Health, Social Security and Housing Scrutiny Panel
Prescription Charges

THURSDAY, 25th JULY 2013

Panel:
Deputy K.L. Moore of St. Peter (Chairman)
Deputy J.A. Hilton of St. Helier (Vice-Chairman)
Deputy J.G. Reed of St. Ouen

Witnesses:
The Minister for Health and Social Services
Consultant, General Hospital
Hospital Director
Chief Pharmacist

[11:00]

Deputy K.L. Moore of St. Peter (Chairman):

Welcome to this hearing of the Health, Social Security and Housing Scrutiny Panel. Thank you very much for attending. We will start with our introductions, if we could. So I am Deputy Kristina Moore, Chairman of the panel.

The Deputy of St. Peter:

Thank you, and welcome also to the members of the public. Minister, if we could start by asking why the prescription charge was removed initially in 2008.

The Minister for Health and Social Services:

I was not Minister at that time and I understand that they were not removed, I think they were put at zero charge, and that was after Social Security removed charges to prescriptions or zero charged them. I cannot remember what exactly they did but we put it at zero charge at that time.

The Deputy of St. Peter:

Did you support that, because you were in the States, were you not?

The Minister for Health and Social Services:

It did not come as a States debate.

The Deputy of St. Ouen:

When you said about zero charge, you and the Minister for Social Security have been at pains to point out that the Social Security provision of prescriptions is different from the hospital. Why did the hospital decide to no longer charge for prescriptions?

The Minister for Health and Social Services:

I think that is very difficult because I was not there at the time, and I do not know if Paul was there at the time, but it was definitely before my time.

Chief Pharmacist:

I think the feeling at the time was that historically hospitals always followed Social Security, so there was consistency in charging, and at that time I believe the decision, although not being involved with it, was made that the hospital should follow suit and set the charge to zero to mirror that in Social Security on G.P. (General Practitioner) prescriptions.

The Deputy of St. Peter:

So why now has the hospital decided to go against that?

The Minister for Health and Social Services:

I do not think it is going against that. I think, like everything else, we need to sit back, review and move forward. As you know, a lot of work has been done over the last 2 or 3 years with the Green Paper and the White Paper about how to redesign Health and Social Services. Part of that is more community care and that is why we looked at prescription charges. One of the reasons is encouraging people to be in more care in the community and prescription charges, prescribing it back where it should be, back in the community. As you know, we looked at the whole thing again in very many different ways of making sure that we look after the most vulnerable and the exemptions are different to what was back in 2008.

The Deputy of St. Peter:

We will move on to discuss the exemptions later, I think. If we could just stick with this line of questioning for the moment. In 2008, the prescription charge was about £2.10, I believe; is that correct? Now it is a rate of £5 that is being introduced, only 5 years after the event. What is the rationale behind the £5 charge?

Chief Pharmacist:

I think previously there was a £2.10 charge but there were very few exemptions. What we have done this time is looked to widen the exemptions and the cost when you put up the charge for those that can afford to pay. Also we are mindful of the total cost of obtaining a prescription when the charge was £2.10 in that there would be an additional charge to obtain the prescription from your G.P. even if it was a repeat prescription, so the total charge around obtaining a prescription was probably round about £5 back in 2008. That was where the £5 figure came from.

The Deputy of St. Ouen:

So the total charge now?

Chief Pharmacist:

The total charge now varies between G.P. practices. If you phone up and request a repeat prescription a practice may charge you anything between £2, and £5 or £6 in order to obtain that prescription from them.

The Deputy of St. Ouen:

Sorry, we are not talking about G.P.s. We are focusing on hospital prescription charges because the Minister for Social Security has confirmed publicly that he has no plans to reintroduce charges for G.P. prescriptions.

Chief Pharmacist:

That is correct, there is no charge at a community pharmacy when you have your prescription dispensed however there is often a charge from the G.P. in order to obtain the prescription in the first place, and that is the current system in primary care. Within the hospital there is no charge at all.

The Deputy of St. Ouen:

Sorry, you missed perhaps the question. We asked why the hospital is planning to introduce the £5 charge, and what does it relate to?

Chief Pharmacist:

It relates to looking at what the charge was previously and what the total cost was in order to obtain a prescription when charges were in place previously, and that was roughly about £5, and that is where the £5 has come from.

Hospital Director:

What it does not relate to is covering the cost of the drugs. Even the average price of the lowest category of drugs is greater than £5.

The Deputy of St. Peter:

The Minister also mentioned that it is part of encouraging people to receive their care in the community. How do you perceive that this policy encourages that?

The Minister for Health and Social Services:

I think it encourages people when they go and see consultants, and Dr. Gibson will give you more on the operational side of things, that they may ask for prescriptions which can be prescribed by the G.P. and also encourages them to go back to their G.P., so the G.P. has a more rounded holistic approach to that rather than coming back into the hospital again to see their consultant and asking for a repeat prescription that way.

The Deputy of St. Peter:

Obviously we are all aware that going to the G.P. costs most people a reasonable sum of money and if they feel that they are seeing a doctor, a consultant, perhaps they have a long-term condition, they see that consultant regularly, could the consultant not have 2 prescription pads, one for the hospital pharmacy and one for the green items that they could collect at the community pharmacy?

The Minister for Health and Social Services:

That is a very good question, and that is the question that we have asked many times, and they did do many years ago, and I think one consultant still can do that, but talking to Social Security it is not feasible.

The Deputy of St. Peter:

Why?

Hospital Director:

Paul can explain that. There is actually some legislation that prevents that.

Chief Pharmacist:

Yes, under the Health Insurance Law, which was amended probably about 20 years ago, which changed that Social Security would only be able to issue Health Insurance prescription pads to general practitioners as opposed to previously any approved doctor. So in order for our consultants to have access to effectively G.P.-type prescriptions, which can be supplied and dispensed at a normal pharmacy, you require a change in Health Insurance legislation.

The Deputy of St. Peter:

But that would only be a minor amendment. It could not be difficult.

Chief Pharmacist:

My understanding is it is subordinate legislation.

The Deputy of St. Peter:

Have you considered making that change?

Chief Pharmacist:

Over the years we have broached that subject with Social Security and they have been minded not to change the status quo at the minute. It is possibly something that could be looked at in the round along with the overall review that is going on with the White Paper.

The Deputy of St. Ouen:

Could you tell us why would they be resistant to change?

Chief Pharmacist:

I would not know. I think that is probably a question you need to ask ...

The Deputy of St. Ouen:

Maybe, Minister, can you help?

The Minister for Health and Social Services:

I think that is a question you would have to ask Social Security at the moment. I know we have had this discussion around the ministerial table. They are not minded to at the moment. But I mean that is one of the things that we can put in the primary care review.

The Deputy of St. Ouen:

Can you just help us to understand: who determines whether patients attend the Outpatients Department or visit their G.P.?

The Minister for Health and Social Services:

It is the consultants that do that.

The Deputy of St. Ouen:

Let us be clear, the consultants invite people to attend the Outpatients Clinic.

The Minister for Health and Social Services:

The pathway starts off by a patient visiting their G.P. and a referral letter is made to the appropriate consultant because it is done on clinical need, but I am sure Dr. Gibson can tell you the pathway there.

Consultant, General Hospital:

Patients come under my care, either acutely by being admitted to hospital so there would be patients in the Outpatients who have been admitted as emergencies or they are referred, having been seen by their G.P.s. It is not possible to refer yourself to a clinic, for instance. The patient will then be seen, a treatment plan will be formulated, investigations may or may not be done, drugs may or may not be supplied. Thereafter if they come back through the results of investigations, for instance, there would be a follow-up appointment. If that is not required then a recommendation will go out to the G.P. to continue or attend this treatment. The drugs then ... obviously there are a small number of drugs prescribable only by the hospital consultants or specialists, but otherwise we would expect those drugs to be thereafter supplied by the hospital consultant, and the follow up is then decided, depending on clinical need, as to whether you need to follow up a condition or not. So obviously there are conditions that are progressive and therefore get worse or a new symptom, it will be expected over time, and there are those conditions which you would expect to stay more or less the same, but nonetheless may require long-term treatment. I think the issue from a consultant point of view is that we get a fair number of people who come back with what are effectively stable conditions and then wish you to prescribe additional medication they are also taking. So as well as the drug you have prescribed, drug A, there will be drug B, C, D and E, which they also want, but they are a bit short of medication at that time and “could you just supply it”. So we get quite a lot of that kind of request. Obviously as it stands, it is not an even playing field in terms of cost. It is significantly cheaper if we prescribe it because at the moment it costs nothing at all, because obviously there is a charge associated with getting those drugs from the G.P., and the idea, when we discuss it at the Medical Staff Committee, is really just to bring those charges more or less level so there was no reason to be one place or another. Because what we are aiming in certainly the White Paper is to move people out of the hospital service into the community. In addition to which, when they go to their G.P. for a repeat prescription their G.P. will check their blood pressure, so there is all that sort of health screening preventative medicine that goes on by interacting. There are certainly patients

who avoid, I think, their next appointment with their G.P. because we have prescribed the medications for them. You are aware that is likely to occur. So we try not to do that. I think the charge is just one of those things that tends to push people back into the hospital and make them a little bit less ... when you say: "I think this could be managed by your G.P." they get a bit anxious about that because obviously they are ... and then the cost is just another issue that adds on to that. I think it would be one of those ones where it just tips the balance and makes the difference between whether people followed up. Now if I follow up 2 extra patients for conditions that potentially could be followed up by their G.P. then that is one new patient I will not be able to see, because there is 2 follow-ups to a new patient effectively.

The Deputy of St. Peter:

Could you just describe why you feel that patients are anxious about the idea of going to see their G.P.?

Consultant, General Hospital:

I think sometimes people get quite attached to a hospital about a particular condition so there is always inevitably, when you change necessarily ... I mean there are patients who go the other way and get anxious, so when they get referred to the hospital you can tell they are very anxious because they are going to see somebody they are not familiar with or whatever. So you cut that string and they go back into the community fully, there is inevitably a little anxiety, and that is very much a personal thing. So we have got patients who are inevitably just a little bit nervous, and you try to reassure them we will see them happily if their G.P. thinks they need any extra help or whatever.

Deputy J.A. Hilton:

Ultimately it is the consultant who decides when to discharge a patient from outpatient appointments back to the G.P., is it not?

Consultant, General Hospital:

Yes, obviously we do that. That is the decision, yes.

The Deputy of St. Ouen:

But given that the Minister for Health is developing a new programme to provide greater care in the community and part of the rationale behind this proposal is to encourage people to go back to their G.P., it sounds as if the people have got little choice at the moment because if the consultant is requiring to be an outpatient and a consultant is choosing to issue the prescription, and not necessarily encouraging the individual to go back to the G.P., what choice has the patient got?

Consultant, General Hospital:

We generally encourage people to go back to their G.P. as soon as we are comfortable that the condition is stable and hospital intervention is not required. We always try to encourage people to go back to their G.P.s.

The Deputy of St. Ouen:

I suppose my question is then: would you be able as a group of consultants to simply limit access to outpatients to those who definitely need it rather than have a more general approach to the matter?

Consultant, General Hospital:

I think it would be extraordinarily difficult to the individual, so I think to put that kind of blanket cover on it then I think that would be extraordinarily ... we like to treat people as individuals on this Island and I think we have got the numbers that allow us to do that.

[11:15]

I would be very nervous about any kind of blanket cut off. I think the general ethos should be that patients who are stable should be managed in the community and the White Paper really is there to support the beefing up those sides of the community that will encourage people to do that. I am fully in support of that.

Deputy J.A. Hilton:

What I just do not quite understand, in the letter of 22nd January from yourself, Dr. Gibson, to the Minister, you said: "As well as a significant increase in the workload through the hospital pharmacy it encourages patients to remain under follow up at the hospital for conditions that could be safely managed by their general practitioner thus increasing hospital waiting times significantly." But surely ultimately, as you said before, it is down to the consultant to make the decision about whether when and whether he discharges the patient back to the G.P. So I do not quite understand that.

Consultant, General Hospital:

All to say that it does occur. I think there are those patients where it is very difficult to discharge them because they feel they need to come back for their prescriptions.

Deputy J.A. Hilton:

But surely it is a medical decision that has got to be made by the medical practitioner.

Hospital Director:

The follow-up ratios in Jersey are higher than you would see in the U.K. (United Kingdom) and the U.K. has done a lot of work on new to follow-up ratios in clinics. What I have seen since I have been here, and spoken to lots of consultants, they feel obliged almost to keep people coming back because the patients will say: "Oh, can I come and see you in another 3 months or another 6 months?" Now it is the consultant's decision but I think there has been a pattern of bringing people back to the hospital perhaps more than I have seen in the U.K. Long-term conditions should be treated in the community, they should be managed in the community. People should come to hospital when they need specialist drugs or specialist opinion, and I think we have just probably shifted the wrong way, and part of the White Paper is shifting that back towards the community.

The Deputy of St. Peter:

But as senior professional people, surely a simple conversation with your consultants could not just encourage them to be a little more direct with their patients perhaps?

Hospital Director:

I have spoken to the consultants and of course, I mean, the consultant has the relationship with the patient and they know what that patient needs. They feel that introducing the prescription charge will stop the patients asking them for writing out all of their medication and perhaps the only drug we will write is the one we have to prescribe because it is a secondary care drug, and they feel that that would change behaviour more naturally for some of the requests that they get. Howard, obviously has lots of colleagues in the same position but I think there are a lot of patients that have an expectation to keep coming back to the hospital. We just need to reverse that.

Deputy J.A. Hilton:

Are you able to tell us how much this practice increases hospital waiting times for people waiting to see consultants?

Hospital Director:

I might not be able to put an actual figure on it but for every 2 follow-ups we see it is one new patient we do not see. So if we could cut the follow-ups down, for every 2 patients we cut back we can see one new, and there are some specialities - Howard's is one of them - where we have got quite a wait.

Deputy J.A. Hilton:

I was just going to come to that because it has become apparent to the panel over the previous year that hospital waiting times for some specialities are very, very high. So surely it does place

an obligation on the consultants to discharge those patients back into the community for the sake of those new patients waiting to see the consultant.

Hospital Director:

That is part of our waiting list plan, and we are doing that. The specialties you will notice with the longest waits are the ones that are caring for long-term condition-type patients. That is part of our waiting list plan, is to increase the care in the community to make sure they are properly looked after out in the community and discharge them from the hospital, and the consultants are working with us on that.

Deputy J.A. Hilton:

Which specialities do you think that involves most of all?

Hospital Director:

It involves neurology, which is Dr. Gibson's specialty. It involves the care of the elderly, rheumatology, some of the respiratory patients, anybody where you have got a chronic ongoing condition.

The Deputy of St. Ouen:

Can I ask, just for clarity sake, are patients invited to the Outpatients' Clinics or do they just turn up?

Hospital Director:

They have appointments.

The Deputy of St. Ouen:

They are invited. So basically the hospital is in control of who is seen?

Hospital Director:

Yes.

The Minister for Health and Social Services:

By referral letter from the G.P.

The Deputy of St. Ouen:

So you are absolutely in control, not the patient of who you see and whether it would be more appropriate to see a consultant or G.P.

Hospital Director:
It is the G.P. who sends the initial referral, so that is a G.P. decision, and then we ...

The Deputy of St. Ouen:
I appreciate that.

Hospital Director:
Then the specialist consultant will see them. After that it is the specialist consultant or their team that make the decision as to whether they come back to the hospital or not.

The Deputy of St. Ouen:
So this idea of introducing a charge does not solve the problem, one could argue, that the consultants are choosing to invite more patients back to their clinics than they should be.

Hospital Director:
I think it has an influence and unless we try to see and measure it we probably cannot prove that, but I am certain it would have a behavioural impact on this.

The Deputy of St. Ouen:
But why, because the patient is being invited to the hospital. They have no choice. The issue of: "Because we are going to invite you we are now going to levy a charge and you cannot avoid it because you are being invited to this department and we are not going to and we cannot issue you with a G.P. prescription, we have got to issue you with a hospital prescription", you have a captured market.

Hospital Director:
We would rather the patient go back to the G.P. and get a free prescription.

The Deputy of St. Ouen:
So I come back to why have you not discussed with the consultants ...

Hospital Director:
We have.

The Deputy of St. Ouen:
... to reduce the amount of people being invited to the outpatients' clinic?

Chief Pharmacist:

I think the other thing to bear in mind is that often patients are coming back legitimately because they need to be seen in the hospital and they have been on a number of medicines before they were referred by their G.P. and they may well need to come back every 3 months to be seen by the consultant for valid reasons and the problem is that while they are doing that they are asking for the prescription, so they were getting it from their G.P. beforehand.

The Deputy of St. Peter:

We understand that. In Dr. Gibson's letter he says, and it is repeated again in the proposition by the Minister: "The scheme will remove the perverse financial incentive whereby patients request a prescription from the hospital clinic for medicines they would normally obtain from their G.P." Can you explain what you mean by "perverse financial incentive" and to whom is it perverse? Because essentially if the patient goes back to the G.P., yes, they receive a free prescription but that is at the cost of a fee for visiting their G.P.

Consultant, General Hospital:

At the moment if you go to your G.P. for your basic prescription it costs you some money but if you come to the hospital and you stay in the hospital system, then that becomes free. So that ideally just means making the same so that there is no incentive to stay in the hospital simply to obtain a prescription.

The Deputy of St. Peter:

The department has been very helpful and provided us with some information and broken down the amount of different kinds of levels of drugs that are prescribed and dispensed by the hospital pharmacy, and it says here that 69.7 per cent of items dispensed are green, so they are things you could almost get from any pharmacy. The cost of those prescriptions is 11.6 per cent of the total cost, so is that 11.6 per cent for the majority, almost 70 per cent of the items being dispensed, is that a perverse cost?

Hospital Director:

I am sure Paul could answer this better than I could but it is the volume, there is the volume that is put on to the hospital pharmacy that need not be for dispensing all of those. They are lower cost drugs, still more than £5 as an average, but it is the volumes, so we are being asked to prescribe simple medications that should be coming through the G.P. in high volumes, and that is part of that extra workload that was described.

The Deputy of St. Ouen:

I have to come back to the fact though that it is not the patient that is determining what is being prescribed, it is the consultant or the hospital doctor that is writing out the prescription. Surely if you feel that certain drugs should be obtained from the G.P. through the pharmacy then you simply give an instruction to the consultants: "These are the group of drugs that you will prescribe which only can be accessed at the hospital and for the remainder the patient needs to go to the G.P." because I presume that when a person comes to the Outpatient they not only are seeing a consultant but they continue to see and link with their G.P. in between time; is that not the case?

Consultant, General Hospital:

Not always. I think there are patients who avoid seeing their G.P. because they come regularly to the hospital, so they take the opportunity of skipping the bits in the middle because obviously they have to pay.

The Minister for Health and Social Services:

Correct me if I am wrong, Howard, but I would think some patients think: "I am going to see the consultant next week, I am running out of my medication so while I am sitting with my consultant, I usually get from my G.P., 'Would you write my prescriptions too because I am going to run out?" So there is very little choice in some ways.

Deputy J.A. Hilton:

For some patients who are presumably on a large amount of drugs the cost, if this was introduced, would be quite high for them, because it is £5 per item, is it not, on a prescription?

The Minister for Health and Social Services:

It is £5 but there is an easier way if people are on a lot of drugs. They can either get a 3-month prepayment or £100 for the year, and that brings the cost down quite significantly.

Deputy J.A. Hilton:

What was the thinking behind penalising those people buying a 3-month certificate and having to pay £30 for it when the yearly charge was £100, can you explain the thinking behind that?

Chief Pharmacist:

Yes, with the production and issuing of certificates there is a fixed cost for doing that, which is about £5, and then the monthly charge on top of that for each benefit is about £8 so that is why if you have £5 and then 3 months at £8, that is roughly £30, or £5 and then 12 months at £8 is roughly £100.

The Deputy of St. Peter:
Related to the administration costs?

Chief Pharmacist:
Absolutely, yes.

The Deputy of St. Peter:
Because if you understand the train of thought, for somebody who cannot quite afford £100 upfront it seems quite perverse to charge them a higher rate for a smaller amount because of their inability to pay the higher amount.

Chief Pharmacist:
I follow your argument but the way the figures were worked out was based on the fixed cost and the cost, and the £30 and the £100 are almost identical to the cost for the same prepayment certificates in England.

Deputy J.A. Hilton:
In your experience, Dr. Gibson, how many of your patients do you believe when they are attending prearranged appointments with you avoid going to the doctors because of the cost of the doctor?

Consultant, General Hospital:
I think there are some who do that. We try to encourage people to attend their G.P. because I think particularly with conditions that they have, it is important their G.P. is aware of where their condition is at the moment. Although we write letters that is not a substitute for patient contact. I do not think the numbers are enormous who do that, but I think there are definitely people who do and we try to keep the G.P. contact, but it is pretty obvious when you do that that they have not seen their G.P. for some time.

Deputy J.A. Hilton:
I think in an earlier question, when I asked which specialities were most effective, I think you said neurology, and this was to do with waiting lists, but I get the feeling this is more about older people. It was neurology and older people services. Do you think that there should be scope for free prescriptions for older people in our society over a certain age? Do you think that would help in some way?

Hospital Director:
We have that though. They can get them through their G.P.s, and that is where these people with long-term conditions should be being managed, so they are free through their G.P.s.

Deputy J.A. Hilton:

They are at the moment, yes.

The Deputy of St. Peter:

But there is a cost to visiting the G.P.

Hospital Director:

There is, but that is where these long-term conditions should be managed, whether it is a couple of times a year, but that is the best place for them to be managed with community services wrapped around that. They should only come to see the specialist when the specialist requires it.

The Deputy of St. Peter:

But take a condition like rheumatoid arthritis, for example, which is a condition that generally people go to the hospital for ongoing care and treatment, monitoring; are G.P.s able to prescribe the level of drugs that say somebody with that condition might require?

Hospital Director:

I think Paul would be able to answer this better, but there are some drugs that only the hospital can and should prescribe and some of the rheumatoid ones are some of those, are they not?

Chief Pharmacist:

Yes. I mean a lot of the older rheumatoid drugs G.P.s can prescribe, and have been for years and have been monitoring and following patients up accordingly. Some of the newer, more specialist drugs, which have been around a shorter period of time, are currently restricted to hospital consultant prescription only, however as their use becomes more widespread it is likely that G.P.s will be able to provide those drugs in the future. So I think at the minute because of the great steps forward that there have been in the management of rheumatoid disease in the last 5 to 10 years a lot of the drugs are still quite specialist and it is only the hospital clinicians that prescribe at the minute, but that could very much change going forward.

The Deputy of St. Ouen:

If the aim is to save money, why is the scheme costing £36,000 a year to run?

Chief Pharmacist:

As I understand it, the costs to run are, one, for getting an automatic payment machine into the Accident and Emergency Department so the nurses would not have to handle cash or collect money so that patients can go and either by credit card or cash buy a voucher for the costs of the prescriptions that are issued from the Emergency Department.

[11:30]

Then also because in the pharmacy we would be collecting additional charges and issuing prepayment certificates and for any patients who pitched up who said: “I am on income support but I have not got anything with me”, contacting Social Security clarifying that, there was a need for an additional resource there in order to not compromise our current waiting times in operations.

The Deputy of St. Ouen:
So you do not see the ability to reduce staff because more people are going to be getting their prescriptions from their G.P.?

Chief Pharmacist:
I think that is something that is absolutely possible. I think the unknown at the minute is how many patients would take up the option of a prepayment certificate and continue to come to the hospital pharmacy and how many would go to their G.P. So certainly if we achieve what we are hoping to achieve with more patients being managed by their G.P. then we can look ... if it reduces our workload, look at cost saving in that respect.

The Deputy of St. Ouen:
But the question is: one would have expected you to do that work before you said: “We need another member of staff in the Pharmacy Department.”

Hospital Director:
We cannot do that until we see the impact because we do not know whether patients will still come to the hospital and expect to get their drugs from the hospital, in which case they will not be able to reduce staff, or if they do go back to their G.P.s then, yes, we can. So we have to see what the impact is before we can take that step.

The Deputy of St. Ouen:
What is your aim then? Your aim is to generate an additional income.

Hospital Director:
No, our aim is to get people to go back to their G.P.s.

The Deputy of St. Ouen:
We have already said there are all sorts of different ways and you have informed us of the ways that you can do that in addition to levying a charge.

Hospital Director:
We need to do all of those things.

The Deputy of St. Ouen:
If your aim is to reduce the amount of work that your pharmacy undertake why are you planning at the outset to introduce an additional member of staff?

Chief Pharmacist:
The other benefit that has is, I mean, currently 40 per cent of our outpatients have to wait longer than 30 minutes because of the volume of work that we do, so if we were able to move work out then we would reduce our waiting times without the need for additional resources. So we really need to see what the impact is before we look to do anything regarding staff on this.

The Minister for Health and Social Services:
If we can reduce the number of staff then we will reduce the number of staff. I think that is important, but if we did put anything like that in you will be asking a different question of how much might it cost and why have you not put anything in about staff time. Our aim, if we can reduce the staff and not need this person, then we will do it.

The Deputy of St. Ouen:
Can I just ask one final question on the matter? How much income will be generated per annum when running costs are excluded?

The Minister for Health and Social Services:
£156,000?

Hospital Director:
It is an estimate because again it depends on the behaviour of the patients. Are they going to go to their G.P. and get a prescription, in which case we save the cost of dispensing the drugs, or are they still going to come to us and we get the £5 charge? So we have estimated £156,000 a year.

The Deputy of St. Ouen:
That is taking into account the running costs, the additional cost of staff, the £36,000?

Hospital Director:
Yes.

The Deputy of St. Peter:

Let us look at the exemptions. Essentially from what we have understood this morning, you have aimed the exemptions at those people who will have to continue attending the hospital for their treatment, is that right?

The Minister for Health and Social Services:

Ideally.

The Deputy of St. Peter:

We mentioned earlier rheumatoid arthritis and other conditions where a person could not receive the same prescription from a G.P. so therefore could not attend a G.P. to receive their ongoing care, although they will face a charge at the pharmacy and the hospital. Why is it that it is only cancer treatments and those prescribed for public health reasons, such as tuberculosis, who will receive an exemption? Why not, say, rheumatoid arthritis or diabetes?

The Minister for Health and Social Services:

I think it is fair to say that we have changed the exemptions to what they were before, and there is a list of slightly different ... those children under 16 will be exempt and vulnerable groups like psychiatric patients, and also patients who need cancer medicine. We thought those were the right ones at this time.

The Deputy of St. Peter:

We have ascertained that there are some groups who have long-term conditions who require that prescription from a hospital consultant so why are they not included in the exemptions?

The Minister for Health and Social Services:

We looked at this issue and we came up with this because we felt this was the right bit at this time.

The Deputy of St. Ouen:

Your mind is made up that you are going to limit the exemptions to those that are described in the report accompanying the proposition, P.72?

The Minister for Health and Social Services:

At this moment in time.

The Deputy of St. Ouen:

So if I were to say those who are suffering with diabetes will not be exempt?

The Minister for Health and Social Services:
As it stands at this moment in time, yes.

Hospital Director:
And they were not previously.

The Deputy of St. Ouen:
The reason for that would be?

The Minister for Health and Social Services:
As I said, we decided that at this time this was right ... looking at individuals rather than diseases.

The Deputy of St. Ouen:
Sorry, I am struggling to understand that because you are wanting obviously in the department to minimise the ongoing health costs of individuals with long-term illnesses, which presumably include diabetes, so why would you not offer them the similar support to those who have cancer for argument's sake?

Chief Pharmacist:
I think it is not going to be cancer patients who are going to be exempt, it is going to be the treatment for cancer, so if they are on drugs for their high blood pressure they would still be liable for a charge for those. When coming up with a range of exemptions we did liaise quite closely with Social Security mindful of what could or may or may not happen in the future, so we were very much guided on the income exemptions by Social Security. Previously when charges existed there were very few exemptions at all, and people on H.I.E. (Health Insurance Exemption) never paid diabetics long-term care so I think the thinking was these were a reasonable place to start with our list of exemptions and that if and when a decision is made about charging in the community to have a joined-up approach we would bring them all into line with whatever exemptions were listed at that time.

The Deputy of St. Ouen:
I just need to pick up on something you said. You have just spoken about exemptions, and there is an exemption certificate. Are you saying that that will not cover all medication that that particular individual will need?

Chief Pharmacist:
No, the prepayment certificate, which you purchase for £100 will cover all medicines that individual needs. So that is the protection for people on long-term conditions, such as diabetes, rheumatoid

arthritis. That effectively can cap their charge at less than £2 a week. So the way we sought to protect people with long-term conditions from excessive charges and indeed those people on lots of medicines from excessive charges is to offer a prepayment certificate?

The Deputy of St. Ouen:

When you are talking about a patient that obviously is receiving cancer treatment, but equally has other medical problems, are you saying that that individual will only be exempt from paying for the drugs that are limited to the cancer treatment?

Chief Pharmacist:

That is the proposal as it stands at the minute, and they will have the option if they are getting other medicines from the hospital rather than their G.P., to purchase a prepayment certificate to mitigate those costs.

The Deputy of St. Ouen:

Minister, can I come to you just to explain, you include those prescribed for public health reasons and you give the example of treatment of tuberculosis. Can you just elaborate on public health reasons because we know that you have focused on encouraging and being more proactive in helping people deal with diabetes at an early stage, they do not have the secondary illness, can you just explain what would fall into that category of public health reasons?

The Minister for Health and Social Services:

One of the examples is tuberculosis because of where it is in the community and they usually are very vulnerable people, so we felt that was important, and that exemption was there before anyhow, whether they were on H.I.E. or not.

The Deputy of St. Ouen:

What other treatments would fall in, apart from T.B. (tuberculosis)?

Hospital Director:

Where we say “public health” it is wherever you need medication treatment to prevent the spread of illness between individuals. So anything infectious that we need to treat we believe should be exempt so that we are protecting the rest of the population.

The Deputy of St. Peter:

What consultation have you conducted prior to lodging this proposition?

The Minister for Health and Social Services:

There was some limited consultation and it is fair that perhaps we could have done a little bit more, but I think we were keen to understand if the States approved it then there was going to be quite a bit of consultation and understanding of how it would work.

The Deputy of St. Peter:

You have not conducted meetings with G.P.s and ...

The Minister for Health and Social Services:

This was discussed at C.M.E.X. (Corporate Management Executive), which is the managing directors of the hospital, of which there was a representative from the G.P.s there as well.

The Deputy of St. Ouen:

At what stage in their treatment will patients be able to purchase a prepayment certificate, which effectively allows them to cut the prescription charges liability?

Chief Pharmacist:

At any stage.

The Deputy of St. Ouen:

How does a patient know? You say “at any stage”.

Chief Pharmacist:

If we go ahead with this, prior to the prescription charges there will be publicity in the hospital to say that you can do this and we will in fact be issuing them in advance to anybody of the charges coming in, so that they are not being immediately charged.

The Deputy of St. Ouen:

Maybe I will come to the consultant. The reality is that a patient is referred to you by the G.P. in the first instance in the Outpatients Clinic for a particular problem. Can you just explain the sort of process that will happen and when the patient realises that they have a long-term problem?

Consultant, General Hospital:

Obviously we will take the story, get the impact of the condition on the person that is examined, and produce any tests and form a treatment plan with a diagnosis, so the key thing is to get the diagnosis. When they have a diagnosis you can then explain whether this is an acute thing that is really just a one-off and 2 weeks’ later they are going to be fine. If it is going to last 2 or 3 months, in which case, again, they are not likely to take long-term medication. Say we diagnose somebody

with some illness where you will go: “This is a lifelong treatment. You are going to need to take this treatment long term to prevent recurrence of your symptoms” in which case they will then know that they are on a long-term drug, not necessarily the same one, but they are likely to require a treatment long term going forward. There are quite a lot of people who will say: “You are likely to need to take medication for the rest of your life because this has happened to you.” It is either that it is needed to control symptoms or to prevent recurrence of the disease. A lot of the cardiac patients, for instance, are on protective medications to reduce their risk of a further heart attack or heart failure. The heart failure patients’ main treatment is simply to prevent recurrence of their symptoms, to improve their breathing or their exercise tolerance.

The Deputy of St. Ouen:

In general, what would be the sort of time between a patient first arriving at the Outpatients Clinic and likely to be prescribed medication and knowing what their diagnosis is and whether or not they have a long-term problem or a short-term issue?

Consultant, General Hospital:

A significant number of patients will get a diagnosis when they are first seen in the clinic. We will say: “This is what it is, this is what we need to do about it.”

The Deputy of St. Peter:

But you just suggested that as that patient’s care continues they sometimes need to change to a different drug if one is not suiting them, sometimes they start off on a cheaper drug and they move up to the next level if the symptoms are changing; who is equipped and able to make that decision? Would a G.P. be able to?

Consultant, General Hospital:

The G.P.s will do it quite a lot. So a lot of G.P.s, you will start the medication and G.P.s will adjust the dose and then there are hospital only medications which are initiated by a consultant, continued by G.P.s, so they will adjust the doses according to a clinical response. There are obviously those patients who have progressive conditions where you know that a year later they are not going to be as good as they are now, probably, and they are likely to need even more medication as time goes on. Now those are the ones I think where they tend to remain under review in the hospital quite a lot because often they ... firstly they often need a multi-disciplinary approach which is easier at the moment in the hospital, but that is obviously one of those things that is going out into communities so would be another issue, but frequent dose adjustments and frequent changes in medication. Once the patient however is stable they may well stay on those drugs for quite some time in the doses that they are, followed up by their G.P. with some adjustments. If the G.P. feels perhaps this is slipping a little and the patient is not as good or have

made some changes but the changes made are not holding this end, then they will ask for a further review at the hospital to make some recommendations, then they go back out into the community.

[11:45]

That will be the aim, I think, with long-term conditions; that they are largely managed by their G.P. with advice in as required by the hospital. There are just the occasions where we are using drugs exclusively available in the hospital, and those patients obviously are not discharged because as we are prescribing them we are obliged to review them.

The Deputy of St. Peter:
What percentage of your patients would you consider to be in a stable situation?

Consultant, General Hospital:
There is a very high proportion of patients becoming stable eventually. So the patients who come into the hospital, there will be a period where you are adjusting medication and then we will try to discharge them. There will be then those conditions in certainly neurology where you are dealing with progressive neurological conditions where over time they will get worse and they will need different treatments, many of which ... I mean some of the preventative treatments are hospital only, certainly for Multiple Sclerosis, are only administered by the hospital. To come back to what Paul was describing about patients being given additional medication, I think it is important that if you have a condition that requires you to have hospital only medication but you also have high blood pressure, it is important that that high blood pressure is managed by your general practitioner in the community and not by a neurologist, or whoever else may see them in the hospital, because they are then taking the whole of that patient rather than just this ... I mean obviously as specialists we tend to focus on the condition. We try to take it holistically and certainly in a lot of disabling conditions you have to do that, but some of those other things, it is very important, all the other things get monitored as well, otherwise another condition comes in underneath and nobody is looking after it, and I think the G.P. ... one of the great strengths I think of medicine in that area, particularly in the Channel Islands, is that general practice are the centre point with the patient, and then they access services, and that is guided by the G.P.s. I think that really needs to be strengthened and this, I thought, may do that.

The Deputy of St. Ouen:
Is it likely that the consultants will be advising patients at what point they should be considering purchasing a prepayment certificate?

Consultant, General Hospital:

It has not been my plan to advise a patient whether to purchase a certificate or not. I can advise them that there is a certificate available, but I certainly would not make a recommendation to them.

Hospital Director:

What the consultants will do though, at the point of writing the prescription, is advise the patient how long that medication is likely to be needed for. So is it a one-off, 2 weeks, 6-week course, or is it lifelong. So I think that is a really important message for the patient, so they can take that decision themselves. So the consultant will have that conversation with the patient at the point of writing the prescription.

The Deputy of St. Ouen:

I am just trying to understand how the patient is supposed to judge whether or not they would be better off to purchase a prepayment schedule or continue to pay the fixed charge that you are going to levy.

Hospital Director:

If you are on 2 or more medications all the time then it will be cheaper to have a prepayment.

The Deputy of St. Ouen:

For existing patients I can understand, I am just thinking of the new patient that is going to walk in after being referred to by the G.P. to the consultant. How are they supposed to plan and manage this additional charge?

Hospital Director:

Pharmacy will help them with that when they go down to the pharmacy to get the prescription filled. They will be able to advise them.

Chief Pharmacist:

I think the key there is whenever doctors write a prescription for a patient they would explain to the patient why they are on it, what the anticipated length of treatment is going to be, and that is the information that the patient will need in order to judge whether a prepayment certificate would be of benefit to them. So I think it is important, as in all prescribing decisions, that patients are involved and understand what is being prescribed and how long they can anticipate being on that treatment. It is that information which will help them make the decision as to whether a prepayment certificate will be an option for them.

The Deputy of St. Peter:

It says in the proposition that you will introduce a process which enables individuals or groups of patients to be considered for exemption based on clinical need or specific individual circumstances. Who will be on that board or panel?

Chief Pharmacist:

I would anticipate we would have a Drugs and Therapeutics Committee within the hospital which looks at seeing which drugs we use and things like that, and I would imagine that committee, which has got pharmacists and consultants and nurses on it, would be the committee that would make decisions particularly about groups or further exemptions.

The Deputy of St. Peter:

How quickly will they be able to make decisions?

Chief Pharmacist:

If needed, very quickly. It does not necessarily need to be a physical meeting to make a decision if the information is available to email round to all members. So I think it is important that it is responsive. Within the pharmacy we would have the option to evade the charge initially while the decision is being made anyway. So I think the important thing is that we know there is consideration being given to a particular case or particular group of patients that we do not necessarily charge until that decision is made.

The Minister for Health and Social Services:

I think it is very important that it is a clinical decision.

The Deputy of St. Ouen:

I would just like to ask the Minister, have you consulted the G.P.s before bringing this proposition to the States?

The Minister for Health and Social Services:

As I said before, we could have done more consultation but when it was discussed at C.M.E.X., there are 2 representatives of the G.P.s from the primary care body on C.M.E.X. when they discussed this.

The Deputy of St. Ouen:

Are you suggesting that you have not officially spoken to the primary care body?

The Minister for Health and Social Services:

There are 2 representatives from the primary care body on C.M.E.X. when this was discussed, and it was discussed with them. They are representatives of the primary care body.

The Deputy of St. Ouen:

So they have confirmed that the primary care body supports the re-introduction of hospital prescription charges?

The Minister for Health and Social Services:

I am not quite saying that. There were representatives of the ...

The Deputy of St. Ouen:

What were they saying?

The Minister for Health and Social Services:

I was not at C.M.E.X. so I cannot tell you what they said. They were part of the discussion at that time.

The Deputy of St. Ouen:

But you say they were supportive of your proposal, you just said that.

The Minister for Health and Social Services:

No, I did not quite ... no, they were part of the discussion that the C.M.E.X. had at that time.

Hospital Director:

They are fully aware that this is where it is in the process and they have not put forward an objection at all.

The Deputy of St. Ouen:

But they have been asked?

Hospital Director:

They have been asked through their representative, through the formal meetings that we have. That is where it gets discussed. There has not been an objection put forward.

The Deputy of St. Ouen:

Are you saying with some confidence that if we contacted the primary care body and asked them whether they support this particular new introduction of charges that they would say: “Yes”?

Hospital Director:

I think we can say with confidence that their representative has said that but whether they can represent all 80, 90 of them ...

The Minister for Health and Social Services:

101, I think now.

The Deputy of St. Ouen:

Moving on, have you consulted with the public, charities and other stakeholders about this proposal?

The Minister for Health and Social Services:

As I said, I think we could have done better with consultation. I have been down to Good Companions, I have been down there this week, to discuss this with them. I think it is fair to say that they assumed it was all prescription charges and so when I explained to them it was just hospital ones, obviously they were quite relieved and the feedback I had from them was: "Well, yes, I suppose if I have a hospital one, okay, it might cost me."

The Deputy of St. Ouen:

I am pleased you have gone and spoken to the Good Companions, but what about Diabetes Jersey, for argument's sake? Have you discussed with, what I recall, the charitable organisations that represent long-term diseases and medical problems?

The Minister for Health and Social Services:

No, I have not personally.

Hospital Director:

We had correspondence with the lead clinician for diabetes who links obviously very closely with the charity and they asked if they were going to be exempt and we said: "No" because they were not previously and it is a long-term condition, but it is still all free from their G.P. and they were satisfied with that response.

The Deputy of St. Ouen:

But what about other major charitable groups that represent people with long-term ...?

The Minister for Health and Social Services:

No, I have not personally.

The Deputy of St. Ouen:

Do you not accept that that might be a good idea?

The Minister for Health and Social Services:

I think if and when the States do approve this then it is important that the correct message does go out where it is with the exemptions and how to access it and to get the prepayment certificate, and that is important to give that correct information at the right time.

The Deputy of St. Ouen:

I think it is a bit perverse, using your words perhaps, that you can ask the States to approve the introduction of charges when you have not spoken to the people that are going to feel the impact of it.

The Minister for Health and Social Services:

That is one way of looking at it, but it also can be turned around the other way, as to say, why get everyone very anxious when it is not going to be approved in the first place. I think it is important that we get the correct messages out, that it is providing that care back into the community where the G.P. is, as Dr. Gibson said, the centre of the care with that patient.

The Deputy of St. Peter:

While we are talking about communication, I am quite interested in just going back over that relationship between the consultant, the G.P. and managing long-term cases. What checks and balances will be in place? so if a patient is discharged out to the community to see their G.P. to manage their ongoing long-term condition, what would be the checks and balances to ensure that that happens?

The Minister for Health and Social Services:

You mean with the G.P.s?

The Deputy of St. Peter:

Yes. How will that relationship be managed?

Consultant, General Hospital:

Each time the patient comes to the clinic a letter goes to the G.P. with recommendations for ongoing management or what medications are likely to be required. I mean I usually put something like: “As they are stable I am not really seeing them again routinely, but happy to do so should things change or if you have any concerns” so there is that offer that: “If you feel it is not going well please let me know and I will see them back in” and we go to a slightly new pathway

then because normally they would ... rather than go back into the wait they would come in through the side effectively because they are already a patient we are familiar with. So they get a sort of pseudo follow-up appointment as a result.

The Deputy of St. Peter:

What I am trying to make sure is that if that person does not appear at the G.P. over a certain period of time how will anybody know?

Hospital Director:

That is difficult because we cannot make patients do things. The primary carer for a patient should be the G.P., not the hospital consultant. The hospital consultant should be there for advice and specialist advice and treatment. If the consultant believes that the patient needs following up on a regular basis, so a surveillance-type approach, then they will arrange that, so the patient will come back once a year or whatever is appropriate. But at the end of the day it is the G.P. who is responsible for that patient, and if they have received a letter saying: "We have asked your patient to come in and see you" and they do not, the G.P. should follow it up because they are the responsible practitioner.

Consultant, General Hospital:

And if they do not, then certainly the other way round if they do not turn up at the hospital for a condition which needs monitoring then we will generate a letter back to the G.P. saying: "Your patient ought to attend the clinic, it is important that they have the following" so that they do not drop in the middle of the 2. That is important.

The Deputy of St. Peter:

Thank you.

The Deputy of St. Ouen:

A couple of questions. I want to just pick up on this automatic machine in Accident and Emergency. Can you just explain to me how will charging for medication issued in the Accident and Emergency Department work in practice?

Chief Pharmacist:

Obviously patients who come into A. and E. quite often will need prescriptions for antibiotics, painkillers and what have you, and if we were to introduce charges, because they are effectively outpatient prescriptions they will be charged just as they are in England. So it would be unreasonable to expect nurses and medical staff to be handling cash, particularly in the middle of the night. So the proposal is, and it is something that is widely used throughout the U.K., is to

have a kiosk, similar to a car park-type payment machine where you would go in, you would put your cash or your card in, and you would get a voucher which you would exchange for your prescriptions when you leave.

The Deputy of St. Ouen:

That sounds great, but I mean generally people arrive at Accident and Emergency because they have had an accident or it is an emergency and they are hardly likely to have their wallet in their pocket. I just want to understand what is going to happen in those sorts of cases?

Chief Pharmacist:

Patients obviously who are seriously ill may be admitted to hospital and there will not be any charges. It is those that are able to leave A. and E. and quite often the medicines they need may not needed to be started immediately. They could be given a prescription to come back to the hospital pharmacy the following day or they could be given a medicine in the Emergency Department to tide them over until they can come back with a prescription the next day, or indeed ...

The Minister for Health and Social Services:

Or go to their G.P.

Chief Pharmacist:

Or if it is during normal hours it is cheaper to go and buy something from the chemist down the road. They can be given the option to do that. I think the important thing would be that I do not think we would ever withhold medicines that is needed just because they did not have the ability to pay. I think it is important that ...

The Minister for Health and Social Services:

That message comes across.

The Deputy of St. Ouen:

I think for everybody's peace of mind it would be useful to see a copy of the policy that is going to be adopted in the Accident and Emergency Department with regards to charging for medication because on reading this, I mean, if I come in with a broken leg one would expect at the very least to have some pain medication.

[12:00]

That is medication and if you are then going to turn around say: “By the way before you go we wanted you to pay for it. Go to that machine and purchase your voucher” it is ridiculous.

Chief Pharmacist:

Perhaps if I can just clarify that. It would not be for any medicines that are administered within the Accident and Emergency Department. It would be only if you are fit and well enough to leave but need some antibiotics to take home with you, so any medicines that are administered within the Accident and Emergency Department there will be no charge for whatsoever.

Deputy J.A. Hilton:

Just a point of clarification: I think I understood from a previous answer that currently the consultants have their own prescription pads and they do not have the prescription pad that is issued by the Social Security Department, which would enable people, for instance, going into an A. and E. if they did have them to get the drugs elsewhere; that is correct?

Chief Pharmacist:

That is correct. If hospital clinicians had access to a Health Insurance prescription pad they could issue those prescriptions, which a patient could take to their local pharmacy close to their home and get their medicine dispensed.

Deputy J.A. Hilton:

To change that would require a change to the law to enable the hospital to be able to do that?

Chief Pharmacist:

Yes.

The Minister for Health and Social Services:

But then saying that, part of this is the potential for people going back to be cared for by their G.P.s so it is a fine balance that.

The Deputy of St. Peter:

Thank you. I think I just heard the town church strike 12.00 so we will draw the meeting to a close and we thank you very much for attending.

[12:01]