



## **Conservative party consultation on Top-Up Payments**

### **A joint response from the Association of British Dispensing Opticians, Association of Optometrists, and the Federation of Ophthalmic and Dispensing Opticians.**

Together ABDO, AOP and FODO represent the 10,000 optometrists and over 5,000 dispensing opticians and optical businesses in the UK who provide high quality and accessible eye care services to the whole population. An increasing number of our members also provide audiology services in the community to private patients.

This is an important and complex issue which cannot easily be resolved and will have a different impact in different areas of the NHS. We have confined our response to setting out how top-up payments work in eye care and our views on how this has impacted on eye care services. We are aware that there are concerns about extending top-up payments in other areas of the NHS, however in a primary care setting for services such as eye care and hearing services, top-up payments offer greater choice for NHS patients. Eligible patients who do not wish to top-up still have access to the NHS sight test and are able to get glasses and contact lenses on the NHS. Any system of top-up payments needs to define clearly, to both patient and professionals, who is paying for what and where the liability lies.

Much of the debate with regard to top-up payments for drugs has centred on cancer treatments. It is important to consider patients with other long term conditions such as those with eye disease. Treatments for age-related macular degeneration, the leading cause of blindness in the UK, have been the cause of much debate recently with huge variations in access to treatment on the NHS. The recent high profile cases of patients having to go blind in one eye before getting access to NHS treatment for age-related macular degeneration, have highlighted the flaws in the system. Without treatment patients will lose their sight within two years.

There is often confusion between top-up payments and co-payments. In optics a system of top-up payments has existed since 1951, where eligible patients receive a voucher which they can use to purchase glasses or contact lenses. If they wish they are able to use the voucher towards the cost of a more expensive pair of glasses. This system has worked extremely well in optics and has ensured patients have greater choice. It also fits with the principles of the NHS as set out in the 1946 NHS Act which states, "It will be open

to people if they wish, in certain cases, to pay for additional amenities within the arrangements of the service – for example, to pay for articles or appliances of higher cost than those normally made available.”

***1. Do you agree that whilst receiving NHS care, no-one should be charged for the treatment they receive?***

Yes if treatment is clinically necessary. Treatment on the NHS should be available to all based on clinical need rather than ability to pay. For treatments such as cataracts, patients who wish to have a more expensive refractive lens have the option to go private. This should continue unless there is a clear clinical case for the patient to have them and if so, this should be available on the NHS.

The debate then arises over charging for treatments which are not available on the NHS and those which are not appraised by NICE or they have been rejected by NICE. We believe patients should be able to buy treatment privately where a decision on the use of a drug has been delayed from NICE. If a drug is not available on the NHS but a cheaper version is, then patients should have the right to pay privately for the drug that is not available. We would support a system which allowed top-ups for treatments either rejected by NICE or where NICE has yet to make a decision. However we do believe that much more discussion on the issues surrounding funding of our health care system is needed.

The role of PCTs in funding treatments not appraised by NICE or where a decision is still awaited, also needs to be examined. This is an issue which we have concerns with. In the case of AMD treatments, some PCTs have decided not to pay for drugs and patients have then paid for the treatment privately. Other PCTs have allowed for the diagnostic tests to be paid for by the NHS with the patient paying privately for the drug costs only. There have also been cases where patients have been refused treatment on the NHS because they have started treatment privately. These huge discrepancies between different areas must be avoided. We are therefore concerned that leaving it open to PCTs to decide over which treatments they fund, will lead to wide regional variations. A solution needs to be found to prevent widespread variations in access to treatment and local decisions need to be transparent.

With regard to services there are examples where charges are rightly made. This fits with the NHS principle mentioned above of allowing for charges for certain services and appliances. As we have explained, in eye care eligible patients are able to make a top-up payment for a more expensive pair of glasses according to personal preference.

***2. Do you agree that NHS resources should be used solely for NHS patients and that there should be no cross-subsidy from NHS resources to private patients treated in the NHS?***

In optics there is the existence of a cross-subsidy but it is from private patients to the NHS, not the other way around. The low fee paid to practitioners for the NHS sight test

has a knock on effect of creating the need for a cross-subsidy from the sale of spectacles and contact lenses to maintain the viability of optical practices. The low sight test fee also affects the cost of private tests for private patients. The result is that spectacle wearers pay more than they might otherwise have to for their spectacles in order to ensure the economic viability of optical practices, hence the cross-subsidy of private patients to the NHS.

We would also like to add that like the British Society of Hearing Aid Audiologists (BSHAA), we have a concern that NHS Trusts may be competing unfairly in the market for private patients. As BSHAA have stated in their response to this consultation, some NHS Trusts have sought to make a profit from using NHS staff and audiology clinic resources by offering “competitively priced private hearing aids” to NHS patients.

***6. Do you agree that if patients access private care in relation to treatments not provided by the NHS, this should not affect their entitlement to NHS services; and their access to NHS treatment should be based on clinical priority?***

Yes. Patients should also have information about treatment options which fall outside NHS provision.

**Additional background to the use of top-up payments in community eye care.**

As we have mentioned above, a system of top-up payments has existed almost since the NHS began. When the NHS first started in 1948, it was not only sight tests that were made available to everyone without charge; in addition spectacles from a standard range were also provided. Not surprisingly there was a huge surge in demand, which overwhelmed the capacity of the optical profession and industry. This resulted in long waiting times for appointments and even longer for the supply of spectacles (six months or more).

The unprecedented demand caused costs to run far in excess of budget, so in 1951 the Government introduced patient contributions towards the cost of each pair of spectacles, initially set at £1.00. To counter criticisms of the “standard range” of NHS frames it was permitted to have a pair of NHS lenses fitted into a frame (of suitable shape) purchased privately (“hybrids”).

In 1986 the NHS range of frames and lenses was abolished. In its place a limited range of people, following a sight test, were entitled to be issued with an optical voucher on grounds of age, income or complex prescription. This provided a cash grant which the patient could put towards the cost of any spectacles (and from 1988 contact lenses) they wished to choose. It was welcomed by patients and profession alike. It also enabled manufacturers to develop lens technology and materials and the dated design of NHS bifocal lenses gave way to more efficient types of bifocal and varifocal lenses.

This voucher system continues to exist but due to the low value of the voucher even those spectacle wearers entitled to financial help are part subsidising non-spectacle wearers due to the low level of the sight test fee.

If you require any further information about any of the points we have raised please contact;

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