Government Response to the Health Committee's Report on NHS Charges

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
October 2006

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Introduction

1. The House of Commons Health Select Committee (the Committee) published its report on NHS Charges on 18 July 2006. The principal areas covered by the report were prescription charges, dental charges, sight tests, additional charges for some clinical services, assistance with transport costs and charges for car parking and bedside communications. This Command Paper sets out the Government's response to the recommendations in that report.

Prescription Charges

2. A prescription charge is payable for each item (NHS medicine or appliance) dispensed unless the patient is entitled to free prescriptions. The charge, as of 1st April 2006 is £6.65.

3. Categories of exemption from prescription charges are as follows:

- Age
- Medical condition
- Income
- Type of item prescribed
- Method of delivery

4. Patients who need to have several items prescribed over a period may purchase Prescription Pre-Payment Certificates (PPCs) and are not required to pay a further charge at the point of dispensing. As of 1st April a PPC costs £34.65 for four months and £95.30 for 12 months for an unlimited number of items.

5. The current arrangements mean that around 50% of the population are exempt from prescription charges and around 87% of prescription items are dispensed free of charge. In 2005 a charge was paid at the point of supply for only 7.8% of items dispensed and a further 4.6% were dispensed against a PPC.

National Health Service Low Income Scheme (LIS)

6. The LIS provides income related help for people who are not exempt or automatically entitled to remission of NHS charges. The scheme covers help with NHS prescription and

dental charges, wigs and fabric supports, entitlement to NHS sight tests and optical vouchers and payment of travel expenses to receive NHS treatment.

7. The LIS can provide full help whereby a qualifying patient will not pay any charges. Those with slightly higher income may receive partial help with health costs. The extent of any help is based on a comparison between a person's resources and requirements at the date a claim is received by the Prescription Pricing Division (PPD) of the NHS Business Services Authority (NHSBSA) or the date the charge was paid if a refund is claimed. There is a ceiling based on capital and any calculation is referenced to Income Support Regulations arrangements (with slight modifications in some instances) with "needs" being equivalent to the Income Support applicable plus full housing costs and Council Tax payable.

Dental Charges

8. The new dental charges system introduced from April 2006 has replaced a complex system of over 400 different charges for individual items of treatment with just three different charges for whole courses of NHS dental treatment.

- *Band 1 – £15.50:* this covers courses of treatment that include an examination, diagnosis, preventive dental work such as scaling and polishing and/or the provision of oral health advice.
- *Band 2 – £42.40:* this covers courses of treatment that (in addition to one or more of the items in Band 1) include simple treatments such as fillings or extractions.
- *Band 3 – £189.00:* this covers courses of treatment that (in addition to one or more of the items in Bands 1 or 2) include the fitting of appliances such as bridgework or dentures.

9. This mirrors changes to the system of dental remuneration. Dentists no longer have to claim separately for each individual item of treatment. Instead, they receive an agreed annual contract value in return for providing an agreed number of courses of treatment (weighted between the three bands) over the course of the year.

10. Children, expectant and nursing mothers and those receiving some income based benefits or credits continue to be exempt from NHS dental charges.

11. The new charging system is designed to ensure that dental patients know exactly how much they are being charged before they receive their treatment and can distinguish clearly between NHS treatment and any private treatment they are offered. It is also less bureaucratic for dentists to administer.

NHS Optical Services

12. There are no NHS charges for optical services. Rather, eligibility for free, NHS-funded sight tests is targeted at children, older people, those with or at risk of eye disease, and people on low incomes. Eligibility for optical vouchers relates predominantly to income and is targeted at those who might otherwise have most difficulty in purchasing glasses or contact lenses. The intention of these arrangements is to provide support to people who are most at risk from eye disease or who might otherwise be discouraged on financial grounds from having their eyes examined.

The groups eligible for free sight tests are as follows:

- those under 16 years of age and students in full time education aged between 16 and 19;
- those aged 60 or over;
- individuals on low incomes including those receiving some income based benefits or credits;
- individuals diagnosed as having, or being at risk of, glaucoma;
- diabetics.

13. Patients who have received a NHS sight test, and who need glasses or contact lenses to correct their eyesight, receive a prescription showing the required strength and type of glasses or contact lenses. Eligible patients also receive an NHS optical voucher, which they can use to meet (in whole or in part) the cost of these glasses or contact lenses. Eligibility to optical vouchers is primarily targeted towards children and people on low incomes. There are 8 voucher bands, each to a set value according to the strength and type of the prescription. As of 1st April 2006 voucher values vary from £33.90 – £185.90 – with eligibility for a particular voucher based on the nature of the prescription. The optician who dispenses the glasses or contact lenses redeems the value of the voucher from their local Primary Care Trust (PCT).

14. The groups eligible for optical vouchers are:

- those under 16 years of age;
- students in full time education aged between 16 and 19;
- individuals who have been prescribed complex lenses;
- individuals on low incomes including those receiving some income based benefits or credits.

Transport costs

15. The Hospital Travel Costs Scheme (HTCS) provides financial assistance to those patients who do not have a medical need for ambulance transport but who, nevertheless, require assistance in meeting the cost of travel to and from their consultant-led care.

16. Patients who are receiving some income based benefits or credits are automatically entitled to full reimbursement of reasonable travel expenses. Other patients who are on low income need to make a LIS claim for an assessment whether they are entitled to full or partial reimbursement of reasonable travel expenses. Travel expenses of escorts are included where medically necessary, or if the patient is a child. Travel expenses of visitors are not included.

Additional charges for some clinical services

16. The Committee looked at the dermatology clinic in Harrogate and the Jentle Midwifery scheme in London.

Car Parking

17. Income generation powers enable NHS bodies to market any spare capacity resulting from a non-core function or exploit intellectual property rights to raise additional income for health services. Car parking charges are one of the most common examples of an income generation scheme.

18. NHS bodies must abide by certain rules when operating income generation schemes. Schemes must be profitable and profits must be used to improve health services.

19. The Department of Health has issued specific guidance on car parking charging schemes, advising on a range of issues to be considered when NHS bodies charge for car parking on their premises.

20. It is for individual NHS bodies to decide how best to utilise their spare capacity to raise additional income for health services, as long as they abide by the income generation rules.

Bedside Communications

21. Over 80,000 patients now have access to a bedside television and telephone system. Charges for the patient to use the systems are up to £3.50 per 24-hour period to watch the television and 10 pence per minute to make a telephone call. The incoming call charge ranges from 35 pence per minute to 50 pence per minute.

22. The Department of Health has set up a review group to determine if the service can be viably provided without charging as high a price for incoming calls. The review group was formed as a result of an Ofcom investigation into the price of making telephone calls to hospital patients, which closed on 18 January 2006. The review group will report its findings by December 2006.

The Government's response to the Health Select Committee's Conclusions and Recommendations

Recommendation 1 (Paragraph 53)

The dermatology clinic in Harrogate and the Jentle Midwifery scheme in London differ significantly. The former involves charging for purely cosmetic procedures while the latter charges a fee for services that should be available, according to the National Service Framework on maternity services, as standard. The Jentle Midwifery scheme provides cut-rate private care within an NHS hospital. This is unacceptable. Essential care of this type should be given to all or paid for privately at full cost.

We agree with the Committee that the Jentle Scheme, as originally set up, was unacceptable and we have expressed this view to the Hammersmith Hospitals Trust. We are committed to the promotion of easy access, high quality maternity services for all women, designed around their individual needs and those of their babies to ensure that the NHS delivers the best care for all pregnant women, free at the point of need.

The Department of Health understands from the Hammersmith Hospitals Trust that it will change the Jentle scheme to operate entirely under its private healthcare umbrella and women accessing it will be classified as private patients in order to avoid any ambiguity. The Trust has indicated that this will not happen immediately, as there are still women on the scheme who have not yet given birth, and it would be inappropriate and unprofessional to alter their arrangements mid-pregnancy. However, new patients seeking to access Jentle will do so on a private patient basis once insurance and administrative arrangements have been put in place. We will continue to monitor the situation to ensure that this happens soon.

Recommendation 2 (Paragraph 74)

The Government claims that its exemptions policy is based on income: those who can afford to pay, those who cannot do not. However, this is not the case: many wealthy people are exempt, but many poor working people are not. The exempt medical conditions have not been revised for almost 30 years, creating many anomalies. It is evident that Government policy is to maintain the status quo and not to upset any existing beneficiaries.

We do not agree with the Committee's statement that it is the Government's policy to maintain the status quo. A number of relatively small but significant changes have been made to prescription charge exemptions over the last few years. For example, LIS entitlement has been extended to include those whose income exceeds their requirements by up to 50% of the prescription charge. In addition, the system has been changed to reflect the introduction of tax credits. Nevertheless, the Government has concluded that the time is now right for a wider review of the current arrangements for prescription charges. Accordingly, Ministers have asked officials in the Department of Health to undertake a review of the current exemptions for prescription charges and to put forward options to them that would be expenditure neutral for the NHS. The Government will report the outcome of this review to Parliament before the 2007 Summer Recess.

Recommendation 3 (Paragraph 163)

We recommend that evidence is gathered on:

- **public attitudes to health charges;**
- **the extent to which charges affect the use of health services and, in the long term, health;**
- **the extent to which charges reduce 'frivolous' demand.**

The Government accepts that there is little evidence available for the UK other than some generally small scale studies that have been undertaken over the last 10 years. It also agrees that such evidence would be useful in informing future policy. As a result, the Department of Health will include both qualitative and quantitative studies in its future research programme. The timing of this work will be determined by overall research priorities within the resources available.

Recommendation 4 (Paragraph 164)

We recommend the immediate introduction of a monthly Prescription Pre-Payment Certificate (PPC). We also recommend that the annual certificate be pegged at the cost of 12 times the price of a single prescription. The monthly certificate should be pegged at the cost of one prescription.

The Government agrees that PPCs should be more readily available to patients that have an on-going need for NHS medicines and appliances. Since the Prescription Pricing Authority (now PPD of the NHSBSA) took over responsibility in 2002 from Health Authorities for issuing PPCs, there has been an increase of around 9% in the number of 12 month PPCs issued and 13% in the number of 4 month PPCs. Systems such as telephone and online ordering and payment by credit or debit card have been introduced to make PPCs more accessible to patients.

We recognise that more needs to be done to make PPCs more readily available but we are not convinced that introducing a monthly PPC represents the best way forward. Significant additional administrative costs would be incurred in issuing 12 certificates a year for a patient rather than one or three per year under the current system. At the same time the Government recognises that there will be occasions when patients find it difficult to meet the cost of the 4-monthly or 12-monthly PPC in one payment. To address this, systems at the NHSBSA are being amended so that PPCs can be purchased by monthly direct debit from 1st July 2007. As a result, 12-month PPCs will be available for a monthly payment of £7.95 based on the current cost of a twelve monthly PPC of £95.30. A three monthly certificate will replace the four monthly certificate.

Over 97% of PPCs are purchased through the banking system. We will consider ways in which monthly payments can be made by those who do not have a bank account.

With the introduction of the facility to pay for PPCs monthly, the Government does not agree that the annual cost of a PPC should be pegged at the cost of 12 times the price of a single prescription. We estimate that this, with the introduction of a monthly PPC, could cost up to £100 million in lost revenue from prescription charges income. The Government does not consider that this can be justified in the light of other pressures on NHS resources.

Recommendation 5 (Paragraph 164)

We recommend that a reduced price PPC be introduced for those receiving limited help through the NHS Low Income Scheme.

We have considered the operational implications of this recommendation and have concluded that access to PPCs by monthly instalments as outlined in our response to Recommendation 4 would be more straightforward. Reduced price PPCs for those receiving help through the NHS Low Income Scheme could not be available until after a patient had made a claim and entitlement had been calculated. In addition, we believe that it may generate a significant number of additional claims with no certainty that those would result in provision of the help sought with consequent disappointment for those involved.

Recommendation 6 (Paragraph 165)

Once the NHS IT system is in place, we recommend that the Government consider introducing a yearly cap on payment for medicines, as is in place in Sweden.

The NHS Care Record Service and the Electronic Prescription Service have been designed to meet specific functional requirements that do not include monitoring of payments made for medicines by individual patients. Whilst a full technical study would be needed to assess the feasibility and cost of implementing such a system in the NHS, it is clear that significant changes would be needed to the systems for the NHS Care Record Service and the Electronic Prescription Service and systems at the NHSBSA. The Government has placed a clear priority on the delivery of the clinical aspects of the NHS Care Record by Connecting for Health. In addition, the Capacity Improvement Programme at the NHSBSA is intended to deliver significant expenditure savings which will be redirected to frontline patient services.

PPCs already place an annual limit (currently £95.30) on the amount that patients are required to pay in prescription charges if they are not eligible for an exemption. The Government believes that improving awareness and access to PPCs as outlined elsewhere in this response is a quicker and more effective means of achieving the objective that the Committee is seeking to achieve.

Recommendation 7 (Paragraph 166)

We recommend that the Department of Health after one year institutes a review to report on the effects of the new (dental) contract:

- **on patient access and care, including prevention; and**
- **on NHS dentist numbers and recruitment, their salaries, workload and how many signed the new contract `in dispute' and how these disputes were resolved.**

The Government is fully committed to reviewing the impact of the recent dental reforms to ensure that they are delivering their intended benefits for patients and for the profession. In March 2006 Ministers announced the establishment of an Implementation Review Group consisting of senior dental stakeholders (representing the interests of patients, dentists and the NHS) to monitor the impact of the reforms and make recommendations on any changes that may be needed. The group has already agreed the main success criteria against which progress will be monitored, including patient access and quality of care.

We intend to produce a report on the first twelve months of the dental reforms based on the work of the Implementation Review Group.

The information Centre for Health and Social Care now publishes regular information on NHS dental activity and workforce indicators. This includes information on patient access, dentist numbers, and dental earnings.

The Department of Health made information available in April on the number of dentists who signed new contracts and is providing regular updates on progress on dispute resolution. The most recent data showed that over 50 per cent of disputes had so far been resolved and that in the vast majority (99%) of cases, the dentists involved had decided to continue with their contract.

Recommendation 8 (Paragraph 167)

We recommend that, as part of the General Ophthalmic Services contract negotiations, the Department of Health require all opticians' practices to carry a range of spectacles within the maximum NHS voucher value.

The Government supports the aim of ensuring that patients have access to a wide range of spectacles. We consider that the current arrangements support this objective by giving patients maximum choice in deciding where they purchase spectacles using NHS optical vouchers.

The General Ophthalmic Services (GOS) contract covers the provision of NHS sight tests. The range of spectacles carried by an optician's practice is not a matter that is within the scope of the GOS contract.

The system of NHS optical vouchers, which is separate from the GOS contract, provides help in buying glasses or lenses for children of those on low incomes and other eligible groups. The voucher scheme gives eligible patients flexibility over which glasses or lenses to choose. Patients are able to take their voucher to the provider of their choice, i.e. not just the optician who issued the voucher, so are able to shop around from a wide range of providers to obtain the glasses. The scheme also gives patients flexibility to top up the voucher value (if they wish) to obtain more expensive frames of their choice.

We would be concerned that restrictions which prevented patients from using optical vouchers at certain opticians (on the basis that they did not stock a range of glasses within the voucher value) would reduce patient choice.

Recommendation 9 (Paragraph 168)

We recommend that the Department increase efforts to target people at risk of eye disease. All young children should be fully screened for visual impairment. The Department should look at eye examination schemes in place elsewhere in the UK with a view to implementing them in England.

Information about the availability of NHS funded sight tests is routinely provided to patients. The Children's National Service Framework sets out plans for the introduction of a national pre-school vision screening programme. Children are also one of the groups eligible for NHS funded sight tests.

As part of its current work programme the National Institute for Health and Clinical Excellence (NICE) will be preparing clinical guidelines for the NHS on the diagnosis and management of glaucoma.

As part of the Department of Health's current review of eye care services, we are looking at how best to support the NHS in commissioning a wider range of eye care services in primary care. The review is looking at the available evidence from eye examination schemes elsewhere in the UK. The review will make recommendations to Ministers on the scope to improve eye care services in England, within the context of wider NHS reform policy, and is expected to report to Ministers in late 2006.

The review will also consider what opportunities exist to get messages about visual health across to people who are at increased risk of eye disease.

Recommendation 10 (Paragraph 169)

We recommend that all pharmacies, hospitals, and GP and dental surgeries make available to patients information on charges to which they might be liable, eligibility for exemption, and possible assistance with costs associated with attending for treatment.

We have a portfolio of publicity material which is managed by the PPD of the NHSBSA. It includes a poster advertising help with health costs (code HC10 plus a students' version), a leaflet "*Help with Health Costs*" (code HC11), a summary of the HC11 "*HC11 Quick Guide*" (plus a students' version), a leaflet listing NHS charges and optical voucher values (code HC12) and a poster advertising pre-payment certificates (code HC20).

The PPD distributes copies of the Quick Guide and the HC10 poster several times a year to all pharmacies, GP dispensing practices and other GP practices. Periodically, the PPD includes in the pack the HC20 poster and the HC12 leaflet. All publicity material is available free of charge and may be ordered from the Department of Health Publications Orderline by telephone, fax or email: Tel: 08701 555 455, Fax 01623 724 524, email dh@prolog.uk.com.

Pharmacy Contractors

All pharmacies and appliance contractors who provide NHS pharmaceutical services must, under their respective terms of services as set out in the National Health Services (Pharmaceutical Services) Regulations 2005, Schedule 1 and 3, ensure that appropriate advice is given to patients to meet the patients' reasonable needs for general information about the drugs or appliances provided.

A poster is supplied by the Pharmaceutical Services Negotiating Committee (PSNC) to pharmacy contractors which shows the current charge, lists the exemptions and mentions the availability of PPCs.

We will discuss with representative bodies including the PSNC what steps can be taken to improve the availability of information and what further posters or leaflets would assist pharmaceutical services contractors to provide the necessary information to patients.

Hospitals

Guidance has been issued to hospitals about the hospital travel costs scheme (HTCS) and is also on the Department of Health's website. The guidance states that provider units should have adequate arrangements for:

- informing all NHS patients of their entitlements;
- checking the appropriate travel costs; and
- refunding patients the travel costs to which they are entitled.

In or outpatients should be able to obtain travel cost refunds at any time of the day or night. This applies particularly to those discharged from hospital or sent home from an Accident and Emergency Unit during out-of-office hours. Notices about the HTCS should be displayed in all patient areas. A poster about the scheme (HC10) should be displayed and leaflet HC11, which summarises the arrangements, should be made freely available in appropriate hospital departments or clinics, as well as in the community. Provider units should ensure that details of the local arrangements for payments under the HTCS are displayed prominently in patient areas.

For all patients, provider units should ensure that they provide details of the HTCS and of local transport and concessionary fare arrangements with appointment or admission letters. Ideally those who may be able to claim low income entitlement should receive the information early enough to be able to apply to make a LIS claim for an assessment in advance of their travel. They should be advised to use the claim form HC1 which should be held by hospitals and can be obtained from any local Jobcentre Plus office or from the Department of Health Publications Orderline.

The guidance will be revised and updated in the light of changes to the arrangements made following "*Our Health, Our Care, Our Say*".

Dentists

Under the new dental contracts, all dentists providing NHS services are required to display for patients the following information:

- a statement on the practice's quality assurance system;
- a patient charges poster as supplied by the Primary Care Trust;
- information on the complaints system; and
- a patient information leaflet which must be kept up to date.

The Department of Health produced a poster explaining the new system of NHS dental charges and a template for the practice patient information leaflet. We also produced a national leaflet "*What You Need to Know About the Changes to NHS Dentistry in England*" and distributed 100,000 copies to primary care premises, dental practices and CABs between January and April 2006. This includes a panel listing all the exemptions. A regularly updated template of the leaflet will continue to be available to Primary Care Trusts to adapt as necessary for local use.

Optical services

Under the National Health Service (General Ophthalmic Services) Regulations 1968, opticians are required to display a notice and a leaflet showing the services available under the NHS general ophthalmic services and listing which patients are entitled to a free NHS sight test and/or an optical voucher towards the cost of glasses or contact lenses.

The Department of Health produces a poster "*Sight Test and Optical Voucher Entitlements*" for opticians to display. This poster lists the eligibility criteria and gives details of the help available for those on a low income.

GPs

The Department of Health will consider whether general practices should be required to display information about charges. However, information is already available on the tear off section of FP10 prescription forms about PPC exemptions and help with the cost of prescription charges.

Practices currently are not obliged to display information to patients about charges, exemptions and help for those on a low income, unless the practice offers repeat dispensing or dispensing services.

Some practices are members of the Waiting-room Information Service (WIS) and this service, paid for by the Department of Health, supplies the leaflets HC11 and HC12 on a quarterly basis. The PPD of the NHSBSA sends a mailing pack to practices which consists of the HC11 summary (or the "Quickguide") leaflet "*Are You Entitled to Help with Health Costs?*" and the HC10 which advertises all assistance with NHS charges. Periodically the PPD includes in the pack the HC20 which advertises PPCs and the leaflet HC12 which lists all NHS charges and optical voucher values.

Recommendation 11 (Paragraph 170)

We recommend the HC1 form should immediately be re-written in clear English.

The HC1 claim form has to collect all the information necessary to calculate entitlement based on income support arrangements with the addition of housing costs and Council Tax.

The form has been written professionally in language designed to be understood by those with limited reading ability. It has also been designed professionally so that many questions may be answered as "no" with signposting to the next relevant question or "yes" with a box to enter the required details. The signposting means that many questions do not have to be answered by all applicants.

The design and production of the form is now managed on behalf of the Department of Health by the PPD of the NHSBSA. The PPD is looking at ways in which the content may be simplified but with regard to the information that needs to be collected. The PPD is working with the Plain English Campaign with a view to submitting the form to the Crystal Mark Scheme.

Recommendation 12 (Paragraph 170)

We recommend that the Department of Health and the Department of Works and Pensions work together to find ways of automatically extending health charge exemption from means-tested benefits so that the HC1 form can be abolished.

We will explore possibilities as part of the review described in our response to recommendation 2. However, it is likely that there will always be some people on a low income who will not be entitled to means-tested benefits and as such will need to seek help through the LIS.

Recommendation 13 (Paragraph 172)

We recommend that the Hospital Travel Costs Scheme be extended to cover patients attending for treatment at primary care facilities, in accordance with *Our Health, Our Care, Our Say*. Consideration should be given to including dental surgeries under the scheme where patients have to travel considerable distances to access care. Information provision on the HTCS and the Patient Transport Service should be improved to increase uptake of the schemes.

We will extend the HTCS next year, as described in '*Our Health, Our Care, Our Say*' that is to include people referred to health care professionals in a primary care setting.

We will look at how providers and commissioners can raise awareness of the scheme as well as alternative ways of reimbursing patients in primary care settings. All our proposals will be informed by the views of patients and professionals following a consultation.

Providing adequate primary dental services is a priority for primary care trusts, who will address the issue by commissioning dental services that meet their populations' needs through the new dentistry contract, rather than through extension of the HTCS. The HTCS will remain focused on helping those patients who have a specific financial need in meeting travel expenses to treatment.

Recommendation 14 (Paragraph 173)

We recommend that the Government consider extending the Hospital Travel Costs Scheme to some hospital visitors on low incomes (for example, to those visiting long-stay mentally ill patients for whom it may be particularly important to maintain links with family and friends).

We do not consider that it would be appropriate to extend the HTCS to include hospital visitors on low incomes visiting patients with particular conditions. It is for local PCTs, as commissioners of services with an overview of the needs of their patient populations, to commission services based on clinical need and cost effectiveness. This may include attendance of visitors as part of a care package for long stay mental health patients where it is proven to be effective to do so.

Help with costs to visit someone who is ill may be available in the form of a Community Care Grant from the Social Fund.

Recommendation 15 (Paragraph 174)

We recommend that the guidance on car parking arrangements be reissued by the Department of Health. It should recommend that trusts:

- **issue all regular patients, or their visitors, with a `season ticket' that allows them reduced price, or free parking;**
- **introduce a weekly cap on parking charges for patients;**
- **provide free parking for patients who have to attend on a daily basis for treatment; and**
- **inform patients before their treatment begins of the parking charges, exemptions and reduced rates that will apply.**

The Government welcomes the Committee's comments and agrees that this is an issue of considerable importance for patients and the public and one that is sometimes not given the attention it deserves. As this is a matter for local Trusts, we suggest that they look carefully at the Committee's recommendations. The Government believes that to enable choice, it is important that Trusts give a clear, accessible statement of car parking policy including the availability of permits/season tickets and will take the Committee's recommendations into account when re-issuing guidance on car parking arrangements.

In February 2006 the DH Estates and Facilities Division issued guidance on "Transport and Car Parking" which addressed the need for free passes or permits (operating on a similar basis to season tickets), low cost or free parking, for exactly the groups of patients/visitors that the Committee is concerned about. This guidance also stressed the importance of making information, particularly about financial assistance, freely and widely available such as in appointment letters, visitors' arrangements, and on websites and other communication routes.

The Department of Health's Income Generation Team also intends to update and reissue four guides on specific income generation activities, one of which covers car parking charges. This guide will be revised and reissued, making clear the Department of Health's commitment to supporting the Committee's recommendations and the need for trusts to review car park charging arrangements taking into consideration weekly caps, permits/season tickets, free parking; and for this information to be made widely available. This will take place by the end of this year. This will have the added advantage of making clear to trusts that the estates management and income generation perspectives of car parking issues are working in tandem.

Recommendation 16 (Paragraph 175)

We recommend that urgent consideration be given to short-term measures that could be taken to reduce the costs of calls to bedside telephones, such as shortening the recorded message and making it avoidable. In the longer term, we recommend that hospitals should make greater use of the bedside units as soon as possible since this would reduce the costs of incoming calls. It is an utter waste for these units, which could contribute significantly to the transfer of information within hospitals, to be used as little more than glorified telephones and televisions. If the NHS cannot make use of the additional services in the near future, the Department should pay the difference in cost between the standard rate and the amount charged by the companies. Patients' relatives and friends should not be penalised for the Department's failings.

The Department of Health has set up a Review Group to explore the issue of costs to users of the bedside television and telephone systems in National Health Service hospitals as a result of an Ofcom investigation into the cost of telephone calls to hospital patients. It continues to have significant concerns about the level of charges for incoming calls to hospital patients. The Review Group report will be published by December 2006.

The Review Group is currently considering numerous aspects of the charging structure, including whether it is appropriate for a recorded message to be played in its entirety at the outset of each incoming call.

Ofcom published "*Telephone Numbering – Safeguarding the Future of Numbers*" on 27th July 2006. This includes notification of modifications to the National Telephone Numbering Plan. The report concludes that, if the review of the bedside telephone charges does not result in call charges in accordance with the call charge ceiling outlined in the above Ofcom report, original operators of the telephone service will have to implement a free, recorded message when originating a call to a hospital patient.

Should this be the case the private providers of the bedside television and telephone services will have to agree what agreements should be in place with the telecoms companies they use and with the Department of Health.

As a result of the review, five new products are now being trialled. Evidence is being gathered to demonstrate whether or not they can provide cost savings and/or efficiencies to NHS Trusts. If proven and sold into the NHS they will provide additional income streams for the private providers of the bedside entertainment services.

These new products are: electronic food ordering, bed management/call flow system, telephone based interpreter services, electronic questionnaires and patient information services. Adequate uptake of these services may enable the private providers to reduce significantly the cost of their incoming calls.

However, the Department of Health is not in a position to mandate the NHS to use these additional products and therefore cannot guarantee that the take-up will be sufficient for the private providers to significantly reduce their incoming call charge.

In the event that the take-up is not sufficient, the Department of Health is not in a position to pay the difference between the standard rate and the amount charged by the private providers. The Department of Health cannot distort competition by favouring certain undertakings or the production of certain goods by using State resources.

Recommendation 17 (Paragraph 176)

We recommend that, provided they do so sensitively, patients and their visitors should be able to use mobile telephones within certain areas of hospitals.

The Patient Power Review Group has reviewed the existing guidance about the implications of patient, staff and visitor use of mobile phones in hospitals and other NHS premises.

As a result of the work of the group, the Department of Health has issued guidance that recommends that mobile phones, and all electronic equipment that transmit radio-frequency energy above a very low power level, are only permitted to be switched on and used in

specifically designated areas well away from possible interference with medical devices. This guidance can be found on the Estates and Facilities Management area of the Department of Health's website

There is a need to balance patients' welfare, privacy and dignity and environment against the need for appropriate communication between staff, visitors, patients and their family and friends. Any policy needs to be justifiable and clearly understood, bearing in mind the variety of situations found in different parts of NHS premises.

The use of mobile phones and other digital & wireless technology, in suitable locations, perhaps designated areas, and with respect for others, can be managed. However, this requires a clear policy, understood by staff and backed up with appropriate advisory signs and notices throughout the organisation.

The Medicines and Health Care products Regulatory Agency has produced suitable posters, which can be obtained from their website (www.mhra.gov.uk – "FAQ on the use of mobile phones in hospitals"), together with advice on the use of mobile phones generally. These signs should indicate where devices can and cannot be used. A review process should be put in place to ensure that any policy is enforced and adhered to, and to look at changes where appropriate.

It is a matter for NHS Trusts themselves to make decisions about their own policy on the use of mobile phones in hospitals.

Recommendation 18 (Paragraph 176)

We recommend that the Government establish a review to examine the costs and benefits of the following:

- **abolishing all the existing health charges;**
- **abolishing only the prescription charges;**
- **abolishing only charges for initial consultation and diagnosis, such as dental check-ups and eye tests;**
- **establishing a system of reference pricing for medicines;**
- **completely revising the list of medical exemptions to the prescription charge;**
- **introducing a flat-rate prescription charge with no exemptions; and**
- **basing exemption to charges solely on income so that those who can afford to pay for their prescriptions, dental care and sight tests do so. (Paragraph 177)**

Recommendation 19 (Paragraph 177)

The terms of reference and results of the review should be published.

Review of Charges

Abolish charges: health charges from prescription and dental charges currently generate income for the NHS of some £1 billion per annum. A new dental charges system was introduced from April 2006 and the Government accepts that it would now be appropriate to review prescription charges to consider options for possible change to those charges that would be cost-neutral to the NHS. However, the Government does not agree that it would be appropriate to abolish health charges as this would reduce by some £1 billion, the money available to deliver other health priorities.

Review of prescription charges: as set out in our response to Recommendation 2, the Government will undertake a review of prescription charges and report the outcome of this review by the Summer Recess 2007. This review will include options to

- revise the list of medical exemptions to prescription charges;
- introducing a flat-rate prescription charge with no exemptions;
- basing exemption to prescription charges solely on income.

These options will be considered on the basis that any changes to prescription charge exemptions, if implemented, are cost-neutral for the NHS.

Dental care and sight tests

The Government and NHS have only recently introduced major reforms to the system of NHS dental charges. These changes were based on the unanimous recommendations of a working group chaired by Harry Cayton, National Director for Patients and the Public, which brought together representatives of patient and consumer groups, dentists and other key stakeholders. The Implementation Review Group that is monitoring the impact of the dental reforms will be looking, amongst other issues, at the impact of the new charging system.

Whilst the new system is bedding down, we consider that it would be premature to consider significant further changes. The Government is not in any case persuaded that abolishing charges for dental examinations would constitute an appropriate priority for the use of NHS funds. A Band 1 course of treatment, which costs £15.50, covers not just an examination, but any diagnosis, treatment planning, scale and polish, and oral health advice that is needed. Abolishing this modest charge would mean not only diverting significant resources (probably some £170 million) from other areas of NHS expenditure, but could reinforce the practice of unnecessarily frequent visits to the dentists for orally healthy patients.

NHS sight tests are already provided free of charge for children, those on low incomes, certain groups with a predisposition to eye disease, and (since 1999) those over the age of 60. We are not persuaded that the benefits of extending eligibility to other groups of adults (who currently have to pay for a private sight test) would justify the costs involved – likely to be some £100 million. As set out in our previous evidence, the re-introduction of free sight tests for over 60s in 1999 appears to have resulted in a transfer of sight tests from the private sector to the NHS, rather than any material increase in the overall number of sight tests undertaken. This suggests that any further extension in eligibility is unlikely to affect significantly the overall number of sight tests undertaken or the associated health outcomes.

We will, however look at whether any of the options considered for prescription charges as part of the review described above have knock-on implications for dental or optical services.

Reference Pricing

Establish a system of reference pricing for medicines: reference pricing is a system used in some other European countries and elsewhere to establish the price that the relevant health system is prepared to pay for a medicine. There are two forms of reference pricing:

- *therapeutic reference pricing:* this involves setting a price threshold or ceiling for a group of therapeutically equivalent medicines (e.g. statins or proton pump inhibitors);
- *international reference pricing:* medicine prices are set in relation to those in a basket of other comparable countries.

In most countries that have implemented reference prices where the price charged by the pharmaceutical manufacturer is higher than the reference price, the patient is required to pay the difference as a co-payment.

In the UK the price of branded medicines is controlled by the Pharmaceutical Price Regulation Scheme (PPRS) which limits the profits and prices that may be charged by brand medicine manufacturers. Since April 2005 the reimbursement of generic medicines in England has been set by a new system – Category M – which is based on the relative market prices of these medicines. Although the comparison of generic medicine prices between different countries is complicated by a number of factors, the Government believes that generic medicine prices in the UK are towards the lower end of those in comparable countries.

The Government is not persuaded that it would be appropriate to consider introducing reference pricing for England at this time because:

- a variable co-payment that is related to the difference between the price of a medicine and the reimbursement price that the NHS was prepared to pay would not be consistent with the Government's values for the health services;
- reference pricing could only be introduced if the current mechanisms for controlling medicine prices (PPRS and Category M) were abandoned.

Recommendation 20 (Paragraph 178)

The use of a limited NHS formulary of medicines, possibly linked to reference pricing, could reduce the drugs bill and improve prescribing practice. We recommend that the Government look at this and respond to us specifically on this matter.

The Government assumes that the recommended "limited NHS formulary of medicines" would entail certain essential features, namely: (1) the development of the criteria underpinning such a scheme. These would almost certainly centre on a systematic and transparent assessment of clinical and cost-effectiveness; (2) an agreed mechanism for the assessment of all drugs, both new and old; (3) an agreed decision-making process for inclusion on the formulary; and (4) an enforcement mechanism for ensuring adherence to the formulary.

Whilst such a system may offer some advantages over current arrangements, the Government considers that they are outweighed by significant disadvantages. We think the Committee significantly underestimates the time and resources involved to develop and administer a national formulary out of the many thousands of medicines with a current marketing authorisation; and do so in a way which is transparent, evidence-based and legally watertight. Additionally, the scheme would require extensive underpinning in legislation.

The Government believes that a national formulary brings with it uncertain benefits at the cost of far greater central process expenditure and a greater number of decisions taken in Whitehall rather than in the NHS locally. Ultimately it may undermine NHS organisations' ability to manage their own drugs spending effectively in the light of local circumstances.

The Government considers that the objective of securing cost-effective use of drugs in the NHS is best served by our plans for development of the current regime. Principally, these involve developing the role of NICE and taking forward work to support local prescribing committees, both hospital-based and in primary care, to encourage collaboration across the sectors to secure rational prescribing.

Recommendation 21 (Paragraph 179)

We need to avoid the risk of new charges being introduced in an ad hoc way, as they have in the past. The Government should review the costs and benefits of an alternative system of health charges. The key principles that should be considered in this review are:

- **services that are clinically necessary should be free;**
- **fees should not deter patients visiting their doctor or accessing healthcare; and**
- **any system chosen should be adaptable (to changing medical practice, treatments etc) and consistent.**

Recommendation 22 (Paragraph 179)

The review should include:

- **the possibility of establishing a package of core services which would be free (these might include prescriptions and dental care);**
- **a set of treatments for which the NHS could charge;**
- **treatments/interventions that are not cost-effective, such as branded drugs where an effective generic exists, could be subject to a charge. The use of charges to promote more responsible use of services could also be considered, including:**
    - **the introduction of a small charge for non-emergency patients presenting to A&E. This would encourage people to register with a GP, and make better use of out-of-hours services; and**
    - **a fee for patients who do not attend or fail to cancel GP or hospital appointments.**

The Government does not agree that the system of charges is a mess. The core philosophy of the NHS is that care is available free of charge according to need; charges for clinical treatment are only levied with statutory authority where there is a legitimate case for using charges to reduce unnecessary demand. A wide-ranging system of exemptions is designed to ensure that people in need do not go without treatment on the grounds of cost. Any change to the existing system would need to be justified according to the same core principle, namely that it did not undermine the provision of a comprehensive health service according to need, and would be subject to public consultation and the consent of Parliament. In any case, the Government has no plans to introduce further charges.

The Government agrees with the spirit of the recommendation, namely that the resources of the NHS should be focused on what works and is already taking steps to ensure that the public receives best value from the record level of investment in NHS services. For example, NICE is reviewing ineffective as well as effective treatments and will encourage the NHS to disinvest in the former. The Pharmaceutical Pricing Regulation Scheme (PPRS) already promotes the use of generic medicines. With regard to charges to promote responsible use of services, the Government is very sympathetic to the intention behind this proposal but would note that implementing such charges would be extremely complex. With regard to charges in A&E, issues include who would decide what was, or was not, a non-emergency use of A&E; what to do if a patient refused to pay; and the possible knock-on impact on the four-hour standard for dealing with patients in A&E. As for charges for non-attendance, setting up appropriate administrative systems would have cost implications and it is not immediately clear that these would be cost-effective. The Government believes that a better way of encouraging attendance is to put in place efficient and patient-friendly appointments systems, for example, the new Choose and Book system for hospital appointments. There is also evidence from the Primary Care Collaborative that general practices which offer responsive booking and appointments system see significant reductions in the number of patients who fail to keep or cancel their GP appointments.

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