STATES OF JERSEY

PRESCRIPTION CHARGES AND INCOME SUPPORT FOR PRIMARY HEALTH COSTS

Lodged au Greffe on 24th February 2012
by Deputy G.P. Southern of St. Helier

STATES GREFFE

PROPOSITION

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

(a) to request the Minister for Social Security to take the necessary steps to reintroduce prescription charges except for residents aged 65 and over;

(b) to request the Minister for Social Security to identify those recipients of income support or other benefit schemes in greatest need of assistance with primary care costs and to amend the schemes to provide those identified with free –

(i) access to G.P. consultations,

(ii) prescriptions,

(iii) x-rays and scans at the Hospital,

(iv) repeat prescriptions;

(c) to request the Minister for Social Security to bring forward the necessary legislation to give effect to the proposals and to further request the Minister, in consultation with the Minister for Treasury and Resources and the Council of Ministers, to make the necessary financial provision in the draft Medium Term Financial Plan to be debated in September 2012 to allow the measures to be introduced from January 2013.

DEPUTY G.P. SOUTHERN OF ST. HELIER

REPORT

This proposition has its origin in P.17/2012, lodged on 17th February. The level of debate this provoked, both among members and the general public, has been significant and quite intense. As a result, I have tried to build further protection from the high costs of primary health care into the proposition. This version maintains the exemption from prescription charges for all residents aged 65 and over, whatever their circumstances. Further, it also enables the Minister to protect those with chronic conditions. The principles, however, remain the same: to exempt those on the lowest incomes from primary health care charges and to fund this, in part, by the reintroduction of prescription charges for most.

Back in 2008, at a time when the economy was booming and tax revenues were increasing above all expectations, the then Minister for Social Security did a very strange thing. Despite repeatedly telling members of the States that they must be very careful always to target all social benefits, the Minister made an Order that removed prescription charges for all Jersey residents. Members were informed that the Health Insurance Fund (H.I.F.) was in such a healthy state that we could afford to remove prescription charges altogether, at a cost of around £3 million.

In giving his reasons for his decision, the Minister described H.I.F. thus –

> ‘**Status of the Health Insurance Fund**
>
> The Health Insurance Fund is in a very healthy financial position and it is estimated that the abolition of prescription charges in 2006 would have cost approximately £2.5 million. Bank interest on the year amounted to just under £2 million. There would still have been a surplus of approximately £6 million (£8.48 million actual) on the year, and a fund equivalent to 2.72 (2.85 actual) years’ expenditure.
>
> Costs will be greater than this in future years in light of the increased numbers of pharmaceutical products recently added to the formulary and given that the prescription charge will no longer act as a barrier to medication. Even after allowing for any such increases, the fund will remain in a very robust position.
>
> In summary, the Health system is currently in a very robust and buoyant state due to economic growth and changes in prescription costs. There is an opportunity to provide more financial assistance to those who use and contribute to the Health Scheme.’

The H.I.F. is in such fine fettle that the States has transferred £12 million out of the fund to pay for primary care over the last 2 years, and changed the law in order to do so.

On prescription charges he had the following to say –

> ‘**Purpose of Charges**
>
> There is no definitive explanation of the purpose of prescription charges in Jersey but the policy has always been to keep them as low as possible to ensure more benefit reaches claimants. International and UK studies have highlighted several reasons for prescription charges:

- Raising revenue
- Influencing patient behaviour to avoid inappropriate use of medicines
- Increasing the public perception of a valued service as payment has to be made
- Influencing doctors' prescribing habits to provide more efficient medicine usage'.

In 2008, there were many members who found that the rationale for this action was hard to comprehend, given that, even though tax revenues were booming, there were already signs that lean times were on the way. The recession duly arrived and has been with us ever since. There was little enough reason for such largesse in 2008, despite the fact that it was an election year. There is no justification for such a non-targeted benefit today.

In January of 2008, the States also introduced the Income Support (I.S.) scheme which rolled up 14 different benefits into one. This involved scrapping the Health Insurance Exemption (H.I.E.) scheme which had previously delivered means-tested free access to G.P.s and free prescriptions for some low-income families. Those low-income families who were ineligible for H.I.E., but had high G.P. bills through acute or chronic illness, could apply to have their bills paid by parish welfare.

We removed a hard-won benefit designed to alleviate hardship and address the medical needs of the least well-off in the community. We scrapped H.I.E. which gave free access to G.P. services. This was a move unprecedented in a modern western democracy, where proper access to medical care is one of the benchmarks of good government.

I believe that both of these measures were wrong in principle and have had damaging effects on our healthcare system. There is clear evidence that the removal of prescription charges has brought about a significant increase in the number of prescriptions dispensed with a marked impact on the budget. There is also clear evidence that the high cost of G.P. consultations has put many low-income families to avoid going to their doctor. This proposition seeks to reverse these poor decisions.

It seems self-evident that any scheme to restore prescription charges must ensure that there is some protection built in for those with high medical needs and those on the lowest incomes. Fortunately we have a new Income Support scheme in place since 2008 which allows us to effectively target this protection at the most needy.

This report attempts to show that –

(a) the high costs of G.P. consultations are causing health inequalities;
(b) the costs of primary medical care are not well covered by I.S., which has had the effect of reducing G.P. visits for low-income families and thus needs reform;
(c) free access to primary care can be targeted at those most in need.

Health inequalities

Dr. Iona Heath, President of the Royal College of General Practitioners, on her recent visit to the Island, pointed out that the high cost of G.P. visits increasingly presents problems for those on low incomes, when she stated –

"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".

This report and proposition makes extensive use of the material and quotes contained in 4 sources –

- S.R.5/2009, *Review of Income Support,* Chapter 13
- S.R.3/2011, *Review of Benefit Levels,* Chapter 20
- Jersey Annual Social Survey (JASS), 2009 and 2010.

The key findings and recommendations from the 2 Scrutiny Reports are reproduced in the attached **Appendix**.

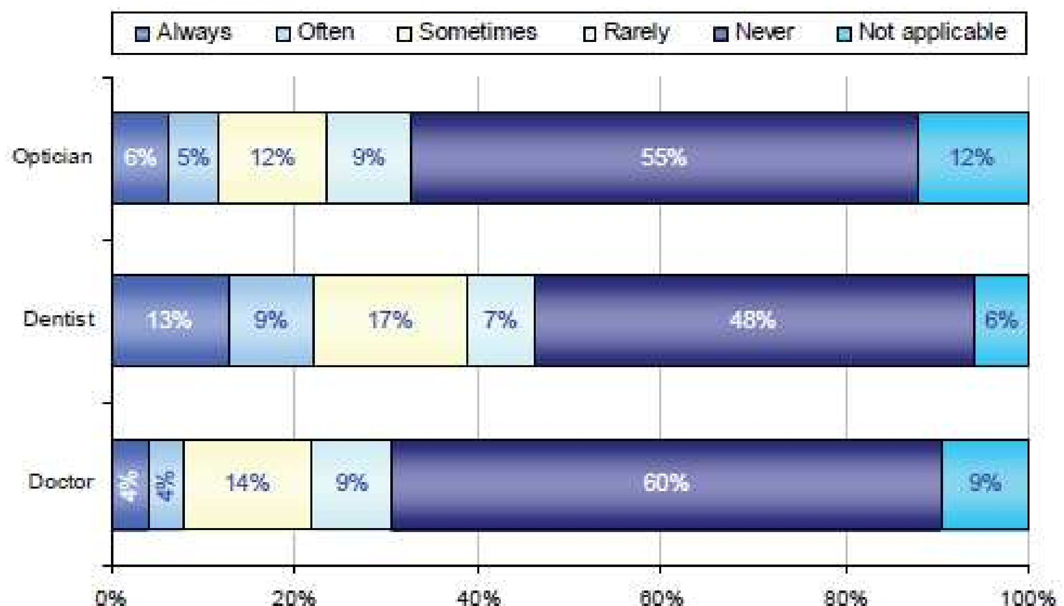
The statement of Dr. Heath about "thinking twice" is graphically illustrated by 2 quotes in S.R.3/2011 –

"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……"

These sentiments are reflected in Figure 12.15 thus –

Figure 12.15 Does your household experience difficulty paying for the following?



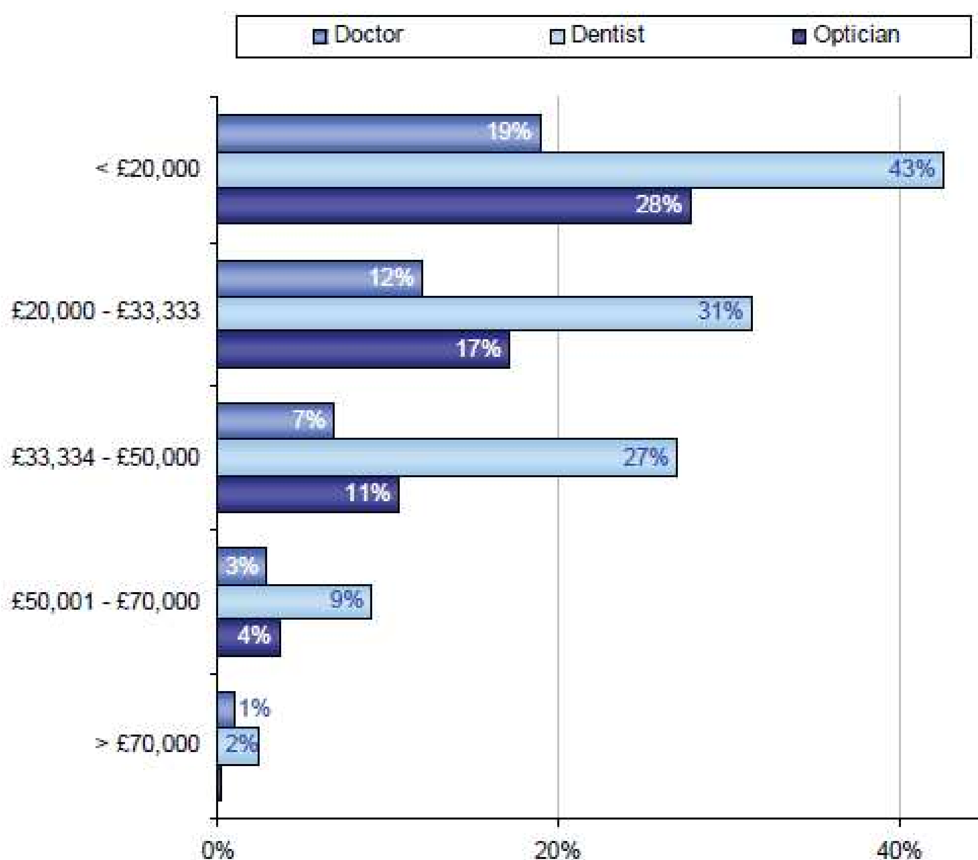
Source: JASS 2010

More than one in five said that their household always or often found it difficult to pay for the dentist and around one in ten always or often had difficulty paying for the doctor or optician.

Analysis of these results by income reveals that a greater proportion of individuals from households with a lower income had difficulty paying, as shown in Figure 12.16 shown below.

Two-fifths (43%) of households with total annual income below £20,000 had experienced difficulty paying for the dentist, over a quarter (28%) had experienced difficulty paying for the optician and a fifth (19%) for the doctor.

Figure 12.16 Does your household experience difficulty paying for the following?
Percentage answering Always or Often, by household income



Source: JASS 2010

The impact on those with children can also be examined –

Table 12.14 Does your household experience difficulty paying for the following?
Percentage answering Always or Often, by household type

	Household with children	Household without children	Household with pensioner	Household without pensioner
Doctor	13	6	4	9
Dentist	34	17	11	24
Optician	19	9	6	12

Half (51%) of households living in States/Parish rental accommodation reported having had difficulty paying for the dentist, compared with a third (33%) living in qualified rental accommodation and one in seven (14%) in owner-occupied accommodation.

Source: JASS 2010

A third (34%) of households containing at least one child had experienced difficulty paying for the dentist, compared with a sixth (17%) of households without children (see Table 12.14 above). The proportions of households with children having had difficulty paying for the doctor or the optician were similarly double those of households without children.

These figures are made worse by the finding, which was reported in JASS 2009, that for nearly a tenth (8%) of all the survey respondents the cost of visiting a G.P. was –

'so expensive that it stops me from going', as shown in Table 11.1.

Table 11.1 Do you think that the cost of visiting a GP is...?

	16-34 yrs	35-44 yrs	45-54 yrs	55-64 yrs	65 yrs or more	**All ages**
Good value for money	2	4	4	6	7	4
About right	12	13	16	19	18	15
Expensive but worth it	20	18	20	25	33	22
Expensive and therefore I only go when I really have to	54	57	55	46	39	51
So expensive that it stops me from going	12	8	5	4	3	8
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: JASS 2009

This finding is strongly reinforced by a submission from Health Plus Limited, a G.P. practice in St. Helier (as shown in S.R.3/2011) –

*"Prior to instituting Income Support with specific reference to change from the H.I.E. system, we had a number of meetings with Social Security representatives. Our concern was that vulnerable people covered at that time by the H.I.E. system might be deterred from seeing the Doctor for financial reasons. We were led to understand that financial constraints would never restrict the access to medical care for those people and that if their medical budget were to run out, Social Security would increase their medical budget to meet the reasonable fees that they required……**However, that has not been the case from our experience. Many H.I.E. patients are very concerned about their medical budget and restrict their medical treatment to the detriment of their health.**"*

Another G.P. practice had previously informed the Sub-Panel (in S.R.5/2009) that they had identified a problem with the H.M.A. fees –

'… those patients who have spent more than their medical budget are being asked to contribute from their other income towards medical expenses. This again means that patients who require medical attention may not come forward for this, as they know that it will reduce their already small level of income for other purposes.

The concerns expressed by this G.P. practice that some Income Support patients are restricting their medical treatment are reflected in the figures shown in the Table below.

Table A: Impact of cessation of HIE and removal of prescription charge

	2006	*2007*	*2008*	*2009*	**2010**
HEALTH INSURANCE					
Number of persons in the scheme	84,177	85,013	90,800	91,800	**92,500**
Number of doctors' visits during year by claimants	393,590	392,416	350,360	366,757	**344,054**
Number of prescriptions during year	1,251,616	1,324,335	1,489,319	1,590,227	**1,651,355**
Cost per prescription	£8.89	£9.02	£10.43	£10.35	**£10.07**
Gluten Free Food beneficiaries	205	216	235	266	**281**

Source: R.122/2011 – Social Security Department: Minister's Report and Financial Statements – 2010 (page 74)

We have now been informed in the answer to written question 6709 on 21st February that the figures given for G.P. visits are incorrect –

'The Deputy is right to draw attention to the anomalous General Practitioner visit figures reported on page 74 of the 2010 report and accounts. These are due to a transcription error in a final draft which led to some historic numbers being stated incorrectly in the published version.

I will circulate an addendum with the correct figures. I can reassure Members that the statistical information is provided as an Appendix to the Report and Accounts and it does not form any part of the full audited Fund accounts, which are not affected.

The correct figures are as follows:

Year	*Number of G.P. visits*
2006	346,465
2007	345,645
2008	346,782
2009	366,757
2010	344,054'.

The Minister had the following to say about these revised figures –

> *"They show small fluctuations from year to year with the highest value recorded in 2009 – almost definitely as a result of swine flu during that year. Visit numbers will always vary depending on a range of factors including the severity of the winter weather and the timing of outbreaks of common infections.*
>
> *Given these natural, seasonal variations, it is impossible to draw any firm conclusions from a difference of less than 1% between 2006 and 2010. In particular, there is no evidence to suggest that families are avoiding necessary visits to their General Practitioner."*

The Minister shows a remarkable lack of understanding in making such a statement. The new figures show that, although the number of persons covered by the Health Insurance Scheme has increased over the period 2006 to 2010 by 10%, there has been no corresponding increase in the number of G.P. visits. In combination with the public attitudes reported above, this leads me to conclude that the high cost of G.P. consultations has led to significant numbers of patients, especially those on low incomes, avoiding going to their doctor.

In proposing the reintroduction of prescription charges, one has to be careful to maintain appropriate protection for the most vulnerable. The Minister in his response to questions in the States made that commitment when he stated –

> *"I am not prepared to consider reintroducing prescription charges without adequate protection for individuals with chronic health conditions."*

This proposition allows such protection to be put in place.

1. By maintaining the exemption from prescription charges for all those aged 65 and over; and

2. By permitting the Minister to consider other benefits other than income support (perhaps Long Term Incapacity Allowance (LTIA), or Incapacity Benefit) for full protection from charges.

I believe that most of those requiring protection will be caught by the Income Support of over 65 conditions, but if the Minister decides that protection should be extended, he can do so.

Of course there will be a trade-off between the sums raised by the charge and the numbers exempted. These financial calculations are addressed below.

Income Support: access to primary health care

The treatment of medical costs by Income Support has been an ongoing issue since its introduction in 2008. Under the previous welfare schemes, there were some who received free G.P. consultations by virtue of the Health Insurance Exemption Scheme (H.I.E.).

In the new scheme, a Household Medical Account (H.M.A.) was brought in. The H.M.A. was not a replacement for the H.I.E. H.I.E. claimants were allocated an H.M.A. under Income Support. H.I.E. recipients were not required to budget for G.P. visits, and the H.M.A. was to help them adjust to the new system.

Initially, it was proposed that Income Support recipients with H.M.A. would pay £5 per G.P. consultation, with the balance paid from the clients H.M.A. This £5 part-payment was soon abandoned.

Income Support households with a H.M.A. have a small weekly amount (£1.93 per person initially) withheld from their benefit and set aside to pay for up to 4 G.P. consultations annually.

Should the client require more visits to the G.P. due to a chronic or progressive condition, then the client can apply for the additional cost to be met from funding via a Clinical Cost component at Level 1 (up to 8 visits) or Level 2 (up to 12 visits). Should urgent extra treatment be required for a short-term illness requiring G.P. assistance, then the cost of any G.P. visits may be met by Special Payments.

Both clients and G.P.s appear to have been unaware that the clients were able to seek financial assistance with the unforeseen extra medical costs from Special Payments. This resulted in clients becoming anxious as to how they could cope with doctors' bills (sometimes amounting to hundreds of pounds). In some cases the Social Security Department demanded that the clients arrange to pay back the overspend on their H.M.A. accounts.

It is clear that the H.M.A. does allow Income Support clients to make provision to pay for their planned G.P. bills in the form of regular small amounts from their weekly benefit. The existing Clinical Components are set up to address chronic or debilitating illness, but are not designed to cope with unforeseen medical visits and expenses. This provision is only available through Special Payments and requires either the G.P. or the client to make an application for the funds to be paid into the H.M.A.

Communication failure

Overall, the Social Security Department failed to communicate how the system for primary medical care, involving H.M.A.s, Clinical Components and Special Payments, was supposed to operate. Both the 2009 and 2011 Scrutiny Reports contain ample evidence, not only of this failure to communicate, but also how the system produced anxiety in patients, even when understood.

Early concerns about the removal of H.I.E. and the effectiveness of H.M.A.s was reflected in the comments submitted to the Scrutiny Panel in 2009 by the Citizen's Advice Bureau.

"The Social Security Department need to carry out a publicity exercise to ensure that all Income Support households understand that the basic personal component for each member of the Income Support unit includes the provision for up to four G.P. visits per year. We also recommend that the setting up of H.M.A.s should be mandatory where there are any members of the unit in receipt of clinical cost components."

The lack of effective communication and publicity for the scheme was so marked that the previous Minister for Social Security, Senator P.F. Routier, was forced to respond in a letter of 22nd January 2009 (one year after the introduction of I.S.) to the Jersey Evening Post that –

'…people who have an agreed medical need will receive additional income support payments to cover the cost the additional visits. When the patient needs the doctor the fee is paid out of the household's own medical account which is added to when needed. Effectively if the patient has an agreed medical need the cost is covered by Income Support. If a patient needs more visits in 2009, they, or their G.P., can tell the Social Security department about the extra medical need and the Income Support claim will be adjusted straight away to give them the additional financial help that they need.'

Representatives of both Family Nursing and Home Care (F.N.&H.C.) and the Parish of St. Helier Community Visitors informed the Panel in 2009 about the real problems and fear that H.M.A.s inflicted upon the public.

F.N.&H.C. representatives informed the Sub-Panel that –

'We know that there is an H.M.A. account but obviously we do not know who has got what. We are totally unaware of how much is in a person's H.M.A. account, how the fees have been allocated, and the patients do not understand themselves… If there is a clinical need for a G.P. visit it is very difficult if the client is afraid to call a G.P. because they are not sure if they are going to get this account paid or not… I think our nurses do spend quite a lot of time reassuring patients that: "Yes, you do need a G.P. visit and do not worry about the funding" but it is a worry to them and we can only advocate for them. We cannot actually make them call the G.P. out if they have that real fear.

The Parish of St. Helier Community workers informed the Sub-Panel that from their experiences –

'H.M.A. has been a problem. First of all, people are allocated X amount of visits, say 6 visits a year. If they have some crisis and they are really unwell and they need to go to the doctor 12 times a year, 6 of those visits are not paid for. You can apply for a special payment, I do not know if you have any idea how long that takes, and if you are not well, having to fill out the paperwork is difficult. So if people have used up their allocated visits they then start to worry because they are not free to go to go and see their G.P. (General Practitioner) or call our their G.P., which makes them stressed, which makes them ill, which makes them need to see the doctor. So the whole system is wrong...".

It is evident that it is not only I.S. claimants who are confused by the system. One G.P. informed the Sub-Panel that he had asked one of his senior colleagues what was his understanding of the H.M.A. scheme and his colleague replied –

> *'It's a mystery'!*

The questioning G.P. subsequently stated in his Practice's submission that –

> *'…I think that this would accurately cover the understanding that many of my G.P. colleagues have of the H.M.A. scheme, myself included'.*

The G.P. went on to say that –

> *'Prior to the initiation of the scheme, we (the practice) did have a number of briefings from senior members of the Social Security Department. I have to say that these briefings as much added to our confusion as clarified the situation. There seemed to be a number of unresolved issues that would be sorted out 'as we get going'.'*

H.M.A. overspends – Patient Stress

The 2009 Sub-Panel received submissions from individuals illustrating the problems they were experiencing with H.M.A.s. One individual illustrated much of what was (and still is) wrong with the operation of H.M.A.s, which caused her considerable stress.

The woman in question was allocated 12 doctors' visits per year on her account, but stated that she avoided going to the doctor for fear of being charged for visits over and above the 12 she was allocated and not being able to pay. Her doctor believed she would not have to pay for additional visits and that he would just have to request additional visits and explain why they were necessary.

However, the patient believed that due to the experiences of her son that this was not the case. The claimant stated that –

> *'I felt far happier with H.I.E., but now try to self-medicate rather than run up a large bill as my son has done, he was having £1.98 a week taken out of his money to cover 4 visits a year, but due to psychological problems has gone over that and now has a letter stating he will be paying £7.62 a week in future, so his money will be less that per week, and also he owes about £650 on his H.M.A. when I asked how that was to be paid the I.S. said they don't know because everything's up in the air at the moment.'*

This is not the only case that has come to our attention where a client has built up a large debt on their H.M.A. and the Department has written to them to ask them to pay this money back, and in one case has held on to a refund for a previous underpayment of over £300.

The patient was also advised by the Department that should she require a number of additional visits, she could be re-assessed the following year and pay more into her H.M.A. This is something she is seeking to avoid as she fears that her other I.S. components would be reduced. At the time, the patient's doctor had tried to make

appointments to discuss the issue with Social Security, but the meetings had either been cancelled or had simply not taken place.

Her doctor advised her that he would rather not charge her for visits than see the caller go without essential care. This did not reassure the patient, who was convinced that she would be required to pay for additional visits.

The issue of what happens to those who incur high G.P. bills from the onset of acute illness continues to be of concern. There have been many assurances from the Minister for Social Security that those on low incomes should not fear the cost of G.P. visits; for example –

> **Senator P.F. Routier:**
> (in answer to oral question asked by Deputy Scott-Warren in 2008)
>
> *"Certainly I reiterate the point, which I have made on several occasions, that **there is no reason whatsoever that anybody should not go to the doctor and delay going to the doctor** if they have a genuine medical need."*
>
> **Senator P.F. Routier:**
> (also in response to a further question in 2008)
>
> *"The costs of home visits for people who are in medical need, and the G.P.s decide that it is right for them to have a home visit, will be met from the income support system. **There is no need for anybody to fear that they cannot afford the G.P. through the costs not being met** by income support, if there is a strong medical need."*.

Despite this, those I.S. recipients who suffer a bout of acute illness with the consequent need for many G.P. consultations, with or without a H.M.A., are often asked to pay the G.P. bills out of their benefit award.

I first became aware of this practice in 2009, when I raised the issue with the Minister in an oral question –

> **Deputy G P Southern:**
>
> *"Is the Minister aware... that additional medical cost will be picked up as extra payments... a person phoned the (Social Security) department to be told that her H.M.A. was £260 in the red and how was she going to propose to pay this sum back?"*
>
> **Deputy I J Gorst:**
>
> *"... perhaps we need to sit down and go over this evidence to see if changes are required. I am perfectly open."*

The practice of charging Income Support recipients for additional G.P. bills continues.

In April 2010, I met one person who was having £25.13 deducted from her weekly benefit to pay off her H.M.A. deficit. After intervention, this was eventually paid off by Special Payments. More recently, I have had to contact the Department over deductions for medical costs of £24.50 per week, and in November last year, a person

having medical deductions of £35 per week. This had the effect of reducing the contribution to her rent to £26 per week.

The inclusion of 4 G.P. visits in every I.S. award and the need for further visits (up to 12) to require a "chronic or progressive" condition, impose a severe restriction on the access to G.P.s.

There are, for example, many reasons why the "average" usage may be higher that have nothing to do with chronic conditions. These cases will receive no additional weekly I.S. to help with G.P. consultation costs. A person, especially a child, may be "sickly" without having a single chronic condition and succumb to numerous infections, for instance.

Additionally, it is not always possible to predict what is a chronic or long-lasting condition at the outset – a child may have a lung infection that appears to be a one-off, but recurs and then is not diagnosed as chronic until 3 to 4 months have passed, because the test of chronic is in this case *post facto*. For the first period of the treatment the child will not have costs. Thus, the additional visits to the G.P. will be paid for and not recognised by I.S. until a diagnosis is made, with no back payment to cover the costs (other than through Special Payments).

Pregnancy and post-natal care are good examples of where non-normal circumstances will lead to the need for more than 4 annual G.P. visits. It also provides a clear example of incentive problems. There is a choice between using G.P.s and using community maternity services through the Hospital or other providers. Clearly, an expectant mother faced with a choice between G.P. – with a rationed 4 visits – and the community maternity services with no charges will choose the latter.

In addition to the levels of anxiety these situations produce in I.S. recipients, the result is that recipients have to rob Peter to pay Paul, that is, they have to use other living components to meet their G.P. bills. This should not be happening, since it is incumbent upon the Department –

> "*to ensure that those who genuinely need general practitioner services are not denied them purely because of cost*".

Targeting

This section outlines how those in greatest need of free access to primary health care as expressed in the proposition might be defined, and how they might be targeted.

The new Income Support scheme is highly targeted, as stated earlier, but contains over 8,000 households or some 19,000 persons. H.I.E. benefited only 4,000 persons. Expanding free access to the whole of the I.S. households would require significant extra funding. Further focus is required to better deliver to those in most need of G.P. services.

In discussing access to primary health care, one measure of need can be obtained from NHS costs by age group 2002/3, taken from "*The economics of health care*" –

Table B: NHS 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

This Table of medical costs is a direct reflection of demand and therefore of the need for health services. 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 free access to their G.P., and who should also be exempt from any prescription charge. All of these groups can readily be identified from the income support computer record.

These I.S. groups are –

Those with disability/chronic illness (recipients of I.S. personal care components PCC2 and PCC3)

Lone parents (with children under 5)

Couples with children (under 5)

Pensioners

To these groups must be added women in pregnancy.

The table below is based on the document "*Distributional Analysis of Income Support Households"* published by the Minister for Social Security in June 2008. It shows how the number of households eligible for free G.P. access can be very easily and sharply focused. The Income Support system is already well focused, but this can be further refined to target only those in greatest need by only including those who were not eligible for transition support at the outset of I.S. These are the least well-off households.

The total number of households in the Income Support scheme in June 2008 was 8,079. This rose slightly to 8,362 by the end of 2008 and by 5% to 8,529 in 2009. The total number of households in the system has now dropped to 7,617, a reduction of 11%, largely I believe, due to the phasing-out of transition protection.

I have included a figure for the proportion of children who are under 5 (derived from the 2011 Census), along with a figure which would cater for the annual number of women on I.S. who fall pregnant. I have not included any figures for those in residential care, as details of how I.S. will be delivered to this group are still in development, as I understand it.

Table C: Targeting of I.S. households for free primary health care access

Household type	*% of all I.S. households*	*Number of households*	*% eligible (no transition)*	*Number of households*	*Children under 5 only (x 24.2%)*
PCC2 & PCC3	9	730	61	443	443
Lone parents	15	1,250	65	808	196
Couples with children	8	650	53	351	85
Pensioner	29	2,330	48	1,113	1,113
Add pregnancies					(+180)
Total:	61	4,960	–	2,715	1,837 (2,018)

The figure of 2,018 households eligible for free G.P. consultations means that this benefit will be highly targeted, representing some 4.5% of the 44,700 households on the Island (Jersey Census 2011). These households probably contain some 4,400 persons in total. This compares with the 4,287 persons who were eligible for free G.P. consultations under the H.I.E. scheme in its last full year of operation, 2007.

In that year, there were a total of 46,771 G.P. consultations by H.I.E. recipients (an average of 11 visits per year) at a cost of £1,276,000 (*see* page 81, Social Security Report and Accounts of 2008).

Costs

As seen in Table A of this report, over the period 2006 – 2010, despite rising numbers of members in the H.I.F., G.P. consultations have remained static. However, the number of prescriptions issued rose by almost one third over this period, most significantly since 2008 when prescriptions charges were dropped.

This of course has had a significant impact on the costs of prescribing to the Health Insurance Fund. Had prescribing habits remained on the 2007 trend, then the bill for prescribing might reasonably be expected to be some £2 million less in 2010. The total bill for free prescriptions for all is of the order of £13 million over the 3 year period since 2008.

The cost of the H.I.E. scheme in recent years is most clearly set out in the Social Security Report and Accounts of 2006. On page 9 it clearly states that –

> *"4,023 people on low incomes are eligible for the Health Insurance Exception Scheme with 100% subsidy on G.P. and prescription costs. This scheme cost £3.0 m in 2006 with 40% of the funding provided from the general revenues of the States."*

This £3 million was thus made up of £1.2 million from general revenues and £1.8 million from the Health Insurance Fund. This covered the 100% subsidy on both G.P. visits and prescription costs.

Scaling this up to the scheme presented in this report, gives the following –

4,400/4,023 = 1.09 x £3 million = £3.3 million.

The subsidy on prescriptions has gone up in the period from £8.89 to £10.07. Assuming that the prescribing habits of this group stay the same, the cost can be estimated at –

£3.3 million x 10/9 = £3.7 million.

In 2009, JASS respondents were asked how much they paid the last time they saw the G.P. For those whose last visit was a surgery appointment, the average (median) paid was £32. The current average cost for G.P. surgery consultations today is in the range of £35 to £40.

Assuming that G.P. consultation fees has risen in line with RPI (17.9% over the 5 year period from 2006, Jersey Economic Trends 2011) which gives a figure of £37.70, one can also build inflation into the costs –

£3.7 million x 117.9% = £4.4 million.

£4.4 million is the total cost of funding free primary care for the 4,400 individuals covered by the Income Support scheme, and targeted by the scheme I have outlined in this report. This cost would be increased should the Minister find that a significant number of those with chronic illness were not covered and extend the scheme appropriately. However, I believe this would be a relatively small number.

In 2010 there were 92,500 residents in the Health Insurance Scheme and 1.65 million prescriptions were dispensed. If a prescription charge were in place at, say, £3.00, then with no exemptions this would have raised some £5 million.

If all those aged 65 and over (14,400, Census 2011) are exempted along with the 4,400 from income support, this leaves some 73,700 residents who will be paying prescription charges. If we exempt a total of 18,800 persons from prescription charges, then if they are average users, this constitutes around a 20% loss of revenue. More likely, given the figures presented in Table B for the costs to the NHS of different age groups, the elderly may account for around 50% of total prescription use. This would reduce to revenue produced to £2.5 million. The net cost to the Health Insurance Fund would therefore be of the order of £1.9 million.

Health Insurance Fund

The Government Actuary's (GAD) Report on the financial condition of the Health Insurance Fund (H.I.F.) as at 31st December 2007 reveals that the H.I.F. is in a healthy state. In the long term, the fund remains able to cover expenditure until 2027 with no change in contribution rates, and even in the worst case scenario, a healthy balance can be maintained with breakeven rates no greater than 2.5%.Table 8.1 of the GAD report, shows the growth of the fund between 2001 and 2009, thus –

Year	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*
Fund at year end £, m	32	37	44	53	63	72	77	83
Months reserve	21	24	28	34	39	37	38	–

On page 10 of the Minister's latest report (2010), the Minister for Social Security states –

> "The net assets of the Health Insurance Fund reached £83.2 million at the end of 2010. The Fund joined the CIF (Central Investment Fund) in July 2010 and continues to perform well…."

Repeat prescriptions

I have been made aware by several members of the public in the course of investigating medical costs, that any charge for issuing a repeat prescription (often between £3 and £5) is described as an 'administration charge' and is not covered by income support H.M.A. Since the alternative is for the patient to attend his or her G.P. for an unnecessary consultation and to charge the cost of a full consultation (£35+) to his/her H.M.A., it seems to me that this practice is counter-productive and costly. The simple solution is to ensure that the costs of repeat prescriptions should be included in any scheme to cover health costs.

X-ray and other scans

It has long been a puzzle to me why there should be a distinction between x-rays requested by a G.P. and those required by hospital specialists. Certainly, in terms of preventive medicine and early diagnosis, it seems to me that to put a charge on access to what should be an essential service must also be counter-productive, and to run against the grain of the recent Health and Social Services public consultation on the delivery of primary health care.

The system for charging or not was tied up with the old H.I.E. system, as can be seen from the following answer given in the States on 16th September 2008. The review did not, as I understand matters, produce any clarity. I believe it is time to produce a new system to include these costs also.

> **Question –** Will the Minister state what progress, if any, has been made towards a scheme that will agree a simple mechanism to identify those on Income Support who need additional financial support for the cost of x-rays or other scans requested by their G.P.?
>
> **Answer –** It should be noted that charges are only made for x-rays and other scans if the patient is referred from their G.P. In most cases, patients will be under the care of a consultant, in which case there is no charge. The Health and Social Services Department is continuing to provide subsidised rates for

x-rays and other scans requested by G.P.s to individuals holding existing H.I.E. cards. The Health and Social Services Department is currently undertaking a review of these services before any new system is introduced.

Financial and manpower implications

The financial costs are outlined above. The manpower costs are difficult to estimate, but can be no more than those which were involved in administering the H.I.E. scheme, and given the new computer base involved in Income Support, following some initial set-up costs, should be within current resources. The cost of repeat prescriptions is not thought to be significant, but in any case, each is a cost saving on the cost of a full consultation. The cost of access to free scans is not known, but in any case, was accommodated in the H.I.E. system prior to 2008.

APPENDIX

S.R.3/2011 – Review of Benefit Levels (March 2011)

Key Finding 20
There is evidence to show that medical costs (G.P., dental and ophthalmic consultations) are a serious problem for many households, especially low-income households in receipt of Income Support, to the extent that significant numbers of people report that the cost stops them going to their G.P.

Recommendation 19
The Minister for Social Security must ensure that information is fully and readily available to the recipients of Income Support about how medical costs are to be met.

Key Finding 21
In principle, Household Medical Accounts are a useful mechanism to assist Income Support clients to save for their G.P. costs.

Recommendation 20
The Minister for Social Security should ensure that all Income Support claimants who wish to can set up a Household Medical Account.

Key Finding 22
The withdrawal of free access to G.P.s for some low-income households under the H.I.E. scheme following the introduction of Income Support has, in many cases, had a negative impact.

Recommendation 21
The Minister for Social Security should review the funding of medical care to develop a costed scheme to provide limited free access to G.P.s for certain vulnerable groups and report his findings within 12 months.

S.R.5/2009 – Review of Income Support (July 2009)

Key Finding 20:
The Department has failed to inform both patients and G.P.s how the H.M.A. scheme works. The H.M.A. is not an adequate replacement for H.I.E. The removal of free access to G.P.s has caused some patients anxiety.

Recommendation 20:
The Department must inform G.P.s and Clients clearly and simply how the H.M.A. system works.

Recommendation 21:
The Minister must examine how repeat prescriptions charges can be included into the benefit components.