STATES OF JERSEY

GOVERNMENT PLAN 2020–2023 (P.71/2019): AMENDMENT

Lodged au Greffe on 11th October 2019
by Deputy G.P. Southern of St. Helier

STATES GREFFE

GOVERNMENT PLAN 2020–2023 (P.71/2019): AMENDMENT

PAGE 2, PARAGRAPH (h) –

After the words "to the Report," insert the words –

"except that in Summary Table 8(ii) the total amount for 'Benefits and other expenditure' should be increased by the sum of £0.9 million and the estimated closing balance be decreased by £0.9 million to meet the cost of providing G.P. consultations at a reduced charge for certain groups".

DEPUTY G.P. SOUTHERN OF ST. HELIER

Note: After this amendment, the proposition would read as follows –

THE STATES are asked to decide whether they are of opinion –

to receive the Government Plan 2020–2023 specified in Article 9(1) of the Public Finances (Jersey) Law 2019 ("the Law") and specifically –

(a) to approve the estimate of total States income to be paid into the Consolidated Fund in 2020 as set out in Appendix 2 – Summary Table 1 to the Report, which is inclusive of the proposed taxation and impôts duties changes outlined in the Government Plan, in line with Article 9(2)(a) of the Law; and

(b) to approve each major project that is to be started or continued in 2020 and the total cost of each such project, in line with Article 9(2)(d), (e) and (f) of the Law and as set out in Appendix 2 – Summary Table 2 to the Report; and

(c) to approve the proposed amount to be appropriated from the Consolidated Fund for 2020, for each head of expenditure, being gross expenditure less estimated income (if any), in line with Articles 9(2)(g), 10(1) and 10(2) of the Law and set out in Appendix 2 – Summary Tables 3(i) and (ii) of the Report; and

(d) to approve the estimated income, being estimated gross income less expenditure, that each States trading operation will pay into its trading fund in 2020 in line with Article 9(2)(h) of the Law and set out in Appendix 2 – Summary Table 4 to the Report; and

(e) to approve the proposed amount to be appropriated from each States trading operation's trading fund for 2020 for each head of expenditure in line with Article 9(2)(i) of the Law and set out in Appendix 2 – Summary Table 5 to the Report; and

(f) to approve –

(i) the establishment of a "Climate Emergency Fund", in accordance with the provisions of Article 6 of the Law, as set out at Appendix 3 to the Report; and

(ii) the estimated income and expenditure proposals for the Climate Emergency Fund for 2020 as set out in Appendix 2 –

Summary Table 6 to the Report; and

(g) to approve the amounts to be transferred from one States fund to another for 2020 in line with Article 9(2)(b) as set out in Appendix 2 – Summary Table 7 to the Report; and

(h) to approve the estimated income and expenditure of the Social Security, Health Insurance and Long-Term Care Funds for 2020 set out in Appendix 2 – Summary Tables 8(i), (ii) and (iii) to the Report, except that in Summary Table 8(ii) the total amount for 'Benefits and other expenditure' should be increased by the sum of £0.9 million and the estimated closing balance be decreased by £0.9 million to meet the cost of providing G.P. consultations at a reduced charge for certain groups; with –

(i) the estimated income to be raised from existing social security contributions defined in the Social Security Law and the proposed changes to contribution liability; and

(ii) the estimated expenditure to be paid to support the existing benefits and functions defined in the Social Security Law, the Health Insurance Law and the Long-Term Care Funds and new benefits, if any, to be paid from the Funds; and

(i) to approve, in accordance with Article 9(1) of the Law, the Government Plan 2020–2023, as set out at Appendix 4 to the Report.

REPORT

Primary Care: the challenges

The challenges presented to our health service by an ageing population were extensively outlined and explored in the Green Paper R.63/2011: "Caring for each other, Caring for ourselves" in 2011. Proposals for the redesign of health and social care services in Jersey were adopted in proposition P.82/2012: "Health and Social Services: A New Way Forward", which contained further consultation on a White Paper.

The majority of responses received across all consultation formats related to Primary Care, with the most common feedback relating to G.P. fees.

Many of those that responded thought that fees were too high and can act as a deterrent to accessing care, particularly to those on low incomes or with children.

Improved access to **Primary Care for under-fives** was presented in the White Paper. This was the most frequently commented on in the responses received, with **strong support for this concept, either as subsidised or free G.P. appointments.**

Some people felt that this should apply to all children under the age of 16 and those in full- time education, and some were of the view **that these principles should also apply to the elderly and those with long-term conditions.**

P.82/2012 set a series of ambitious targets –

(i) for the priorities for investment in hospital services and detailed plans for a new hospital (either on a new site or a rebuilt and refurbished hospital on the current site), by the end of 2014;

(ii) to develop a new model of Primary Care (including general medical practitioners, dentists, high street optometrists and pharmacists), by the end of 2014;

(iii) for a sustainable funding mechanism for health and social care, by the end of 2014.

Members will note the dates on these ambitious targets. Today, 5 years later, some progress has been made, but much of the above has yet to be delivered. However, the problem has not gone away. The health implications of an ageing population continue to grow. Actual Health expenditure rose from £171 million in 2012 to £211 million in 2017.

Where are we today as we examine the Government Plan? In 2012 we promised to *"develop a new model of primary care"*. In the Government Plan 2020–2023, a decade later, we will *"implement a new model of health care"*.

More recently, the Independent Jersey Care Inquiry Panel made the same plea on behalf of children and young people in its report R.123/2019 –

> *"The cost of private G.P. care is a barrier to young people and to vulnerable adults who do not have access to household funds (or do not qualify for income*

support) getting health services, advice or G.P. support because they cannot pay for appointments or treatments. To enhance protections for children and young people we believe new policies are required to allow free or fully-funded access to G.P. care and advice for vulnerable groups.".

The problem of affordable access to primary care is not new. The JASS survey of 2009 found that –

- Approximately 22% of respondents felt that the cost of visiting a G.P. was 'expensive but worth it', 15% felt that the cost was 'about right'.

- **8% felt that it was** '**so expensive that it stops members of our household from going**' and 4% of respondents felt that the cost of visiting a G.P. represented 'good value for money'.

- **Approximately 51% of respondents felt that the cost of visiting** a G.P. is expensive, and therefore members of their household **only go when they really had to.**

Common Strategic Policy 2018–22

The issues that are covered by this amendment in delivering health provision for the Island were summarised in the Common Strategic Policy 2018–22, and consist of a mixture of short- and long-term objectives. The short-term aims can best be summarised by this brief passage –

> **What we will achieve**
>
> As a result of our actions during our term of office, we will:
>
> - Improve access for vulnerable people, including children and an aging population, to all primary care services, including dentistry, and make it easier and more affordable to use
>
> - Support Islanders in taking part in active travel and lifestyles through improved infrastructure, for example, the cycle network
>
> - Create the conditions which, over the long term, will reduce the most common diseases and preventable death, supporting Islanders to live healthier, active, longer lives.

In summary, we still have a long way to go if we are to develop new models for the delivery of primary care in the community. This work has commenced but will not deliver results in the short term.

The immediate emphasis is to deliver:

- ***Increased prevention activity, intervening earlier to reduce future costs***
- ***Improved access to primary care and preventative services for children and vulnerable groups***
- ***Increased focus on prevention and lifestyle factors so people stay well longer***
- ***Access to a diverse, skilled workforce based "closer to home" in the community.***

Primary care – long and short term

Whilst P.82/2012 clearly demonstrated the need for a different health care model to cope with increasing numbers living into old age and making greater demands on primary care in the community, the evidence suggests that the goal of increased access cannot be met without making this access affordable. Long-term solutions for the funding of primary care will undoubtedly be the subject of intense debate and negotiations over the coming months and (probably) years. Notwithstanding any progress, or lack of it, over the long term, this should surely not preclude shorter-term initiatives.

Evidence gathered in S.R.3/2011, "Review of Benefit Levels", quotes Dr. Iona Heath, President of the Royal College of General Practitioners, when she said on a visit to Jersey –

> *"We absolutely know that payment for attendance worsens health inequalities so that poor people have to think twice before they see their G.P., and they do have worse health problems to start with. It also encourages people to go to the hospital where it's free – and hospital care is a high cost to the community".*

Two further quotes taken from S.R.3/2011 from Income Support claimants in differing circumstances support this view –

> *"I have found myself out of work since November through no fault of my own and therefore have gone from earning a good wage to Income Support. I have actually had to cancel Doctors due to the cost of £35 each visit."*

> *"As one gets older, it is a fact of life that visits to the Doctor are more frequent and the fees involved are a continual worry. My surgery charges £35.20 for each visit and considerably more if I need a home visit. I have been in hospital 3 times in the last 2 years, which fortunately is free but it has cost me several hundreds of pounds for Doctors fees in between ……".*

There can be no doubt that a co-payment of £40 is a barrier to accessing primary care through G.P. practices for many. If we are to succeed in any of the laudable aims of increased prevention activity, early diagnosis and treatment, and greater access for all, we must make G.P. consultation affordable for those in greatest need, whether that be medical, social or economic.

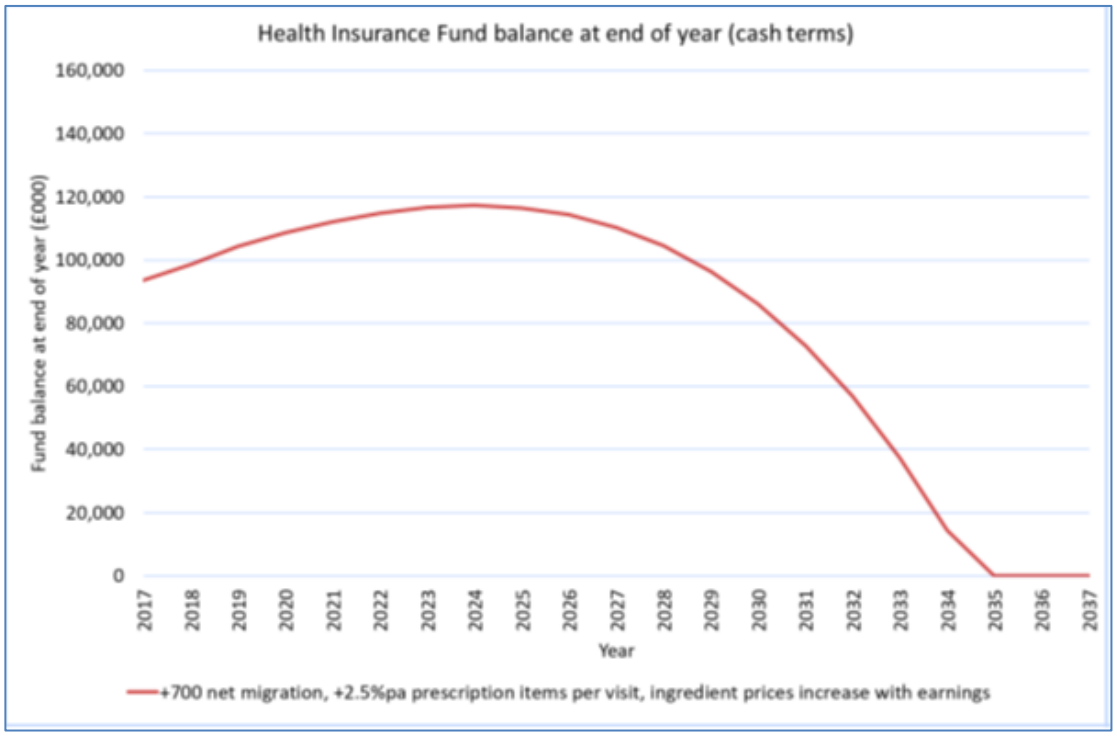
In the short-term, the Health Insurance Fund is in a healthy state, according to Table 35 of the Government Plan, it has a growing balance year-on-year of contributions over benefits.

Table 35

Health Insurance Fund	*2020 £,000*	*2021 £,000*	*2022 £,000*	*2023 £,000*
Opening balance	98,300	107,300	116,900	126,100
Return on investments	4,100	4,200	4,500	4,700
Contributions income	38,100	39,900	40,600	41,600
Benefits	(33,200)	(34,500)	(35,900)	(37,100)
Closing balance	107,300	116,900	126,100	135,300
Annual growth	9,000	9,600	9,200	9,200

As can clearly be seen, the average excess in contributions over benefits amounts to some £5 million, to which can be added over £4 million of returns on investments. Over the period of this Government Plan, the Fund's closing balance grows by some £28 million. This amendment to the Government Plan proposes the use of this excess in the short term to reduce the patient co-payment from around £40 to a sum that is more affordable for selected groups.

However, as demonstrated by the latest Actuarial Review of the Health Insurance Fund ("H.I.F."), shown in the graph below, the opportunity to use the H.I.F. reserve in this way is limited. The Review shows that the peak of the H.I.F. occurs in 2024/25 after which, in the absence of some adjustment to contribution rates or other mitigation, it will be extinguished by 2035.



Actuarial comments

1.13 "*The 2017 review indicates a significantly higher projected Fund balance than the 2012 review – a positive fund balance in 2032 rather than a fund balance that fell to zero by the mid-2020s. The break-even contribution rate is projected to rise far less steeply than in the previous review.*"

Conclusions

1.14 "*The financial outlook for the Fund remains healthy in the short to medium term and has slightly improved from that shown at the 2012 review. However, the Fund is expected to be exhausted by the mid-2030s, as projected outgo of the Fund is above the projected income for most of the projection period. Once the Fund is exhausted, the contribution rate would need to be raised to at least the break-even rates described above".*

Who should benefit?

The H.I.F. currently pays a Medical Benefit of £20.28 to subsidise G.P. consultations. There are currently around 340,000 consultations annually at a cost to the H.I.F. of £7 million.

This leaves the patient to find a co-payment of around £40.00 per consultation. This constitutes a significant barrier to accessing primary care. This results in high numbers inappropriately attending the Emergency Department at the Hospital. Some avoid going to their G.P.s at all; others will not seek treatment until their condition is needlessly worse. Some G.P. practices in response have reduced fees for children, while others will reduce charges for what they see as deserving cases.

If we are to succeed in improving access to health care in the community and meet targets for increased prevention and early diagnosis and intervention, then we have to reduce this co-payment. Further, if we are to lower the need for hospital treatment and hence the size of the new hospital, we need to act now.

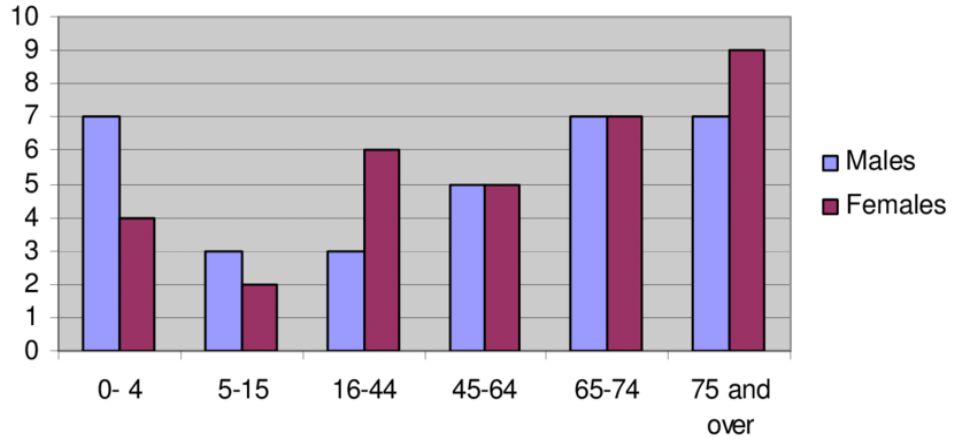
The questions that need to be answered in proposing a reduction in the co-payment are: *"By how much?"* and *"Who will benefit?"* and importantly: *"How much will it cost?"*.

The possibility of adopting the N.H.S. practice of *"free at the point of treatment"* is unsustainable. Free access to all would cost over £20 million and would empty the H.I.F. in under 5 years. One also has to consider whether this approach might then lead, sooner or later, to replicating the UK situation of G.P. surgeries with long waiting-lists and an inability to get timely treatment under the N.H.S.

This amendment proposes that the patient co-payment should be reduced to £10 per consultation. This then would require the medical benefit for a consultation rising by an extra £30 – an additional annual cost to the fund of £10.5 million, if applied to all members of the community, whether old or young, rich or poor, or the chronically ill. This too would soon run down the balance of the Fund, and is not a viable or sustainable option.

In deciding how best to target which groups in our community are to benefit from a reduction in G.P. fees, one has first to examine the demand for primary care.

Average number of N.H.S. G.P. consultations per person per year by sex and age, 2002:



As can be seen in the graph above, one indicator of need is the frequency of demand. This graph is the typical U-shape found in most aspects of health care, with peaks of demand for the under-fives and the over-65s, and increasingly now those over 75.

This is more graphically shown by N.H.S. costs by age-group 2002/3, taken from "The economics of health care", as shown here –

Table B: N.H.S. costs by age-group

Age-group	*Birth*	*Under 5*	*5–15*	*16–44*	*45–64*	*65–74*	*75–84*	*85+*
£ per head	2,655	794	185	327	459	949	1,684	2,689

The 2 peaks in demand are unsurprisingly around birth (which must logically be extended to women in pregnancy), and around old age and death. This leads to a simple means to group those households who would benefit most from a reduction in the cost of access to their G.P.

As a starting-point, the 2 groups of patients with highest need, children under 5 years of age and all Jersey over-65s, should be eligible for the rate of £10 for a G.P. consultation.

Expectant mothers, who clearly have increased medical needs, must also be included.

Turning to those who are in financial need of support with medical costs, we are informed that the award of Income Support, which already has a comprehensive means-test in place, along with a team of administrators, is a good indicator of low income.

The table below shows a total of 35,500 persons eligible for the increased medical benefit to reduce their co-payment to £10. The annual cost to the H.I.F. for a full year would therefore be around £3.5 million. Since the intention of the amendment is to increase the Public's use of G.P. primary care by reducing the £40 barrier to access, the marker of success would be an increase in numbers of consultations. It is noteworthy that a 10% increase in the number of consultations would still leave the cost of the benefit below £4 million.

Since this amendment to the Government Plan can only be put in place with considerable time and effort, it is envisaged that the start date for the scheme would be 1st October 2020, the date on which many benefits are uprated. The amendment therefore only covers the last 3 months of the year, hence the allocation of 0.9 million. If endorsed by the States, the total cost to the H.I.F. over the period of the Plan would be a total of around £11.4 million.

Amending the Government Plan can only entail changes to the figures contained in the Summary Tables; to enable funding for devising a scheme such as this, it is not incumbent on the proposer to fill in every detail. However, when I consider how entitlement to this benefit is to be proven, the simplest way to do this is by a card system. It strikes me that, if that approach were adopted, in effect we would have come to a replacement for the old Health Insurance Exemption ("H.I.E.") card, which in pre-Income Support days gave those entitled free G.P. consultations and free prescriptions.

Group		
All O.A.P.s	18,600	
Children under 5 years	6,000	
Expectant mothers	1,000	
Income Support recipients	5,800 households 7,600 adults	-2,000 pensioners
		+2,300 children under 5 years
	Total:	**35,500**

Financial and manpower implications

As detailed above, a scheme entitling some 35,500 residents to reduced cost G.P. consultations would cost around £3.6 million to deliver in a full year. I am consulting with the Social Security Department concerning administration and staffing costs.