Rethinking primary care user fees:

is charging a fee for appointments a solution to NHS underfunding?

Could a fee for primary care appointments alleviate health services funding pressures and primary care workload? This editorial examines the lessons learnt in other high-income countries regarding intended and unintended consequences of primary care user charges.

Debates over user fees in the NHS are not new. In 1951, Hugh Gaitskell, then Minister of Treasury, introduced charges for prescriptions, spectacles, and dentures in the NHS. Aneurin Bevan, Minister for Labour and architect of the NHS, resigned in protest at this abandonment of the principle of care free at the point of need.

Sixty-seven years later, on the 70th anniversary of the NHS, the debate on user fees is timelier than ever. In 2016, the NHS in England saw the largest aggregate deficit in its history, at £1.85 billion, with a projected £30 billion funding gap by 2020. Capital spending is projected to be reduced by 9% in real terms from 2015–2016 to 2020–2021¹ and is projected to fall to 6.8% of GDP by 2020,² putting the UK in the lowest quartile among Organisation for Economic Co-operation and Development (OECD) countries. Demand for NHS primary care continues to increase, and GPs in England are now busier than 10 years ago. The growing mismatch between supply and demand raises concerns whether the historical concept of a free cradle-to-grave NHS is still achievable. The additional £20 billion indicated by the prime minister in June is a critical aid, yet sustainable solutions are needed to ensure the NHS balances supply and demand in the long term.

One proposed solution is introduction of user fees for primary care services. Many highly developed countries charge users to access primary care, commonly through a flat-rate co-payment. The Reform think-tank has suggested a £10 fee for primary care appointments, which could raise £1.2 billion annually. Other options include a £10-monthly NHS 'membership fee', worth over £2 billion a year, a daily 'hotel' charge for overnight hospital stays, worth £193 million, and changes in prescription charges, worth £1.9 billion.³

However, the Barker Commission on the Future of Health and Social Care in England has acknowledged a 'frustrating' lack of evidence on such fees, and it has been

suggested that charges and co-payments in the NHS might be '*... a dog's dinner lacking any basis in fairness or logic and stuffed with anomalies and inconsistencies*'.⁴ The largest study on their impact in a high-income country — the RAND Health Insurance Experiment — is now nearly 40 years old.

DO USER FEES REDUCE 'UNNECESSARY' PRIMARY CARE UTILISATION AND WORKLOAD?

User fees theoretically encourage patients to act prudently and so reduce 'unnecessary' use. Indeed, European countries with user fees for primary care access have seen lower healthcare utilisation. However, this is based on the assumption that patients can safely and effectively distinguish between necessary and unnecessary care; in reality, preventive care and chronic disease management are both likely to decline, with patients delaying presentation until costly crises occur. Expectations in the UK NHS are already high, and user fees may further increase expectation of a return on investment. Doctors may feel pressure to provide prescriptions and referrals, or carry out investigations, to satisfy patients who have paid to see them.⁵ Finally, user fees may result in hoarding of health problems, with expectation of clinicians to address more within existing 10-minute appointments.

IMPACT OF USER FEES ON HEALTH INEQUALITIES AND UNIVERSAL ACCESS

Flat-rate user fees might introduce a financial barrier to accessing health care for low-income groups. Following implementation of primary care user fees in Ireland, people on low and middle income were five times more likely to forgo a primary care appointment than wealthier patients.⁶ The highest users of primary care, women seeking maternal care, and those aged <5 or >85 years, are also those who would likely be exempt from fees. If those with low income are exempted from fees, we may see little reduction in GP workload, and only modest revenues. Wealthier patients, when asked to pay for NHS GP appointments, may opt for private primary care, further increasing health inequalities and leading to the fragmentation of care. Consequent expansion in private primary care services

may also increase shortages of NHS GPs, exacerbating workload problems.

DO USER FEES PROCURE NET ECONOMIC BENEFIT?

Collection of user fees would necessitate a new billing and debt collection system across all NHS general practices. Exemptions necessary to safeguard vulnerable populations reduce revenue and further add to administrative costs, and the highest users of primary care are also those who would likely be exempt from fees. After exemptions, fees would be collected from a relatively small population, for example, around 90% of prescriptions in England are dispensed free of charge (Box 1)⁷ and revenues from prescriptions cover only 5% of actual cost. In Germany, a €10 fee in primary care was revoked in 2012.⁸

User fees may also introduce a false

Box 1. Current user fees in England⁷

NHS prescription costs

Prescriptions: £8.80 (as from April 2018).

Exemptions and discounts are available for the following:

- Aged <16, or 16–18 years and in full-time education, and ≥60 years
- People with specific long-term conditions or a continuing physical disability
- Pregnant or have had a baby in the previous 12 months
- Income support beneficiaries
- People with war pension exemption certificate
- NHS inpatients

Dental treatment: £20.60–£244.30

Exemptions and discounts available for:

- Aged <18, or <19 years and in full-time education
- Pregnant or have had a baby within the 12 months before treatment starts
- Staying in an NHS hospital and the hospital dentist carries out your treatment
- NHS Hospital Dental Service outpatients
- Income support beneficiaries

Optical services

Costs of sight tests and spectacles are at the user expense. NHS-funded sight tests and optical vouchers are available for:

- Children (including <19 and in full-time education)
- Aged ≥60 years
- People on low incomes
- Individuals with complex sight problems
- Diagnosed with diabetes or glaucoma, or aged ≥40 years and have a close relative with a history of glaucoma

economy if they deter people from accessing primary care when they should, resulting in costly delayed diagnoses, or lead them to seek care for acute problems only, deprioritising important preventive and chronic care. User fees may represent a false economy if they simply divert costs to other parts of the system. In the US, user fees have led to 'offsetting' of costs, with increased hospitalisations⁹ and use of acute mental health services; patients may choose to use services that are 'free' to the user but expensive to the system, such as community mental health¹⁰ and emergency care.¹¹ A coherent policy would therefore require simultaneous setting of fees in related areas of the system, charging a fee for attending A&E, for example, and charging differential fees between primary and secondary care.¹²

OPTIONS FOR THE NHS

UK residents benefit from a high level of financial protection from the costs of illness. Accustomed to free primary care for many decades, the public is likely to resist such fees strongly; only 15% of a sample of the English population supported a £10 fee to see a GP.¹³ Attempts to introduce similar fees in Hungary were met with such public resistance that they were scrapped.¹⁴

There may be alternatives to user fees with less potentially detrimental impact, such as revision of current exemptions, or charges for missed primary care and hospital appointments. Taxation in the UK is significantly lower than the OECD average and could be increased, as could spending on health.

Rather than levying mandatory user fees and exempting most of the population, the NHS could consider alternative models, such as offering an affordable, voluntary insurance entitling patients to extended services, while standard services remain accessible to most people. Incentivising healthier lifestyles could also be considered, in parallel to 'sin taxes' on undesired behaviours such as smoking or sugar and alcohol consumption.

A TEST OF VALUES

Valid arguments exist for and against primary care user fees. User fees are promoted as a remedy to current NHS challenges. However, primary care workload and NHS deficits are symptoms of deeper problems, such as reactive and fragmented care, and user fees implemented as a 'quick fix' may worsen current problems. Examples of costly failed

introductions in some European countries should make for considerable pause for thought, with serious consideration of other options and careful evaluation of existing evidence before any decision to levy such fees.

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Funding

This article presents independent research supported by the National Institute for Health Research (NIHR) under the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) programme for North West London. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the NIHR, or the Department of Health. The funder has no role in shaping or drafting the manuscript.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Acknowledgements

We wish to thank Mr Maurice Hoffman, an experienced lay adviser to the NHS and an Expert Patient with a rich understanding of the NHS, for his invaluable input to the shaping of the manuscript.

DOI: <https://doi.org/10.3399/bjgp19X703793>

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REFERENCES

1. King's Fund. *The autumn statement: NHS funding*. 2014. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/autumn-statement-briefing-2014.pdf [accessed 6 May 2019].
2. Parliament UK. *Impact of the Spending Review on health and social care*. 2016. https://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/139/13904.htm#_idTextAnchor012 [accessed 6 May 2019].
3. Cawston T, Corrie C. *Reform ideas no 9. The cost of our health: the role of charging in healthcare*. Reform, 2013.
4. Social Market Foundation Health Commission. *A fairer prescription for NHS charges. Report 1*. 2003. <http://www.smf.co.uk/wp-content/uploads/2003/06/Publication-A-Fairer-Prescription-for-NHS-Charges.pdf> [accessed 6 May 2019].
5. Jones D, Loader N. Should patients pay to see the GP? *BMJ* 2016; **352**: h6800.
6. O'Reilly D, O'Dowd T, Galway KJ, *et al*. Consultation charges in Ireland deter a large proportion of patients from seeing the GP: Results of a cross-sectional survey. *Eur J Gen Pract* 2007; **13**(4): 231–236.
7. NHS. When do I have to pay for NHS treatment? 2018. <http://www.nhs.uk/cha/Pages/888.aspx?CategoryID=68&> [accessed 6 May 2019].
8. Busse R, Blumel M. Germany: health system review. *Health Syst Transit* 2014; **16**(2): 1–296, xxi.
9. Chandra A, Gruber J, McKnight R. Patient cost-sharing and hospitalization offsets in the elderly. *Am Econ Rev* 2010; **100**: 193–213.
10. Soumerai SB, McLaughlin TJ, Ross-Degnan D, *et al*. Effects of a limiting Medicaid drug-reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia. *N Engl J Med* 1994; **331**: 650–655.
11. Hsu J, Price M, Huang J, *et al*. Unintended consequences of caps on Medicare drug benefits. *N Engl J Med* 2006; **354**: 2349–2359.
12. Hone T, Lee JT, Majeed A, *et al*. Does charging different user fees for primary and secondary care affect first-contacts with primary healthcare? A systematic review. *Health Policy Plan* 2017; **32**(5): 723–731.
13. Gershlick B, Charlesworth A, Taylor E. *Public attitudes to the NHS. An analysis of responses to questions in the British Social Attitudes Survey*. 2015. <https://www.health.org.uk/sites/default/files/PublicAttitudesToTheNHS.pdf> [accessed 6 May 2019].
14. Gaal P, Szigeti S, Csere M, *et al*. Hungary health system review. *Health Syst Transit* 2011; **13**(5): 1–266.