislation[1] provides that services for the prevention, diagnosis and treatment of illnesses must be provided free unless a charge is expressly permitted by statute. The Beveridge report in 1942[2], which laid the foundations for the post war 'welfare state', stated that:

'a health service providing full preventative treatment of every kind to every citizen without exception, without remuneration limit and without an economic barrier at any point......is the ideal plan'.

In many ways, this underlying principle still governs the operation of the modern NHS, despite the strain which it has come under. Some of these pressures emanate from the Treasury or from the changed political landscape of the last two decades associated with the catch phrase 'rolling back the state'. Some have come from within. Devolved responsibility for budgets, the drafting in of managers from the private sector and the involvement of private companies in the financial management of the health service have inevitably changed the climate in which funds are allocated. Increased running costs and expensive advances in medical treatment place pressure on NHS managers to find ways of generating income. Thus it is that Community Health Councils come to hear complaints concerning unreasonable, inequitable and sometimes illegal charges.

The History of NHS Charges

At the outset of the NHS even Beveridge advocated the implementation of charges for 'hotel' expenses during hospital stays and contributions towards the costs of appliances such as dental and optical equipment. Since that time debates have persisted over whether and what charges should be levied.

Although the imposition of charges has often been justified as a measure to reduce wastage, much of the pressure for increasing revenue through this means arises not from any internal health policy logic but as an effect of wider political or economic agendas, particularly those driven by the Treasury. The need to prioritise defence spending (1951), win favour with international money markets (1968), comply with IMF loan conditions (1975-9) and generally control public expenditure (1979-97) have all been cited as reasons for increasing NHS charges[3].

In many instances, charges have been extended as a concession to the Treasury to enable particular projects to be paid for. A onetime staunch opponent of charges, Richard Crossman, Secretary of State for Social Services in 1969 admitted that the introduction of optical and dental charges within the NHS was to fund school building projects[4].

Over the last two decades political pressures have not been sympathetic to the principle of basing service provision on need rather than cost. The wider political context has seen public services privatised across the board – Jean Shaoul, lecturer in accounting and finance at the University of Manchester, points out that in1999 57% of total government expenditure was spent on the purchase of goods and services, compared to only 28% in 1977[5]. As privatisation has progressed, there have been growing pressures to recoup the cost of services from the user rather than out of government expenditure. Where this is not possible, means tested exemptions from user charges are preferred to universal subsidised provision. Thus in education, grants have been replaced by loans and tuition fees. In transport, provision has been privatised and fares increased. In housing, subsidies have been shifted from

investment in bricks and mortar to (more stringently means-tested) housing benefit.

Yet despite this, the popularity of a free health service has always made the introduction of new or increased charges politically difficult. Thus in order to placate opponents of her plans for an internal market, Mrs Thatcher refused to introduce new charges for GP visits and hospital stays. (Nevertheless, prescription charges increased in real terms fivefold between 1979 – 1997).

For this reason the government is particularly keen to find ways of appearing to preserve the principle of free health care while drastically reducing its scope. One such technique has become increasingly important since the late 1980s. This is the process through which more and more functions formerly associated with NHS non-acute care – particularly of the elderly – have been transferred to local social services – enabling charges to be raised.

Social Care

Changes in the responsibilities of different public bodies for the provision of care are reflected in new and ambiguous terminologies: thus 'long-term care' has increasingly come to be redefined as social care, and 'personal care' (chargeable) has come to be distinguished from 'nursing care' (free). As the Health Select Committee pointed out:

"The confusion is epitomised by the farcical question of whether a person needing a bath in the community should receive a 'health' bath or a 'social' bath – the first comes free, the second (in theory at least) has to be paid for on a means tested basis."[6]

The impact of this change is reflected in NHS bed numbers. Between 1979 and 2000 the number of beds in the NHS in England decreased from 480,000 to 189,000, while the number of beds in the independent nursing care sector, increased from 23,000 in 1983 to 193,000 in 2000. The number of private residential care beds also increased, reaching 345,600 in 2000[7]. The growth of this sector was initially fuelled by an uncapped social security budget in the late 1980s. This funding was then subjected to much sharper means testing in the NHS and Community Care Act 1990 and in subsequent legislation. Thus, formerly free NHS services became increasingly self-funded social services. It has been estimated that in 1995 40,000 pensioners were forced to sell their homes to pay for care[8]. Under-funding by central government of local social services effectively forces councils to charge pensioners the full cost of their care if their capital exceeds the disregard limit[9]. Even despite this a shortfall of social services beds remains. The result is that many elderly people cannot be discharged from hospital because they have nowhere to go.

The legality of these charges may be in some doubt. The ruling in *ex parte Coughlan* makes clear that even where an individual had been placed in a home by the local authority, responsibility for provision of nursing care stays with the NHS where the primary need is a health need. The assessment process carried out by social services and health bodies by which eligibility for 'free continuing care' is decided is not transparent or open, and not always rigorous. Patients have little say in decisions about where they go and who will pay for it. Support for this vulnerable group of people not easy to come by. A survey produced by the Pensioner's Campaign Team in April 2001 suggests that only around 20% of social services departments employ patient advocates. After April 2002 assessment for continuing care will be integrated with assessment for nursing care under the Health and Social Care Act. Whether the new regime will improve matters remains to be seen.

Shortly after being elected in 1997, the Labour government set up a Royal Commission to consider the future financing and provision of long term care. This recommended that personal care provided in all settings should be made free at the

point of delivery. The Government rejected this proposal. Provisions in the Health and Social Care Act 2000 remove the responsibility for the provision of nursing care from community care services, but limit its availability. The Act also extends the power of local authorities to recover charges for services by laying claim to the sale value of the homes of those receiving care. Despite the fact that this legislative change was introduced with the stated aim of improving the integration of health and social care services, the persistence of two very different funding regimes will ensure that the boundary between them remains hotly contested.

Social and Health Consequences

If charges simply reduced wasteful overuse of health services across the spectrum of social classes, with no adverse health impact either for particular groups or for the general public, then they could be easily justifiable. Similarly, if the imposition of charges just acted to depress the use of ineffective treatments, they might be reasonable. Yet research has confirmed that such a blunt instrument will not achieve such smart results. In the 1970s the US think tank RAND carried out one of the most comprehensive investigations ever into the effect of user charges involving over 7000 participants[10]. This established that charges reduced the uptake of both ineffective and effective treatments at the same rate. Charges were also found to have a disproportionately adverse effect on low income and vulnerable groups. These same points emerged strongly in a World Health Organisation (WHO) global survey of charges. WHO argued that such a 'tax on illness' often impacts adversely upon the control of infectious diseases and undermines preventative medicine while also producing inequality by deterring the poorest from using services[11].

Former Health Minister Gerald Malone claimed 'there is no evidence to suggest that charges deter people from seeking the medication that they need'[12]. This view has been shared by successive governments. Yet, if prescription charges were exclusively effective in reducing unnecessary usage, prescription redemption figures would show no differentiation between the financial status of individuals with similar clinical needs (horizontal equity). However, a 1993 study found that disproportionate numbers of patients (33%) who failed to redeem their prescriptions were liable for charges[13]. A survey by ACHCEW in 1996 found that 58% of Community Health Councils (CHCs) had experience of patients failing to redeem prescriptions[14]. This finding was supported by a poll conducted by Kidderminster and District CHC in 1995, which established that 35% of people who are not eligible for free prescriptions sometimes fail to have their medication dispensed[15].

Low-income, but not-exempt, users are most disadvantaged by health service charges.

"A Citizen's Advice Bureau 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 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"[16]

A recent report by the National Association of Citizen Advice Bureaux suggests that 28% of clients failed to get all or part of a prescription dispensed during the last year because of cost[17]. According to the National Pharmaceutical Association "what can I leave out" is a common question asked of pharmacists[18].

There is no doubt that charges reduce uptake. Treatment figures fell by 25% following the introduction of the new dental charging regime in 1987[19]. The introduction

of charges for eye tests in 1989 had a similar effect, while the rise in prescription charges between 1979 and 1984 is estimated to have caused a 40% reduction in the number of chargeable prescriptions dispensed.

The Bristol Eye Hospital detected a fifth fewer cases of glaucoma following the introduction of eye test charges. Although the numbers have since increased, the BMA have estimated that without the introduction of charging, twenty million more tests would have taken place[20]. Many will have lost the chance to have eye diseases such as glaucoma and retinoblasta diagnosed early enough to be treated. In the case of glaucoma, eye deterioration proceeds slowly – at a rate of 3% per year. The full cost of this short term saving may not become known for some time.

Another instance where the introduction of charges may undermine longer term public health goals concerns the needs of those in their late fifties when ageing may begin to result in deteriorating teeth or eyes. If inadequate intervention occurs at this point the ramifications may undermine general health in old age. The Public Policy Research Unit explored some of the possibilities:

"*What might follow, if for instance, people over 50 are deterred from dental treatment?*

- *Less conservation of teeth*
- *More older people will need dentures*
- *More older people will avoid foods that can be difficult to manage with dentures such as high fibre foods, fruit and vegetables*
- *The quality of nutrition will fall*
- *Illnesses associated with poor nutrition will rise*
- *Greater use of health services will follow, made worse because of the higher costs of treating older people who tend to need longer hospital stays*"[21]

It is illogical to discourage people from receiving health care that might prevent the spread of infectious disease, detect a problem at an early stage, or prevent it arising in the first place. Critics contend that charges do just this.

Legislation

A Free Service?

The National Health Service Act 1977 (the Act) defines the scope of NHS services and provides the legal foundations for the duties and obligations of both the Secretary of State and health service bodies and professionals. Section 1(2) provides;

'*services ….. shall be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed' (emphasis added)*

The powers of the Secretary of State to enact secondary legislation controlling charging tariffs are further defined in sections 77 to 82 and schedule 12 of the Act. Section 77 of the NHS Act states:

'*Regulations may provide for the making and recovery….of such charges as may be prescribed in respect of ….the supply under the Act ….of drugs, medicines or appliances (including replacement and repair of those appliances)*'

Chargeable services include:

- The supply of drugs, medicines and appliances under section 77.
- Dental appliances such as dentures and optical appliances, for example glasses and contact lenses[22] under section 78.

- Any dental treatment as part of general dental services which do not include repair of an appliance or arresting bleeding under section 79.

Other sections allow regulations to be introduced for the supply of more expensive supplies[23], the repair of appliances in certain specified circumstances[24] and payment of travelling expenses[25].

These sections do not require the NHS to levy charges, but merely give the Secretary of State the option to introduce charges for these specific services.

Charging Regulations

Since 1977 a complex network of regulations and amendment regulations have been introduced establishing and revising charging mechanisms. New regulations, when enacted, may revoke or partially revoke previous regulations. The result is a lengthy 'paper trail' which is both difficult to understand and interpret. CHCs supporting complainants have reported that health service managers have sometimes been unable to identify the correct legal basis for charges.

At present regulations are in force providing charging arrangements for:

- Dental treatment and appliances - NHS (Dental Charges) Regulations 1989[26].
- Optical treatment and appliances - NHS (Optical Charges and Payments) Regulations 1997[27].
- Drugs and appliances - NHS (Charges for Drugs and Appliances) Regulations 2000[28].
- Wheelchairs - NHS (Wheelchair Charges) Regulations 1996[29].
- Treatment to overseas visitors - NHS (Charges to Overseas Visitors) Regulations 1989)[30].
- Repairs necessitated by a patient's act or omission - NHS (Charges for Appliances) Regulations 1974[31].

Dental Services[32]

The provision of dental services is divided into two distinct service categories – treatment and appliances. The NHS (Dental Charges) Regulations 1989 detail the charging mechanisms and tariffs for both dental appliances (Regulation 2) and dental treatment (Regulation 3). However, neither 'dental appliance' nor 'general dental services' are defined within the regulations. This lack of clarity hampers interpretation of the legislation.

Dental Appliances

Regulation 2 of the 1989 Regulations states:

'A charge.....may be made and recovered under section 78(1A) of the Act in accordance with these regulations in respect of the supply under the Act of denture and bridges'.

Strangely, it appears that dentures and bridges are the only dental appliances that may legitimately be charged for under this section. However, other appliances, such as the provision of crowns may fall under the umbrella of 'general dental services' and charges made under that section.

More expensive supplies

Under the NHS (Dental Charges) Regulations 1989 an individual may request the provision of appliances which are more expensive than the basic NHS variety. The extra cost to the dentist of both supplying and repairing the non-standard appliance may be recovered from the patient under Regulation 8 (1). Similar provisions do not exist for the provision of superior treatments.

Provision of more expensive supplies must be at the request of the patient being treated and signed request forms must be submitted[33]. There is, therefore, no scope for dental practitioners to charge for more expensive appliances without the express agreement of the person being supplied.

Repair and Replacement of Dental Appliances

A distinction is drawn between repair and replacement of appliances.

'Replacement' is effectively the same as (new) 'supply'. Therefore, whatever charges apply when an appliance is first provided will also apply if a replacement is required, (subject to certain exceptions listed in 5.3 below) Section 25(2) of the NHS Act 1980 widened the meaning of 'replacement' to encompass relining, adjusting and alteration of dentures.

'Repairs' are not included in the definition of supply, and the regulations do not make specific provision to charge for repairs. They should therefore be free, and Department of Health publications HC11 and HC13 do state that dentures and bridges must be repaired free of charge. However since "relining, adjusting and altering" of dentures may be charged for, it may in practice be difficult to say exactly when a given procedure constitutes an adjustment, and when a repair.

The patient may be charged for any repairs or replacement made necessary by an act or omission on their part[34]. This applies even to individuals who would ordinarily be exempt from charges. Where a Health Authority considers an individual personally liable in this manner it may set up a sub-committee, to hear oral evidence. The health authority is responsible for the ultimate decision, and it may reduce or discount the full bill if this would cause undue hardship.

General Dental Services

Although general dental services are not defined in the legislation, they are taken to include, check-ups, the provision of fillings, de-scaling, oral hygiene advice, the removal of teeth, work on roots and gums, the provision of crowns and anaesthesia.

Charging Tariffs

General dental services and regular appliances are provided without charge to exempt patients. The dentist is re-imbursed the full cost of this treatment by the NHS.

The charging tariffs for both general dental treatment and appliances are laid out under Regulation 4 (as amended 1998) which states:

'the amount of the charge which may be recovered is 80% of the Statement Remuneration....being an amount not exceeding that which the Secretary of State considers to be the cost to the health service of the supply or provision'

The Statement of Dental Remuneration is a lengthy document laying down the amount the NHS will pay the dentist for specific treatments. It is published under regulation 19 of the NHS (General Dental Services) Regulations 1992 and is amended twice a year[35]. Non-exempt (paying) patients are charged 80% of the treatment amount. The NHS pays the balance. Where a course of treatment attracts charges in excess of an overall ceiling, also laid down in the Statement of Dental Remuneration, the NHS pays the excess in its entirety[36].

Exemptions

Regulation 3(2) of the NHS (Dental Charges) Regulations 1989 specifies both classes of service and classes of client exempt from charges[37].

Treatments exempt from Charges

Exempted treatments include: uncompleted occasional treatment; calling an additional

practitioner to administer anaesthetics in an emergency; and replacing or repairing within twelve months any defective fillings, root fillings, inlays, pinlays or crowns (subject to certain exceptions). Where a patient sees a dentist out of hours in an emergency[38] or is visited at home any additional costs will be exempt and treatment will be chargeable on the ordinary tariff[39].

Exempted Persons

Regulation 3(2)(a) refers us to Schedule 12 of the NHS Act 1977, which contains details of persons exempted from dental charges[40]. Free treatment is available to:

- Under 18 year olds and 18 year olds in full time education.
- Women who are pregnant at the commencement of treatment.
- A woman who have given birth within the previous twelve months.
- Patients undergoing dental treatment necessitated by operative procedure used to combat invasive cancer[41].

Additionally, individuals with low incomes or in receipt of benefits may also be entitled to a reduction or refund of dental charges. However, eligibility is dependent on strict criteria under the NHS low-income scheme. This severely restricts access to free or low cost dental treatment. Individuals of pensionable age do not automatically receive free dental care. This is inconsistent with the availability of free prescriptions for the over 60's.

Ophthalmic Services

The provision of National Health Services is based on the presumption that services are provided free unless express mechanisms exist for the recovery of a charge. By contrast, the provision of ophthalmic services is based on the premise that charges are levied except where specific exemptions apply.

Sight Tests

A duty to supply free tests only exists under certain specified categories. Originally, these categories were broad and encompassed the majority of the population, however eligibility has repeatedly been narrowed. In 1989, 12,493 sight tests were carried out on the NHS but this figure fell to 5,280 in 1990 following a change in eligibility rules. At its 1997 AGM ACHCEW passed a resolution calling for the restoration of free eye tests, in particular for the elderly, on the grounds that they are a cost effective means of screening for illnesses. We therefore welcome the government's subsequent decision to again make eye tests free eye for the over sixties[42].

Currently free sight tests are available to individuals who are:

- over sixty years old, or
- under 16 years old, or
- aged 16 – 18 and in full time education or under the care of the local authority, or
- diagnosed diabetic, or
- aged 40 or over and the immediate relation of a glaucoma sufferer[43],or
- in receipt of specific benefits (income support, income based Jobseeker's Allowance, family credit or disability working allowance), or
- eligible under the low income scheme, or
- war/MOD pensioners where sight tests are necessitated by their pensionable disability[44] or
- people with glasses with at least one complex lens.[45]

In addition, those patients who need eye tests to manage an eye condition are entitled to have them carried out free of charge. Such tests can be carried out in the hospital or on referral to a retail optician. However, simply receiving advice from a hospital to seek a sight test will not secure a free test unless the individual is ordinarily exempt. Any 'hospital' sight test must be for the management of an optical condition[46].

Contact Lenses / Glasses

Recovering the total cost of NHS optical appliances including glasses and contact lenses supplied on the NHS is permitted under section 77 in conjunction with schedule 12. Only an 'eligible person' in receipt of a valid voucher is entitled to receive optical appliances without charge or at a reduced rate. Section 8 (2) of the NHS (Optical Charges and Payment) Regulations 1997 provides:

'An eligible person is a person who at the time of the supply of the optical appliance is any of the following-

(a) a child

(b) a person under the age of 19 years and receiving qualifying full-time education...

(c) a person whose resources are treated...as being less than his requirements'....

Additionally, under these regulations, individuals who require particularly strong lens or complex lens prescriptions[47] are classed as eligible people.

The redemption value of the voucher is supposed to reflect the minimum cost of supplying the appliance that meets the patient's clinical need. However, in practice it rarely meets the actual cost of spectacles, and in recent years the difference has been growing, with the result that people with vouchers have to pay increasing amounts towards the price of their optical appliances. The National Association of Citizen's Advice Bureaux has suggested that opticians providing NHS treatment should be required to sell glasses within the value of NHS vouchers[48]. Problems can also be caused by the limited range of frames and lenses available at the lower end of the cost spectrum. Uncomfortable or unattractive frames may deter individuals - especially children and young adults - from wearing their lenses. Opticians themselves have concerns that failure to wear prescribed lenses can cause deterioration in some optical and medical conditions. Those who want to buy more expensive lenses or frames simply pay the difference between the desired appliance and the face value of the voucher.

No assistance is available towards the purchase price of contact lens fluid, which makes contact lenses an expensive option for most eligible individuals. Individuals who use contact lenses but who are unable to afford the correct cleaning solutions are at increased risk of infections. ACHCEW considers that the unavailability of cleaning fluids on the NHS is a false economy if it results in increased NHS expenditure on treating eye infections.

Repair and Replacement

Assistance towards the costs of repair or replacement resulting from loss or damage is available only in the cases of appliances dispensed to a child. Other eligible individuals are only entitled to help with the cost of repair where the repair is required as a result of an illness. The Health Authority will first make *'such enquiries as it considers relevant'* to ascertain the true cause of the damage. The cost of making such enquiries is almost certainly greater than the cost of repairing or replacing the appliance. Eligibility for help with the repair or replacement of optical appliances is particularly restricted, as health authorities are reluctant to fund repairs to appliances supplied under the voucher scheme.

Pharmaceutical Services – Prescription Charges

The Medicines Act 1968 divides drugs into three categories, prescription only medicines, medicines that can only be dispensed by a pharmacist and general list medicines. Schedule 10 of the National Health Service (General Medical Services) Regulations 1992 stipulates which products are not available on prescription to patients. This list is regularly updated. Any item not available on prescription must be paid for over the counter at its full retail price.

The NHS (Charges for Drugs and Appliances) Regulations 2000 permit charges for the supply of pharmaceutical products supplied on prescription by chemists[49], doctors[50], health authorities, NHS trusts and Primary Care Trusts[51]. The provisions governing the supply of drugs and medicines for each service provider are primarily the same. However, there are different restrictions and powers governing supplies by them.

The Regulations (as amended) state that a chemist, doctor, health authority or trust that provides pharmaceutical services to a patient shall make and recover a fee from each patient[52]. Each item of the prescription attracts the charge. Two separate fees may be payable where an appliance and a drug is prescribed, for example asthma drug plus inhaler or where a combination pack of drugs designed to make dosage easier is used. In resolution 4 at its AGM in 2000 ACHCEW criticised the inequality whereby

"a pre-packaged course (which) contains two separate types of tablet attracts two charges whereas a compound tablet attracts only one charge. We call upon the Government to review the exemptions urgently in order to make equity paramount."

Regulation 2(3) limits these separate charges. Quantities of the same drug supplied in more than one container, multiple provision of the same appliance or parts of an appliance which are ordered on the same prescription form will be subject to only one prescription fee.

Supply by Chemists

Regulation 3[53] deals with the supply of drugs and appliances by chemists.

Oxygen concentrators were originally supplied under these Regulations. A monthly fee, in line with prescription charges, was levied. This service was altered in 1992 when the provision of oxygen concentrators was removed from the charging regime. Oxygen concentrators are now supplied by commercial oxygen companies under contract with health service providers. Contractual terms often include charges for maintenance insurance, installation and monthly operational costs. The health service provider should meet these charges. In correspondence with ACHCEW in 1999, the NHS Executive confirmed that the provision of oxygen concentrators should be free of charge to all NHS patients.

Supply by Doctors

Doctors who provide pharmaceutical services may not charge for drugs or appliances required for immediate treatment or administered to the patient personally by the doctor. Injections and vaccinations available on the NHS attract no charge

Doctors must also provide free pharmaceutical services to individuals resident in schools or institutions under certain circumstances[54]. This provision is perhaps less significant than might be thought since many individuals resident in schools or other institutions will be already exempt from NHS charges on other grounds e.g. - age, income or medical disorder.

Supply by Health Authorities, Trusts and Primary Care Trusts

No charge can be recovered for the supply of drugs, medicines and appliances to a patient resident in hospital. However outpatients do pay the prescription charge. The precise moment of discharge thus assumes some importance: patients may find that they are given a prescription on leaving for items which might just as well have been provided and paid for by the hospital.

NHS bodies, providing a hospital outpatient service, may prescribe specific appliances that are not available from other pharmaceutical service providers. Schedule 1 of the NHS Regulation 1989 (as amended) states that charges may be recovered for the supply of surgical brassieres, abdominal supports, spinal supports, stock modacrylic wigs, partial human hair wigs, and full bespoke human hair wigs.

The level of charges for these appliances has been increased regularly since their introduction and prescription prices for wigs and fabric supports are surprisingly high. Even charges for surgical brassieres are at the top end of the price range for high street lingerie. Support tights, ordinarily unavailable on the NHS, may be supplied, where necessary, by a hospital. These too attract charges.

Exemptions from Prescription Charges

Some patients and some courses of treatment are not chargeable. Schedule 12 of the NHS Act 1977 details the circumstances where no charge may be recovered for the supply of pharmaceutical services and provides:

'No charge shall be made....in relation to the supply of drugs medicines and appliances in respect of;

(a) the supply of any drugs, medicine or appliance for a patient who is for the time being resident in hospital, or

(b) the supply of any drug or medicine for the treatment of venereal disease, or

(c) the supply of any appliance [other than those contraceptive in nature] *for a person who is under 16 years of age or under 19 year of age and receiving full time qualifying education, or*

(d) the replacement or repair of any appliance in consequence of a defect in the appliance as supplied.'

Regulation 6 of the NHS (Charges for Drugs and Appliances) Regulations 1989 (as amended) expands these exemptions to include people over 60 years of age; expectant mothers; women who have given birth in the last 12 months[55]; those on income support, working family's tax credit, or disability working allowance; war pensioners and individuals suffering from a variety of specified diseases[56].

The list of medical conditions, which entitles sufferers to free pharmaceutical services is very restricted. Those suffering from epilepsy and in need of continuous anti-convulsive therapy are exempt but individuals suffering from schizophrenia or paranoia are not. Similarly, individuals with insulin dependent diabetes are exempt[57] but asthma sufferers must purchase their inhaler on prescription. Individuals who are HIV positive, exhibit a marked increase in the occurrence of medical conditions requiring treatment with pharmaceutical products, but neither AIDS nor HIV are included on the list of medical conditions that warrant exemption. The reasoning behind such anomalies is unclear, although generally those conditions warranting exemption tend to be less common and carry less social stigma than those where prescription charges apply. ACHCEW considers that the current restrictions on the types of illness which entitle sufferers to free prescriptions creates inequality between individuals with long term

illnesses, and passed a resolution to this effect at its AGM in 2000.

Exemptions from charges for wigs, support tights, surgical bras and abdominal or spinal supports are only available to individuals who are under 16; under 19 and in full time education; in receipt of benefits[58] or in possession of a valid exemption certificate detailing the supply of the specific appliance[59]. Expectant mothers, new mothers, and those over 60's are not entitled to the same benefits.

Pre-payment certificates

Individuals who have long-term prescription needs, but who are ineligible for exemption from charges may incur considerable cost over the course of their treatment. This is particularly problematic for patients using combination drug therapies who have to meet the charge for each item on their prescriptions.

In an attempt to spread the burden of prescription charges, a pre-payment scheme was introduced in the NHS (Charges for Drugs and Appliances) Regulations 1989. Under this scheme, individuals pay in advance and obtain a pre-payment certificate. Thereafter they do not have to pay prescription charges for the duration of the certificate. Certificates are available for four-month and twelve-month periods[60].

Medical / Surgical Services

Chargeable Equipment

Only equipment specified in the NHS (Charges for Drugs and Appliances) Regulations 2000 or the NHS Drugs Tariffs may be charged for[61]. At present charges above the prescription rate can be made for elastic tights, spinal supports, abdominal supports and wigs. Further appliances available on the NHS but not listed in the drugs tariff must be supplied free of charge.

This includes orthopaedic equipment and prosthetic limbs. Many appliances, such as walking sticks, frames, and crutches are provided free on loan for the duration of the clinical need.

Wheelchairs

Wheelchairs are loaned to patients for as long as they are required. The NHS pays for maintenance and repair to be carried out by approved repairers. More expensive wheelchairs can be made available through a voucher scheme, which allows the patient to pay the difference between a NHS chair and their preferred model. The NHS (Wheelchair) Regulations 1996[62] extends this provision by authorising individuals to be charged for the additional costs which may be incurred in maintaining and repairing non-standard wheelchairs.

Deposits

Many hospitals operate schemes that require a deposit for the supply of walking aids and wheelchairs, on the basis that charges should reduce the number of appliances which become lost or damaged. However, such charges by way of a deposit are almost certainly unlawful. The NHS Executive, referring to a 'deposit scheme' proposed by Hastings and Rother NHS Trust, stated:

'if the item is medically required, it must be supplied without charge under the NHS, and such a charge would include the taking of a deposit.'[63]

In subsequent communications the Department appears to have retreated slightly from this position. In a letter of the 30 April 1999 Mr N Turnbull, of the NHS Executive, stated that *'NHS Trusts are independent and it is up to them to be satisfied of the legality of any arrangements they may have for providing walking aids on a temporary basis to people who are no longer hospital patients'.*

While ACHCEW recognises the need to reduce equipment damage and loss, hospitals can always seek compensation for this through the courts. The imposition of deposits is a charge and in many cases will affect the accessibility of care. Any charge not authorised by legislation is unlawful.

Audiological Services

As noted above, charges may only be applied if statute and regulations allow. No regulations have been made to provide for charges for the provision of hearing aids supplied by the NHS. These must be supplied, repaired[64] and maintained free of charge.

Unlike the schemes that govern provision of wheelchairs and dental appliances, there is no scope for the supply of superior hearing aids on payment of an extra amount by the patient. The NHS only provides standard models sufficient to meet the clinical needs of the patient. Those seeking more expensive models, for example models which are concealed within the ear, are obliged obtain them from private supplies and pay the full market price.

It is important that patients know about their right to free audiological equipment. Hospital NHS audiological services are often provided by private suppliers. Additionally, hospitals often rent space to private suppliers on their premises. Confusion may arise if patients are unable to distinguish between these services or are persuaded that a non-NHS hearing aid is needed to meet their clinical requirements.

Repair of Appliances

Section 82 of the NHS Act 1977 allows regulations to be introduced permitting the NHS to recover the cost of repairing or replacing NHS appliances where the loss or damage arises from the patients' carelessness.

Regulation 6 of the NHS (Charges for Appliances) Regulations 1974 provides for the recovery of costs incurred in repairing appliances damaged by the patient. This is a broad provision incorporating the cost of repairs to any appliance provided by the Secretary of State.

Under these regulations, any request for repair or replacement of a NHS appliance can be referred to the relevant Health Authority for investigation. If enquiries determine that the patient caused the loss or damage, a charge may be recovered.

Road Traffic Accidents

Road Traffic Act 1988 permits NHS to levy charges for the treatment of road traffic accident victims. Procedures for recovering these charges were changed and simplified by the Road Traffic Accidents NHS Charges Act 1999. Previously hospitals claimed from insurance companies for the cost of treating people injured in road accidents, but the complicated administrative arrangements involved often resulted in the money not being collected. The new Act transferred responsibility for collection to the Compensation Recovery Unit acting on behalf of the Secretary of State. This unit redirects the money raised to the hospital where the accident victim was treated.

Insurance companies, not patients, are liable to pay these charges. When an accident victim makes a successful claim for compensation following an accident, the court will also require the insurer paying compensation to pay for the victim's NHS care. Where the accident was caused by an uninsured or unidentifiable driver, the Motor Insurers' Bureau becomes liable for these charges. The patient will have little or no role in this process.

Charges for Overseas Visitors

Regulation 2 of The NHS (Charges for Overseas Visitors) Regulations 1989 provides for charges to be levied on those overseas visitors who receive NHS medical care. Regulation 3 confers exemptions on various types of service, while regulations 4-7 allow exemptions for various types of visitor.

No charges will be recovered from any overseas visitor for:

- Treatment at an accident and emergency department.
- Treatment for a sexually transmitted disease (excluding HIV).
- Diagnostic testing and associated counselling for HIV.
- Treating an individual detained under the Mental Health Act 1983.
- Treatment for a mental condition included in a probation order by a court.

All other NHS services (which do not attract charges to UK citizens) are provided without charge to any person:

- Who has been resident in the UK for 12 months prior to treatment.
- Who has come to the UK to take up employment or permanent residence.
- Who is a national (and in some cases a resident) of the European Economic Areas or of countries with whom the UK has a reciprocal agreement, and where the need for treatment arose during the visit, (and in some cases where a person has been specifically referred for treatment).
- Who is in the UK as a refugee, a prisoner, a diplomat or NATO service personnel.

For more information see:

http://www.doh.gov.uk/overseasvisitors/patientguide.htm

The regulations can be found at:

http://www.legislation.hmso.gov.uk/si/si1989/Uksi_19890306_en_1.htm

Miscellaneous Charges

NHS Trusts are permitted to generate income so long as it does not interfere with their main function of providing health services to NHS patients. Charges for car parking, retail outlets, catering, and for the provision of occupational health services to local employers all fall into this category[65].

GPs, under their service contracts, are allowed to charge for a variety of non-NHS services. These include holiday vaccinations and private consultations. The BMA publishes recommended fees for these services but doctors are under no obligation to follow these scales. Similarly, hospitals often recover charges for the provision of side rooms and leisure facilities such as televisions.

However, attempts by GPs to levy charges for visits to patients in private nursing homes and suggestions made by ambulance trusts that they should be able to charge patients for non urgent transport, are not permissible under current legislation.

Sale of Goods and Services Legislation

The Sale of Goods Act 1979 and the Supply of Goods and Services Act 1982 are pieces of consumer protection legislation. They give consumers rights, for instance to claim damages for deficient goods and

services. If patients are required to pay charges for NHS services, arguably they are consumers and should be entitled to the protection these laws afford. However, in the case of Pfizer v Minister of Health (1965), it was held that services provided by health authorities under the authority of the Secretary of State are exempt from the provisions of Acts of Parliament unless those Acts specifically state that they apply to the Crown. Recent changes to the doctrine of crown immunity, the growing emphasis on the patient as consumer, and the decentralisation of the health service could lead a court today to take a different view.

Conclusion

The regulations governing charges are diffuse and difficult to understand. The range of charging regimes that apply confuses patients and health professionals alike.

The current government has committed itself 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 raise the health of the poorest fastest*"[66]

Yet apart from the welcome restoration of free sight tests for the over 60s, the only significant initiative to date undertaken by the government in relation to tackling the injustice of NHS charges has been to introduce a tougher sanctions regime for individuals found to have wrongly received free NHS treatment.

As an urgent first step the government needs to:

- Remove eye tests and dental check-ups from the charging regime.
- Significantly reduce prescription and dental charges.
- Redesign exemption criteria and voucher schemes to reduce the hardship felt by those on long term medication.

While charging persists, action must be taken to simplify and make transparent the confusing mishmash of applicable rules:

- Decisions about NHS charges should be brought into the public arena.
- Charging policies must be firmly regulated at a national level to avoid geographical variations.
- A major consolidation of the legislation must be carried out.
- Patients should be told well in advance what charges can be levied and how much each treatment will be.
- The inconsistencies in the exemption criteria need to be addressed to overcome the inequity whereby certain illnesses warrant free prescriptions while others do not, or certain ways of packaging treatments results in several prescription charges rather than one.

None of this would completely remedy the problems identified in this report. Charges markedly reduce take up by patients on low incomes and those who suffer long-term illness, and they undermine preventative public health. ACHCEW remains committed to the abolition of charging and the restoration of free universal health care.

Notes

[1] National Health Service Act 1977

[2] Social Insurance and Allied Services (the Beveridge Report), Cmd 6404, HMSO, London, 1942

[3] On this, see the excellent Health Rights report *Thinking the Unthinkable – the case against charging in Primary Care 2000* available from Health Matters, PO Box 459, Sheffield S1 2UP

[4] see note 4 p. 28

[5]JeanShaoul, http://www.wsws.org/articles/2001/jul2001/ippr-j06.shtml This is for 'annually managed expenditure' (i.e. it excludes welfare payments). Providers of goods and services need not necessarily be private companies in this statistic – they could also be public corporations (eg. NHS Trusts).

[6] *The Relationship Between Health and Social Services* Health Select Committee, First Report, Jan 1999 at www.parliament.the-stationeryoffice.co.uk/pa/cm199899/cmselect/cmhealth/074/07402.htm

[7] S. M Kerrison and AM Pollock, *Regulating Nursing Homes* ***BMJ*** Vol. 323 Sept 8 2001 p. 566

[8] *Thinking the Unthinkable* p. 15

[9] £18 500 at April 2001 – SI 2001/1066

[10] As observed in Chapter 3 of the *NHS National Plan 1999.* See www.nhs.uk/nationalplan/npch3.htm

[11] WHO *European Health Care Reforms – Analysis of current Strategies* WHO European Office 1996

[12] ACHCEW. *NHS Charges – Do they matter?* Health Perspective; ACHCEW April 1997

[13] Beardon, McGilchrist, MsDevitt, MacDonald. *Primary non-compliance with prescribed medication in primary care.* BMJ 1993; 307:846-8

[14] see note 11 above

[15] see note 11 above

[16] NACAB *Unhealthy Charges – CAB evidence on the impact of health charges*, Summer 2001p.19

[17] NACAB *Unhealthy Charges* p.2

[18] see note 17 p. 16

[19] *Thinking the Unthinkable* (see note 4) p.42

[20] see note 19 p. 44

[21] see note 19 p. 41

[22] Schedule 12 (2)(1)

[23] Section 81

[24] Section 82

[25] Section 83A

[26] SI 1989/394

[27] SI 1997/818

[28] SI 2000/620

[29] SI 1996/1503

[30] SI 1989/306

[31] SI 1974/284

[32] some useful general information on NHS dentistry is available from http://www.nhs.uk/localnhsservices/dental/dentistry_leaflet.asp#4

[33] Schedule 3 part 2 (1) NHS (Dental Charges) Regulations 1989

[34] s. 82 NHS Act 1977, and Reg. 9 and Sch. 4 of the NHS (Dental Charges) Regulations 1989

[35] Statement of dental remuneration, amendment 88 http://www.doh.gov.uk/sdr/

[36] Reg. 4 NHS (Dental Charges) 1989 regulations (amended by S.I. 2001 No. 707). As of April 2001 this is £360.

[37] NHS (Dental Charges) Regulations 1989 as amended by S.I.s 1998/2221 and 2001/2807

[38] Reg. 3(2)(c)

[39] Reg. 3(2)(b)

[40] Para. 2 (dental appliances chargeable under section 78(1)) and para 3 (dental treatment chargeable under section79)

[41] Reg. 2(2)(2) of NHS (Dental Charges) Regulations 1989 as amended

[42] SI 1999/693

[43] Immediate relation includes parent, brother, sister, son, or daughter

[44] Repayment available from War Pensions Agency

[45] *'Either: a prism controlled bifocal lens or a lens of ± 10 dioptres in any one meridian"*

[46] p25 HC13 'Advisor's Guide to Help with Health Costs'

[47] see note 41

[48] Unhealthy Charges p. 33

[49] Reg. 3

[50] Reg. 4

[51] Reg. 5

[52] As of April 2001 this charge is £6.10 for the supply of each quantity of a drug and appliance other than elastic hosiery. For elastic hosiery the charge is £6.10 per leg – i.e. £12.20 per pair.

[53] The NHS (Charges for Drugs and Appliances) Regulations 2000

[54] Reg. 4(3)(c)

[55] Either live or still born

[56] Including permanent fistula, insulin dependent diabetes, hypoadrenalism, myxoedema, hypoparathyroidism, severe epilepsy, and continuing physical disability requiring continuous care.

[57] Exemption does not cover the cost of insulin pen injectors

[58] HSC 1998/16 Charges for drugs, appliances, wigs and fabric supports

[59] Reg. 7(2)(a) NHS (Charges for Drugs and Appliances) Regulations 2000

[60] As of April 2001 the cost is £31.90 for a four months and £87.60 for a twelve months.

[61] See para. 5 above

[62] SI 1996 No 1503

[63] Letter to ACHCEW – 17 August 1994 from Mrs J Dummigan

[64] See para 10 for information on repair of appliances

[65] Income Generation – Retail Outlets, a guide to implementation. NHS Executive 1996

Income Generation – Catering Services, a guide to implementation. NHS Executive 1996

Income Generation - Occupational Health, a guide to implementation. NHS Executive 1996

[66] Alan Milburn MP, Secretary of State for Health 28.2.2001 cited in *Unhealthy charges* p. 41

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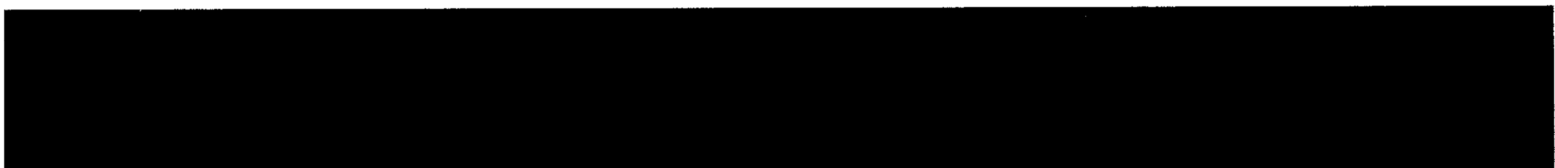

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