Optical Confederation and Local Optical Committee Support Unit (LOCSU) response to the Department of Health's Consultation: the extension of charging overseas visitors and migrants using the NHS in England

QUESTION 1: We propose to apply the secondary care charging exemptions to primary medical care and emergency care.

Do you agree? Disagree.

While we support the general principle behind the changes proposed in this consultation document, we have serious reservations about the practical implications of implementation, i.e. having to determine the status of a patient before being able to treat them.

The primary concern of any clinician must be the best interests of the patient. Establishing entitlement to treatment in a primary care or emergency setting must be secondary.

QUESTION 7: We propose reclaiming the balance of cost of drugs and appliances provided to EEA residents who hold an EHIC (or PRC) (over and above the prescription charge paid by the patient) from the EEA country that issued the EHIC/PRC.

Do you agree? Disagree.

We disagree in so far as this proposal applies to optics.

The consultation is clear that those in receipt of an EHIC (or PRC) will continue to be entitled to a GOS sight test and optical vouchers, if they meet the normal qualification requirements. Paragraph 17.1 of the consultation paper makes clear that it is not proposed to collect the charge for GOS sight tests from EEA countries because of the presumed low volumes of patients and therefore a low cost/benefit ratio.

On that basis the cost/benefit ratio of collecting the costs of optical vouchers or prescribed drugs from the even smaller volume of optical patients who hold an EHIC

and are in receipt of an optical voucher will be even lower and is clearly an anomaly that needs correcting.

Furthermore, we note that the Impact Assessment indicates that extending charging for prescriptions to pharmacy will be contingent on identification of EHIC holders via GP IT systems. This would not be possible in optical practices: not all optical practices have IT systems, and in most cases those that do have no connectivity with GP or wider NHS systems. Although some patients are referred via the GP, the majority are not. Even those that are referred are not necessarily referred in writing and hence identification details will not necessarily be provided.

QUESTION 8: We propose removing prescription exemptions for non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge-exempt categories identified in section three.

Do you agree? Agree

QUESTION 9: Do you have any comments on implementation of the NHS prescription proposals?

Yes

Our comments on the implementation of NHS prescription proposals relate to the inclusion of prescribed appliances.

It is unclear whether holders of EHICs who are eligible for GOS optical vouchers to cover the costs of prescribed spectacles or contact lenses are expected to be identified at optical practices and, once identified, resulting costs claimed back from the relevant EEA country. The impact assessment for eye care (pg 19/20) makes no mention of this as a proposal, however the consultation document states that *'our proposals for NHS prescriptions are to: reclaims the balance of cost of drugs and* appliances *provided to EEA residents with EHICs (over and above the prescription charge paid by the patent) from their home country'.*

Spectacles and contact lenses are prescribed appliances. We believe that these appliances should be excluded from the proposal. As previously stated the lack of GP or wider NHS connectivity means the implementation costs of including prescribed optical appliances would be considerable and not worth the resultant cost and time for the low volume of patients who hold an EHIC card and are entitled to GOS optical vouchers for optical prescriptions.

Primary NHS Ophthalmic Services (Eye Care)

QUESTION 13: We propose removing eligibility for an NHS sight test and optical voucher from non-EEA residents to whom surcharge arrangements do

not apply and who are not in one of the charge-exempt categories identified in section three.

Do you agree? Strongly disagree.

We welcome the fact that, unlike other parts of primary care, the consultation paper only proposes that GOS sight tests and vouchers will continue to be available to everyone who meets the usual criteria, except non-EEA nationals who do not pay the health surcharge (paid by most non-EEA nationals upon applying for long stay visas), and provided that the person is not an asylum seeker or a member included in one of the other categories listed in section 3 of the consultation.

Nevertheless we believe that even these changes should not be introduced because they will be almost impossible to implement and, as the cost benefit analysis demonstrates, in optics this change will have a significant cost with no financial gains in the foreseeable future. We have detailed our concerns at greater length in the response to question 14.

QUESTION 14: Do you have any comments on implementation of the primary NHS ophthalmic services proposals?

Yes.

It is unrealistic to expect an optical practice to be able to make decisions about eligibility based on the criteria set. We note that the consultation document states that NHS England will work with providers to establish the best way for opticians to know whether someone is a non-EEA visitor, who has not paid the surcharge and is not included in the list of exemptions. This is to be welcomed.

However until that work has been undertaken, it cannot be assumed that it will be possible, nor indeed can the costs (financial and time) of implementing this change be properly taken into account. It is worth noting that close on 13 million GOS sight tests are delivered in England each year, each one of which would need to be screened to determine entitlement. We would also draw attention to the fact that the consultation appears to assume that primary care providers will be able to use IT systems to determine a patient's status and entitlement. As already mentioned, not all optical practices use IT systems, and those that do would not have the connectivity to government systems to be able to undertake such checks.

We are therefore strongly of the view that it would be unwise to attempt to introduce this change until NHS England has worked through with the optical sector representative bodies whether and if so how these checks could be managed.

However, even if NHS England can work with us to develop appropriate guidance, we still fail to see the merit in introducing this change since the Impact Assessment clearly demonstrates that the costs of this change in optics will be high for a very low return – the consultation estimates that the cost of providing these services is only

£200,000 per annum. Unlike other parts of primary and secondary care, the Impact Assessment also demonstrates that for optics this will be an ongoing cost, with no financial benefits in either the short or long term. In short, the proposal would cost £32.7m over five years. The forecast savings for the whole of primary care over five years are £33.1m. So if optical services were removed from the charging proposals, the net benefit would double to £65.7m. It would seem perverse to introduce a change that adds bureaucracy, brings no benefits and incurs such significant costs.

In order to screen for chargeable non-EEA patients, optical practices will be expected to screen all potential NHS patients. This screening process is expected to take 1 – 2 minutes per patient (according to the Impact analysis). With 12,764,485 NHS Sight tests conducted in England between April 2014 and March 2015 asking these questions would cost optical practices a considerable amount of additional time, meaning additional cost. Further, once a non-EEA patient is identified it is envisaged to take an additional 5 minutes per non EEA patient to apply the correct charging process.

QUESTION 26: Our proposal for non-NHS providers and out-of-hospital care is to standardise the rules so that NHS funded care is chargeable to non-exempt overseas wherever, and by whomever, it is provided.

Do you agree? Disagree

QUESTION 27: Are there any non-NHS providers that should be exempt from a requirement to apply the Charging Regulations?

Yes

Optical practices that provide community services.

Although we support the general principle that non-NHS providers of out-of-hospital care that is NHS funded should be chargeable to non-exempt overseas visitors, implementing this charge in optical practices which currently provide community services would be a time consuming and costly task.

As mentioned previously in this consultation response the lack of IT connectivity with GPs and the wider NHS system means ascertaining the residency status of patients who receive community services in optical practices is complex. Implementing this proposal would require connectivity between optical practices and GP IT systems to be in place.

QUESTION 28: Are there any NHS-funded services provided outside hospital that should be exempt from a requirement to apply the Charging Regulations (e.g. on public protection grounds)?

Yes

Optical practices which provide community services.

Although we support the general principle that non-NHS providers of out-of-hospital care that is NHS funded should be chargeable to non-exempt overseas visitors, implementing this charge in optical practices which currently provide community services would be a time consuming and costly task.

As mentioned previously in this consultation response the lack of IT connectivity with GPs and the wider NHS system means ascertaining the residency status of patients who receive community services in optical practices is complex. Implementing this proposal would require connectivity between optical practices and GP IT systems to be in place.

QUESTION 37: Do you have any comments on the assumptions made in the impact assessment accompanying this consultation?

Yes

Firstly we fail to understand why, given that the impact assessment clearly indicates that the cost/benefit ratio of applying these changes to optics is not merely low, but that there will be a significant and ongoing cost, that optics is not simply excluded from the proposals.

Moreover, we are concerned that the costs predicted are in fact too low. The time allowance for undertaking each check is very short; there is no recognition that patient record systems (particularly electronic ones) would need to be amended to record this information; that optical practices do not have registers of patients (unlike other primary care providers) and so it would not simply be a case of checking patient records against NHS databases, checks would have to be undertaken repeatedly; and the impact assessment presupposes that optical practices have connectivity with NHS IT systems, when this is not in fact the case.