# GOS FEES 2021/22 – THE CASE FOR AN INCREASE

## Summary

As the OFNC has already discussed with NHS England, there is an urgent need to increase GOS fees in 2021-22 to:

- begin to close the widening gap between NHS sight test fees and inflation
- address the relative underfunding of GOS compared with other primary care contractor professions since austerity was eased
- acknowledge the evolving scope of the sight test and the benefit this has given the NHS
- start to reflect the impact of demographic changes on GOS providers' costs.

A fee increase of around 15% (or £3.18 per test) would be needed to bring the current GOS fee of £21.31 into line with inflation since 2010. Recognising the difficult financial environment at present, including the impact of COVID-19 on public finances, we propose that a fair and reasonable interim step for 2021/22 would be to increase the NHSE sight test fee by 5.6% (£1.19 per test) to £22.50, with corresponding increases in GOS domiciliary fees and the professional training grants for CET and pre-registration supervisors provided through the GOS budget.

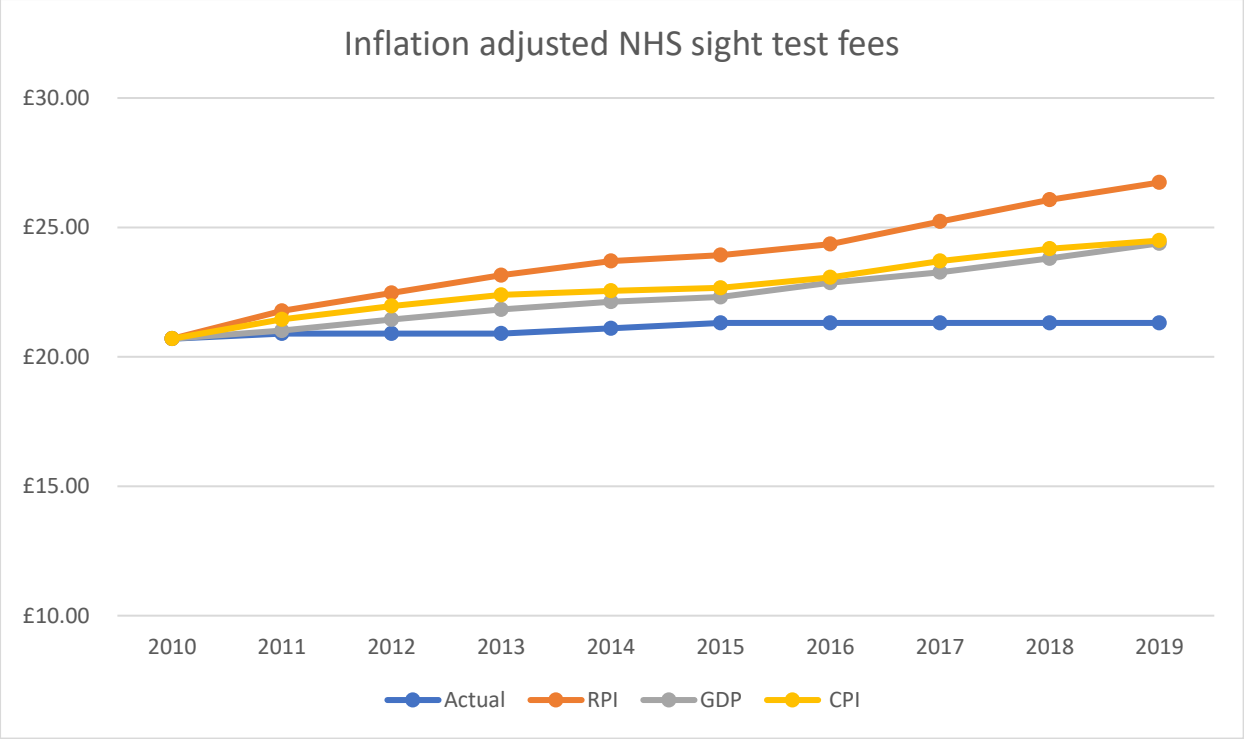
This note sets out the evidence for this proposal. As discussed, this is an interim proposal for the coming year, in the context of the COVID-19 pandemic and other developments.

To provide some context, we attach a note at Annex 1 setting out the expanding scope of the sight test, how this has benefited the NHS with minimum calls on public funds, and the impacts of demographic change.

## NHS sight test fees – eroded by inflation

The NHS sight test fee in England – currently £21.31 – has not changed for five years. GOS contractors, on the other hand, have experienced ongoing inflationary pressures on infrastructure and staff costs in a similar way to other primary healthcare contractor services. In recent years basic pay for clinical staff has risen at between 2% and 3% each year overall, and considerably more in some areas of England, reflecting workforce shortages as well as the rising cost of living.

The graph below illustrates the trend since 2010, showing the GOS sight test fee, the CPI and RPI measures of cost inflation, and the HMT GDP deflator. The underlying data are at Annex 2.




As has long been recognised, leaving aside inflation, the GOS fee does not cover the cost of providing an NHS sight test, which contractors have no choice but to cross-subsidise by income from spectacles and contact lenses. Imperial College in 2006[1] for example warned that the then GOS sight test fee of £18.39 (£27.00 at 2019 prices) was "well below the cost of providing the test (£37.00)" (£54.00 at 2019 prices) and that this needed to be addressed. In the time since that report, practices have become even more dependent on dispensing income to be able to provide NHS care.

As we have discussed, the data set out above demonstrate the necessity of an increase to the GOS sight test fee in 2021-22 to start to close the widening inflation gap.

Recognising the difficult financial environment in the NHS at present, including the impact of COVID-19 on public finances, we accept that it will be difficult to close this gap in a single step. We therefore propose that a fair and reasonable step for 2021/22 would be to move from the current £21.31 to £22.50 per sight test with corresponding increases in domiciliary allowances and associated professional grants for CET and pre-reg supervision – an increase of around 5.6%.

This would help relieve some inflationary pressures on contractors, and would also demonstrate to the sector that the Government and NHS England recognise the importance of eye care in terms of primary and secondary prevention and living and ageing well, including in times of pandemic and when access to hospital-based care is more difficult.

The challenges of COVID have clearly demonstrated just how vital GOS is in meeting needs, preventing sight loss and reducing pressure on GPs and hospitals. Both the Royal College of Ophthalmologists and the College of Optometrists emphasized the need to protect and advance the provision of primary eye care in their April letter to the Department of Health and Social Care about COVID-19:

[1] "Developing a new partnership contract for community eye care in England" Bosanquet, Imperial College 2006

> "primary care optical practices are key to the delivery of eye care in England during and after this unsettling time, and to help reduce the burden on the acute sector. It is imperative, therefore, that core primary eye care infrastructure and workforce are protected and maintained.[2]"

The COVID-19 funding NHS England has provided to GOS contractors during 2020 has been a vital support in enabling practices to continue to provide necessary care. Future GOS funding will however need to be set at a level that supports contractors both to maintain primary care provision in every community on an equitable basis, and also to play their part in transforming other parts of the NHS, especially overstretched hospital eye services.

To provide stability and reduce bureaucracy for all parties, we would be happy to consider agreeing a multi-year settlement with you to bring the GOS fee back into line with the long-term trend, during a period where it will play a key part in meeting the NHS Long Term Plan objectives and meeting growing patient needs linked to the ageing population, myopia in the young and lifestyle changes in the working population.

The Optometric Fees Negotiating Committee

January 2021

[2] See COVID-19: We ask for urgent clarification on financial support in England (college-optometrists.org)

## Annex 1 The context

### Expanding scope of the sight test

The national sight testing and case-finding service was set up by Government to ensure that contractors compete on clinical and service quality for the benefit of patients. As intended, this has generated investment in technology and new techniques (e.g. in retinal photography, visual fields assessment, tonometry, and optical coherence tomography (OCT)) to improve preventative eye care and enable providers to monitor and treat eye health problems in the community. This in turn has benefited the NHS, which has had access to highly trained clinical staff and high-quality infrastructure without having to invest NHS resources in undergraduate training or setting up new facilities.

The scope of the sight test and the cost of providing it have also expanded over time, driven by evolving standards of good practice (e.g. in response to College of Optometrists guidance and General Optical Council standards), in parallel with an increase in the cost of medical malpractice cover. For example, at the outset of GOS:

- intra-ocular pressures (IOP) were only checked in rare cases
- visual fields were conducted manually using a bead on a stick and a cloth on the wall
- slit lamps were rarely found in optical practices so dilated Volk exams did not take place.

These important eye health checks are now a standard part of clinical care, representing a massive gain in value for the NHS. This also means that a practice offering GOS today will be expected to have access to the following equipment:

- a tonometer costing around £3,000
- a visual field screening machine costing between £5,000 and £12,000
- slit lamps costing from £3,000 to £9,000 – usually in every consulting room in the practice.

OCT machine installation (costing from £25,000 to £60,000) and fundus cameras (costing £10,000 - £12,000) are also increasingly available in primary care settings, helping to refine and reduce referrals to secondary care.

We propose that the longer-term service possibilities and financial implications of these developments should be explored further in future discussions. In the meantime, the additional costs that advances in primary eye care impose on contractors reinforce the case for an increase in the GOS fee as proposed in this paper.

### Demographic changes

Eye disease is closely correlated with age, and incidence is increasing rapidly as the population ages. It is estimated that 2.7 million people in the UK will be living with sight loss by 2030. Ethnicity is also a factor. For instance Black African and Caribbean people are four to eight times more at risk of developing certain forms of glaucoma compared to white people, and South Asian people are at three times greater risk of diabetic eye disease compared to white people.[3]

[3] RNIB, The State of the Nation Eye Health 2016. https://www.rnib.org.uk/sites/default/files/RNIB%20State%20of%20the%20Nation%20Report%202016%20pdf.pdf

Over 60s now form the largest cohort of NHS patients, as all patients aged 60 and over have been entitled to NHS sight tests since 1999. The estimated prevalence of the main eye diseases in the UK is:

- Cataracts increase exponentially with age, affecting 0.4% of children, 16% of people aged 65 and over 70% of people aged 85 and over.[4]
- Glaucoma affects more than 1% of people aged 40, 3% aged 60 and 8% of people aged 80 years[5]
- Age-related macular disease has a prevalence rate of 2.4% in adults aged 50, rising to about 12.2% people aged 80 and older[6]
- 48% of people with Type 1 diabetes and 28% with Type 2 diabetes have diabetic retinopathy (DR), with older people, minority ethnic groups and higher rates of deprivation increasing as known risk factors[7]

The ageing population means all these conditions are projected to increase significantly over the next 15 years, for example glaucoma cases have been projected to increase by 44% between 2015 and 2035.[8]

As we have made clear in previous GOS fee discussions and submissions, these changes in demographics, and specifically the ageing population, mean that a growing proportion of GOS patients require significantly longer sight testing times, either because of ophthalmic co-morbidities (which may require more tests to be undertaken as part of a sight test) or simply because by virtue of their age (and the fact that they have other systemic co-morbidities which result in increased frailty) a sight test will take longer.

As we have previously discussed, we would be happy to work with NHS England to survey the sector for meaningful data about this, which has not been done since 2004, to inform future negotiations. However, this should not delay an interim and partial inflation correction to current fees for 2021/22.

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[4] NICE, CKS Cataract, prevalence data, March 2020 https://cks.nice.org.uk/topics/cataracts/background-information/prevalence/

[5] NICE, CKS Glaucoma, prevalence data, October 2020, https://cks.nice.org.uk/topics/glaucoma/background-information/prevalence/

[6] NICE, CSK, Macular degeneration – age related, prevalence data, March 2016 https://cks.nice.org.uk/topics/macular-degeneration-age-related/background-information/prevalence/

[7] Mathur R, Bhaskaran K, Edwards E, *et al* Population trends in the 10-year incidence and prevalence of diabetic retinopathy in the UK: a cohort study in the Clinical Practice Research Datalink 2004–2014 *BMJ Open* 2017;**7:**e014444. doi: 10.1136/bmjopen-2016-014444

[8] The Royal College of Ophthalmologists, The Way Forward, https://www.rcophth.ac.uk/wp-content/uploads/2015/10/RCOphth-The-Way-Forward-Glaucoma-300117.pdf

## Annex 2 GOS fees and inflation

| Year | NHS sight test fee actual | RPI | RPI adjusted sight test fee | CPI | CPI adjusted sight test fee | GDP deflator | GDP deflator adjusted sight test fee |
|---|---|---|---|---|---|---|---|
| 2010 | £20.70 | 4.63% | £20.70 | 3.15% | £20.70 | 1.83% | £20.70 |
| 2011 | £20.90 | 5.19% | £21.77 | 3.60% | £21.45 | 1.52% | £21.01 |
| 2012 | £20.90 | 3.19% | £22.47 | 2.42% | £21.96 | 2.04% | £21.44 |
| 2013 | £20.90 | 3.05% | £23.15 | 1.95% | £22.39 | 1.80% | £21.83 |
| 2014 | £21.10 | 2.36% | £23.70 | 0.71% | £22.55 | 1.38% | £22.13 |
| 2015 | £21.31 | 0.98% | £23.93 | 0.50% | £22.66 | 0.82% | £22.31 |
| 2016 | £21.31 | 1.78% | £24.36 | 1.79% | £23.07 | 2.47% | £22.86 |
| 2017 | £21.31 | 3.57% | £25.23 | 2.74% | £23.70 | 1.76% | £23.27 |
| 2018 | £21.31 | 3.34% | £26.07 | 2.00% | £24.18 | 2.31% | £23.80 |
| 2019 | £21.31 | 2.56% | £26.74 | 1.31% | £24.49 | 2.44% | £24.39 |