

The Treasury

Budget 2012 Information Release

Release Document

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Treasury Report: Improving the targeting of co-payments in primary care

Date:	20 December 2011	Report No:	T2011/2570
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Action Sought

	Action Sought	Deadline
Minister of Finance (Hon Bill English)	<p>Note the contents of this report</p> <p>Indicate your view on the options presented</p> <p>Indicate whether you would like to meet to discuss this report</p> <p>Refer this report to the Minister of Health</p>	Tuesday, 20 January 2012

Contact for Telephone Discussion (if required)

Name	Position	Telephone	1st Contact
[3]	Analyst, Health and Housing	[3]	✓
Ruth Isaac	Manager, Health and Housing	[3]	

Minister of Finance's Office Actions (if required)

If agreed, forward a copy of this report to the Minister of Health.

Enclosure: No

Treasury Report: Improving the targeting of co-payments in primary care

Executive Summary

This report discusses the rationale for cost sharing in the health sector and provides initial options to increase co-payments for community pharmaceuticals and GP consultations. It also considers options to better target subsidies at people with high health need and low income.

In the current fiscal environment the government needs to think carefully about which services it funds, and for whom. Increasing cost sharing is one way to shift a share of health costs from the public health system to those who use and can afford to pay for services. Cost sharing also sends a price signal to patients and can help improve the efficiency and effectiveness of the health system.

The level of out-of-pocket contributions for health care in New Zealand is low compared with OECD countries. Co-payments for primary care and community pharmaceuticals have been reduced in the past decade, in a move away from targeting and towards universal subsidies. Co-payments for pharmaceuticals in particular are now very low; a maximum co-payment of \$3 applies in most circumstances.

Increasing co-payments in these areas provides an opportunity for savings in the order of \$100 to \$200 million per annum. Moreover, increases in co-payments could be targeted at middle and high income groups, protecting those on low incomes and those in poor health.

Increases to co-payments need to be carefully designed to minimise any adverse health impact and downstream health care costs, and considered alongside other health system policy changes.

Changes to pharmaceutical co-payments could be implemented in a relatively short timeframe. There is work underway, in the Ministry of Health, DHBs and PHARMAC, to improve the community pharmaceuticals distribution system, including a new service model for pharmacists. This work provides a good opportunity to review pharmaceutical co-payments in the context of the broader regime. To date, we are not aware that this is happening.

Changes to the funding model in primary care would require a longer lead time. We recommend that options to target primary care subsidies towards the most disadvantaged be considered alongside broader changes to improve accountabilities and incentives in the system.

Communications

This report has no communications implications.

Recommended Action

We recommend that you:

- a **note** that there are options to reduce and target subsidies for community pharmaceuticals and primary care which could generate savings of \$100 to \$200 million per annum;
- b **agree** to discuss with the Minister of Health the possibility of increasing cost sharing in the health sector;

Agree/disagree.

- c **indicate** whether you wish to discuss any of the following additional areas of action with the Minister of Health:

- 1. conducting a review of pharmaceutical co-payments in early 2012, including better targeting of co-payments, alongside current work on the distribution of pharmaceuticals;

YES / NO

And/or

- 2. commissioning advice on changes to the primary care funding model, and better targeting of primary care subsidies, in the context of policy work on the primary care system in 2012;

YES / NO

- d **indicate** whether you wish to discuss this paper with the Treasury;

Agree/disagree.

- e **refer** this report to the Minister of Health.

Agree/disagree.

Ruth Isaac
Manager, Health and Housing

Hon Bill English
Minister of Finance

Treasury Report: Improving the targeting of co-payments in primary care

Purpose of Report

1. This report serves two purposes. First, it discusses the potential for increased cost sharing in the health sector to generate savings while protecting health and equity objectives.
2. Second, it provides you with some initial options to increase co-payments for community pharmaceuticals and GP consultations and to better target government subsidies at vulnerable populations. Further work would be needed to fully develop and assess the impacts of the options.

Context

3. The government is operating under tight fiscal constraints and increasing cost pressures. In order to return to budget surplus by 2014/15 in accordance with the fiscal strategy, Ministers will need to make choices on spending priorities in Budget 2012.
4. One area to consider in the health sector is the level of private contributions for health care. The level and targeting of public subsidies for pharmaceuticals and primary care – and the level of co-payments individuals make for these services – are a key aspect of this. Providing advice on better targeting primary care subsidies is part of Treasury's output plan for 2011/12.
5. Departmental Four-Year Budget Plans are the primary mechanism for exploring options to reprioritise the base of existing spend and to manage cost pressures. At present, the Ministry of Health's draft Four-Year Budget Plan does not present any significant options and analysis for Ministers on co-payments and targeting.
6. We consider that this area offers potential savings for government in the order of \$100m-\$200m per annum.
7. Carefully designed and implemented changes to co-payments could have little impact on health outcomes for New Zealanders while delivering a more equitable allocation of public health resources and reducing cost pressures in the system. Changes to co-payments need to take into consideration:
 - potential downstream impacts on health outcomes and health care costs; and
 - the interplay of subsidy and co-payment changes with other policies in the health sector (for example, implementation of Better Sooner More Convenient (BSMC) initiatives and changes to the pharmaceutical services model).
8. In preparing this report we have discussed the options with the Ministry of Health and PHARMAC. If you are interested in pursuing any of the options in this report, further policy work and engagement with these agencies will be required.

Cost sharing and targeting in the health sector

There is an economic and fiscal rationale for cost sharing in the health sector.

9. Cost sharing in the health sector can be used to:
 - shift a share of health costs from the public health system to those who use and can afford to pay for services, thereby reducing cost pressure in the health budget;
 - send a price signal to patients who would otherwise face a zero price for access to health care; and
 - improve equity in the targeting of public healthcare expenditure.
10. Another argument for cost sharing is to reduce demand for unnecessary or low-value health services. When services are publicly funded people tend to use more, some of which may be low-benefit relative to costs. Moreover, given the power of doctors to influence patient behaviour, moral hazard might be exacerbated by supplier-induced demand.
11. This may not be a large concern in New Zealand, particularly with regard to pharmaceuticals where drugs need to meet a cost-effectiveness threshold in order to be funded.
12. Cost sharing comes in various forms. The most common in New Zealand is a flat amount co-payment for a particular good or service, such as a GP consultation or prescription drug. Cost sharing is also used in insurance schemes, for example coinsurance where the patient pays a percentage share of their medical costs.

Behavioural impacts need to be considered carefully to protect health outcomes...

13. Increasing cost sharing may result in a reduction in utilisation of health services. However, evidence from studies on price elasticity of health services suggests that the demand for health care is relatively price inelastic. Estimates typically centre around -0.2.¹ That is, consumers reduce their health care spending by 2 percent in response to a 10 percent increase in its price.
14. The size of the impact differs by patient group and the level of cost sharing. For example, low income earners are more responsive to cost than those with higher incomes, and the elasticity of demand is lower at low levels of cost sharing.
15. A New Zealand study into the impact of pharmaceutical co-payments in 2004 found that 6.4% of people *deferred* collection of a prescription at least once in the previous year because of cost.² The following groups were more likely than average to postpone filling a prescription:
 - middle income earners, possibly as they are not eligible for community services cards and so face higher costs;
 - Maori and Pacific people;³ and
 - people with poor self-assessed health, psychological distress and two or more co-morbid conditions.

¹ Liu and Chollet (2006)

² Jatrana et al (2010). Results are self-reported. At the time of this study, the maximum co-payment was \$15 (five times the current maximum) and the average co-payment was \$6 (three times the current average).

³ Compared with NZ Europeans, Maori were 1.35 times more likely and Pacific Islanders 1.91 times more likely to defer filling a prescription, after controlling for demographic and socioeconomic factors.

16. The impact of reduced utilisation on health outcomes depends upon the nature of the treatment. Recent evidence shows that the use of preventive diagnostic services and immunisations is lower when cost sharing is higher, whereas people are less likely to postpone emergency care.⁴
17. The RAND Health Insurance Experiment in the late 1970s found that people do not distinguish well between health care services or prescription drugs that are essential and those that are not essential. However, evaluation of the experiment did not detect any material variations in health outcomes associated with charging, apart from on those who were both poor and suffering from poor health.⁵

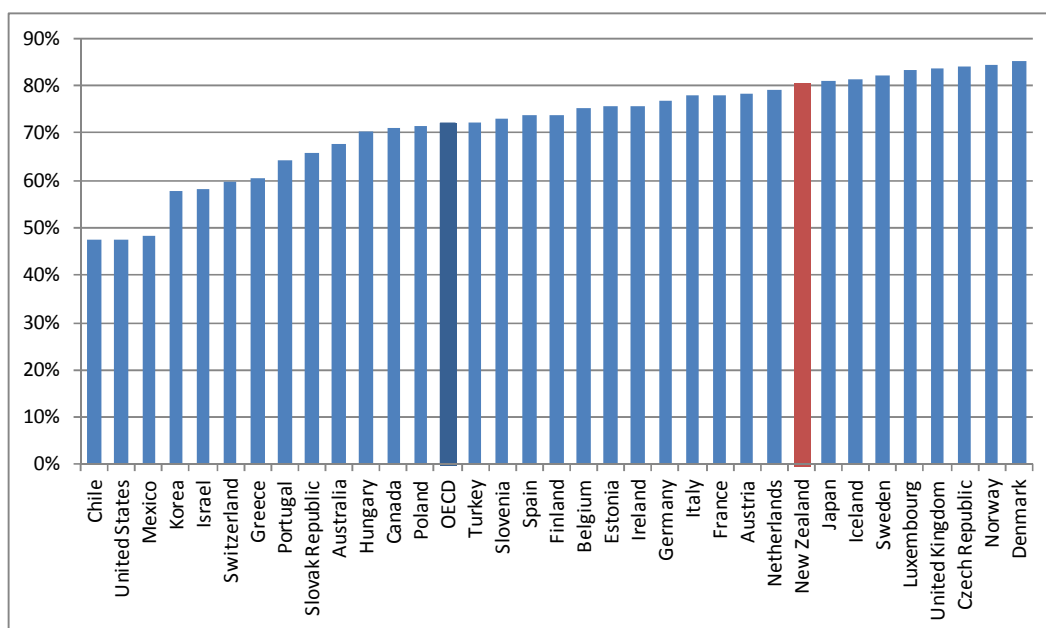
...and prevent increasing costs elsewhere.

18. If patients reduce their utilisation of services that are cost-effective in preventing or managing health conditions, this will harm their health outcomes and may lead to the need for subsequent expensive health treatment. For example, reduced use of statins or asthma inhalers is likely to result in a worsening of the conditions these drugs control, and an increase in health costs elsewhere in the system.
19. Cost sharing should ideally be targeted at low-value and expensive health services to reduce any negative health impact. Some health insurance plans work on this basis. For example, Value-Based Insurance Design plans exempt charges on cost-effective preventive care but charge more for health care services which are deemed of low value to everyone or low value for people who do not meet certain criteria.

There is scope to increase cost sharing and targeting in New Zealand.

20. Across the OECD countries use a mix of public and private sources to pay for health care. In New Zealand just over 80% of health costs are funded by general government revenues, placing us in the top quartile of OECD countries. This proportion has been fairly stable since 1970.

Figure 1: Public Share of Total Health Spending, %, 2009 or nearest year

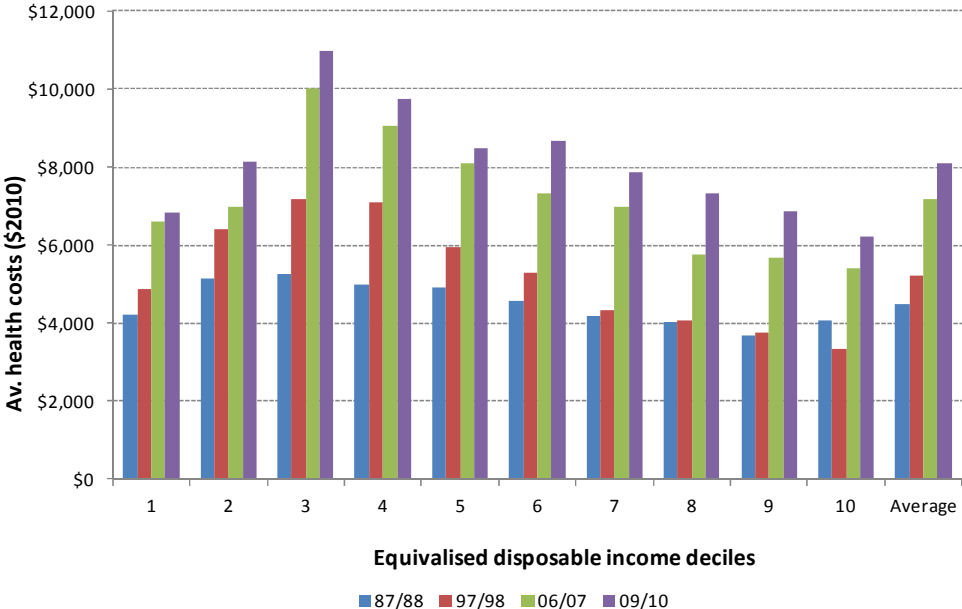


⁴ Robert Wood Johnson Foundation (2010)

⁵ Newhouse, J.P. (2004)

- 21. Private financing comprises out-of-pocket payments by households (co-payments or other types of cost sharing) and private insurance payments. Both these types of private financing are low relative to the OECD. The burden of out-of-pocket health expenditure in New Zealand is in the bottom quartile of the OECD at 2.4% of final household consumption. Out-of-pocket spending in New Zealand decreased by 2% over the last decade as a share of health expenditure.
- 22. Co-payments are currently used in primary care and for community pharmaceuticals. Private financing is also used in areas such as oral health, hearing aids and other disability supports, and aged residential care. However, there is scope to explore extending private financing in other areas, such as for elective surgery, hospital stays, diagnostic tests and obstetrics.
- 23. There is also scope to better target overall spending at disadvantaged groups. Since 1998 health expenditure on higher income deciles has increased more quickly than spending on lower income deciles. This has occurred because of higher expenditure on less targeted initiatives, such as the Primary Health Care Strategy (launched 2001) which emphasises community health and health prevention, and because more older people are in higher income deciles. As a result, the combined share of spending on households in deciles one to five fell to 57% in 2007 and to 54% in 2010.

Figure 2: Average cost of health services received by a household in each decile (\$2010)



Community pharmaceuticals – funding model

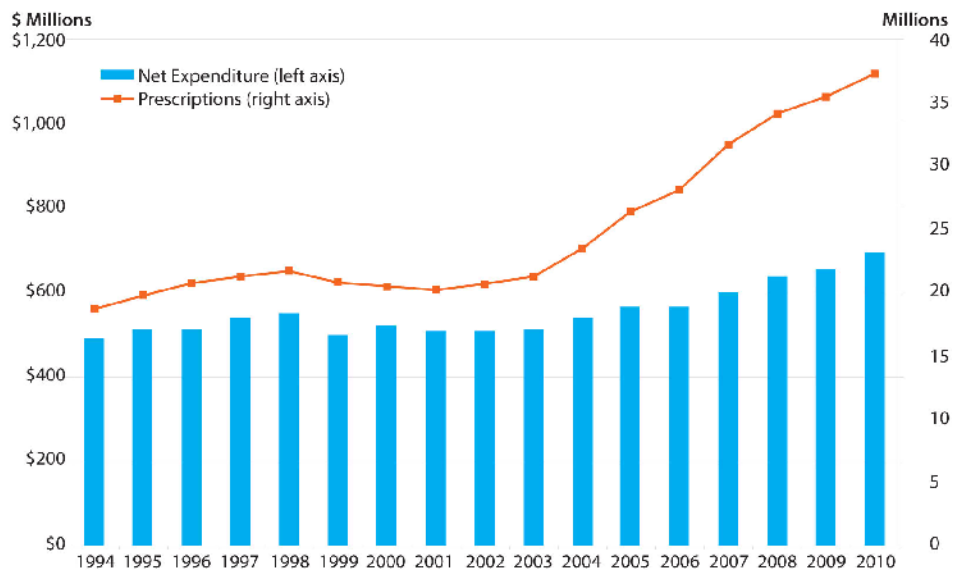
Some aspects of the pharmaceuticals regime are working well...

- 24. PHARMAC has achieved good value for money in pharmaceutical purchasing and has been effective in keeping costs down. PHARMAC’s scope is being expanded to include hospital medicines and medical devices. A greater role for PHARMAC in the vaccine management regime is also being considered.
- 25. The community pharmaceutical budget has grown over the last few years, rising to \$706.1 million in the year to June 2010/11. However, while pharmaceutical spending has increased, the volume of subsidised prescription items being dispensed has increased at a faster rate.⁶ This trend is shown in Figure 3 below.

⁶ Note that the increase in funded prescriptions since 2003 largely reflects a shift in privately-funded to publicly-funded prescriptions as a result of the reduction in co-payment.

Figure 3: Community pharmaceutical expenditure and subsidised prescription items, 1994 - 2010

Drug Cost vs Script Growth



...but there is scope for improvement in a number of areas.

26. There is significant scope to improve value for money in the distribution of drugs and in the targeting of co-payments.
27. The total cost to DHBs of dispensing community pharmaceuticals to patients is large and growing. In 2010/11 DHBs spent \$380 million in dispensing costs, around one third of the total cost of medicines, and costs have been increasing at 7-8% per year. Pharmacists are reimbursed according to the volume of dispensings and the cost of distribution is increasing as the volume of subsidised dispensings increases. Significant savings can be made if the growth in distribution costs can be contained.
28. There are also a number of regulatory barriers regarding the ownership of pharmacies. For example, it is illegal for anyone other than a pharmacist to have a majority share in a pharmacy. This inhibits the development of new commercial models for the distribution of medicines.
29. There is work underway to improve the distribution of pharmaceuticals:
 - The Community Pharmacy Services Agreement (CPSA) between DHBs and pharmacies is currently being renegotiated and will take effect from May 2012. The agreement is likely to shift pharmacists to a new service model, where they are remunerated more for their clinical role as experts in medicines management and less for each item dispensed. The new model is intended to improve patient management of medicines and to control cost growth by removing perverse incentives to increase dispensing volumes. It is not clear how the existing co-payment regime would fit with the new model.

- The Ministry of Health is providing advice on a possible regulation change to extend the period of medicines supply which would enable GPs to prescribe treatments for 6 months rather than the current 3 months. If patients are charged one \$3 co-payment for a 6 month prescription DHB revenues would decrease by around \$10m - \$12m.
 - PHARMAC and the Ministry of Health are leading work to allow pharmacists to prescribe some subsidised treatments. A service fee for patients could be a desirable aspect of this scheme which could be used to encourage the most appropriate first contact with primary care.
30. The above processes will have impacts on the fiscal cost of pharmaceuticals – through the costs of distribution and the level of co-payments received. The new CPSA in particular is likely to improve the affordability of pharmacy services.
31. There is currently little co-ordination of the work on pharmaceutical distribution and no overall strategy to manage costs. Each work-stream will require decisions about patient co-payments. It would be timely to join up the work and review pharmaceuticals co-payments alongside work on pharmaceutical distribution.
32. We support pursuing improvements in the wider pharmaceuticals procurement and distribution system. However, even in the absence of a broader review, there are options to implement changes to co-payments and subsidies within a relatively short time frame. We recommend these be considered alongside other options to ensure the health sector can live within its budget constraint over the next four years.

Community pharmaceuticals – co-payment system

The current co-payment system is complicated.

33. DHBs charge a co-payment for each subsidised item on a prescription. The co-payment varies according to the characteristics of the patient and the prescriber. The maximum co-payment in most circumstances is \$3 per item.⁷
34. There are three overlapping systems for targeting pharmaceutical subsidies to high needs consumers on the basis of health need and/or income:
- The Prescription Subsidy Card (PSC) entitles the cardholder *and family members* to pay a lower co-payment (between \$0 and \$2). A family is eligible for the card once they have paid for 20 subsidised prescription items since 1 February of any year, a total of \$60. There is no income testing.
 - The High User Health Card (HUHC) entitles the card holder to reduced prescription co-payments and cost reduction when visiting the GP. Patients are eligible for a HUHC after they have had 12 paid GP visits within the immediate previous 12 month period.
 - The Community Services Card (CSC) entitles PSC holders to \$0 co-payments. Non-PSC holders with a CSC do not get an additional subsidy.

⁷ There are two exceptions to this: i) if the prescriber is not on the authorised list, and ii) if the drug is not fully subsidised the patient is required to pay a 'part charge', and a wholesale mark-up set by the pharmacist.

Table 1: Summary of pharmaceutical co-payments

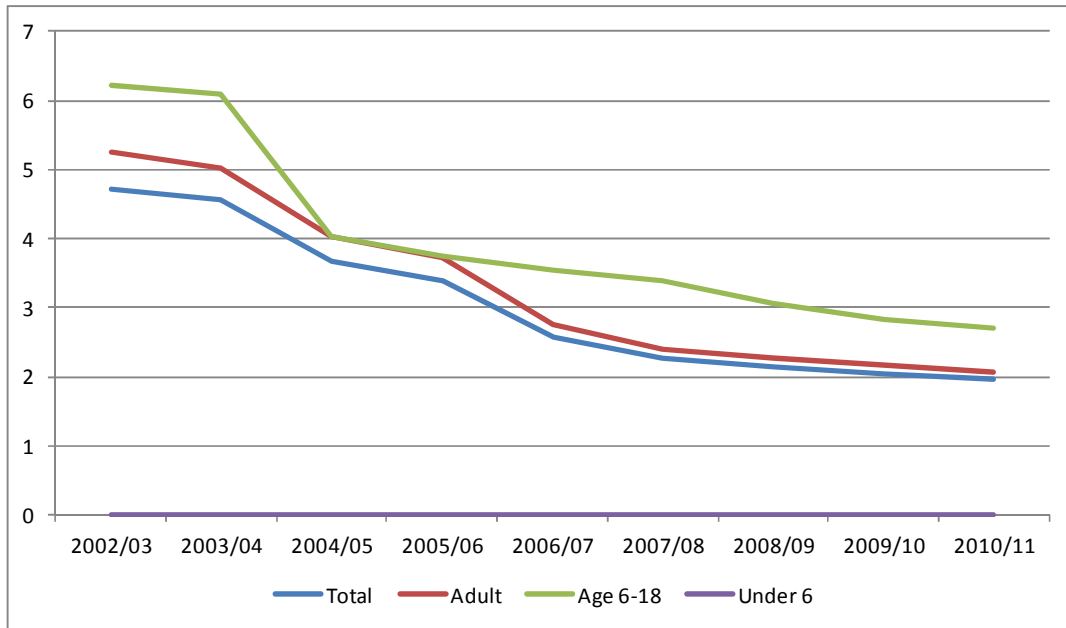
Benefit card	Prescriber	Base co-payment
No card	PHO GP, Public Hospital doctor, Midwife, Family Planning Clinic, Other prescribers with DHB contracts	\$3
	Other Prescribers	\$15
At least one of:	PHO GP, Public Hospital doctor, Midwife, Family Planning Clinic, Other prescribers with DHB contracts	\$0- \$3
• High use health card		
• Prescription subsidy card		
• Community services card		
Children under 6		\$0

35. For comparison, in Australia the maximum co-payment is A\$34.20 for each prescription item. Patients holding concession cards pay A\$5.60 per prescription item. These co-payments are adjusted annually in line with the CPI. Families are entitled to reduced co-payments when their total annual co-payments exceed A\$1317.20 (for general patients) and A\$336.00 (for concession patients).
36. With the maximum co-payment in New Zealand now reduced to \$3, it is likely that only a low percentage of eligible households are taking-up their entitlement to the PSC. The benefits of enrolling for many are likely to be outweighed by the effort and perceived stigma involved in applying. An increase in prescription co-payments is likely to increase demand for the PSC from already-eligible users.

Co-payments have decreased to under \$2 per item on average.

37. From 2004 to 2008 the maximum co-payment paid in most circumstances was decreased from \$15 to \$3 and the scope of the additional subsidy was extended to more prescribers. This was part of a broader strategy to universalise access to public health and reduce income-based targeting.
38. In the very different fiscal environment the Government now faces it is appropriate to reconsider whether the benefits of universal subsidies outweigh the benefits of targeting scarce public funds to the areas and individuals/households with greatest need.
39. There has been a substantial decline in average co-payments over the last 9 years. Figure 4 shows the trend in average co-payments by age group. The average across all groups has decreased from \$4.71 in 2002/03 to \$1.95 in 2010/11 (in 2011 dollars).

Figure 4: Average pharmaceutical co-payment per item by age group, 2002/03 to 2010/11, in 2011 dollars



40. The following table shows the average co-payment per item paid by different age groups in 2010/11.

Table 2: Average pharmaceutical co-payment per item by age group, 2010/11

Age group	Under 6	6 - 18	Adult	All groups
Average co-payment	\$0.00	\$2.69	\$2.06	\$1.95
Key points to note	No co-payments for children under 6	Youths are less likely to hold a subsidy card than adults	65% of prescriptions had a co-payment of \$3 and 34% had no co-payment	Decreased from \$4.71 in 2002/03

Community pharmaceuticals – options to target subsidies

There are options to better target subsidies and generate savings.

41. There is scope to increase co-payments and generate savings in the order of \$100 million or more. Co-payment changes can be designed so the bulk of this additional cost falls on people with higher ability to pay and has minimal impact on access for disadvantaged groups. Moreover, there may be opportunities to structure the co-payment to encourage the most cost-effective use of the pharmaceuticals that are public funded, minimising the impact of any increase on health outcomes.
42. Table 3 outlines Treasury's estimate of annual savings from changes to the maximum co-payment, with and without an exemption that maintains the current \$3 maximum for CSC holders. Without further policy decisions, these savings would accrue to DHBs as additional third party revenue and could be reprioritised.

Table 3: Estimated annual savings from changes to pharmaceutical co-payments

		No new income-based exemption	\$3 max for CSC holders
Increase maximum co-payment from \$3	to \$5	\$45 - 50 million	\$25 - 30 million
	to \$10	\$160 - 170 million	\$90 - 100 million

43. All of the options in Table 3 retain zero co-payments for children under six and current subsidies for PSC and HUHC holders.
44. The savings estimates assume no reduction in prescription volumes. A drop in prescription volumes would represent additional savings.⁸ This may or may not be desirable, depending on which groups are reducing their consumption and of which drugs. Each option should be analysed with respect to its impact on patients' ability to access cost-effective medicines. However, evidence noted above suggests that demand for pharmaceuticals is fairly inelastic, especially for higher income groups.
45. The savings estimates above do not take into account:
- costs of implementing and administering a new scheme;
 - compliance costs for pharmacists and patients; and
 - costs of increased take-up of current subsidies (eg. PSC – see below).

All of the above costs would reduce the savings estimates in Table 3 above.

46. Increases in co-payments above a certain threshold (ie. above the sum of the drug cost and the pharmacy dispensing fee) would encourage patients to buy drugs from the private market.⁹ This would enable the pharmaceuticals budget to be reduced accordingly or allow PHARMAC to make new investments. Note, however, that any new investments are likely to be lower value for money than previous ones.
47. An increase to a \$5 co-payment under the current Community Pharmaceuticals Service Agreement would not result in any shift to the private market (because the dispensing fee is \$5.31). The proposed changes to the pharmacy services model will need to consider how co-payments can be incorporated.

The PSC provides additional subsidies and eligibility could be revised.

48. Based on the current eligibility test of 20 prescription items in a year, the maximum cost increase to households from the options above would be \$40 per year with a \$5 co-payment, and \$140 per year with a \$10 co-payment.
49. It is likely that uptake of this card by eligible households would increase as the maximum co-payment rises, as more households consider the card worthwhile applying for. In 2010 there were around 48,000 people over six who filled more than 20 prescription items in a year but did not apply for a PSC. If all of those people took up the PSC exemption the above savings could reduce by up to \$1.2 million for a \$5 co-payment and \$4.2 million for a \$10 co-payment.

⁸ For example, if an increase in the maximum co-payment to \$10 with no new income-based exemption led to a 10% drop in prescription volumes that would generate additional savings of around \$20 million.

⁹ PHARMAC would also lose data on pharmaceuticals which fall under the co-payment threshold, which would result in a less than complete picture of the community pharmaceuticals market. There may be options to incentivise pharmacists to continue to provide the data.

50. The criteria for the PSC could be revised to generate further savings. The eligibility rules for the PSC could be tightened by:
- requiring that an *individual* fills 20 prescription items;
 - increasing the threshold number of prescription items for the family unit;
 - increasing the threshold number of prescription items for families that do not hold a CSC; or
 - introducing a family income threshold as an eligibility criterion.

It is difficult to ascertain the potential savings from the above options as we do not have unit level data. However, halving the number of prescriptions filled by PSC holders is likely to generate savings of around \$17 million.

51. Another option is to change the timeframe for the PSC. Currently it works as an annual cap. Instead, a maximum number of prescriptions or dollars could apply per month with any subsequent prescriptions that month free. For example, a monthly limit of \$10 per family could apply.
52. This would create a different distribution of costs and benefits, along the following lines: people who face a large number of prescriptions in one month would pay less in co-payments, while people who face a steady number of prescriptions throughout the year would pay more in co-payments. Spreading the costs over time may better match people's ability to pay for prescription drugs. It is unclear whether this would generate savings for DHBs.

Primary care – funding model and policy settings

The current funding model for primary care is fragmented.

53. The Primary Health Care Strategy (PHCS) increased the level of funding available to primary care by establishing a range of dedicated funding streams, each of which aim to promote a particular aspect of personal or population health care. They are supplemented by patient co-payments and payments from ACC.
54. Implementation of the PHCS focused mainly on improving access to GP services through universal public capitation funding of PHOs which replaced the previous fee-for-service system with targeted public subsidies. Patient co-payments remain a core feature of the system.
55. The bulk of primary care funding is delivered through the First Contact funding stream which distributes universal subsidies to PHOs in a risk-adjusted lump sum on the basis of their enrolled population.¹⁰ First Contact funding made up 76% of total primary care funding to PHOs in 2011.
56. There are a number of other funding streams paid to PHOs:¹¹
- Very Low Cost Access (VCLA) and Zero Fees for Under Sixes (Under Sixes) are provided in exchange for practices voluntarily reducing their fees;

¹⁰ First Contact funding is adjusted for age, gender, High Use Health Card status. The population-based funding streams (Services to Improve Access, Health Promotion) are adjusted for deprivation decile and ethnicity as well.

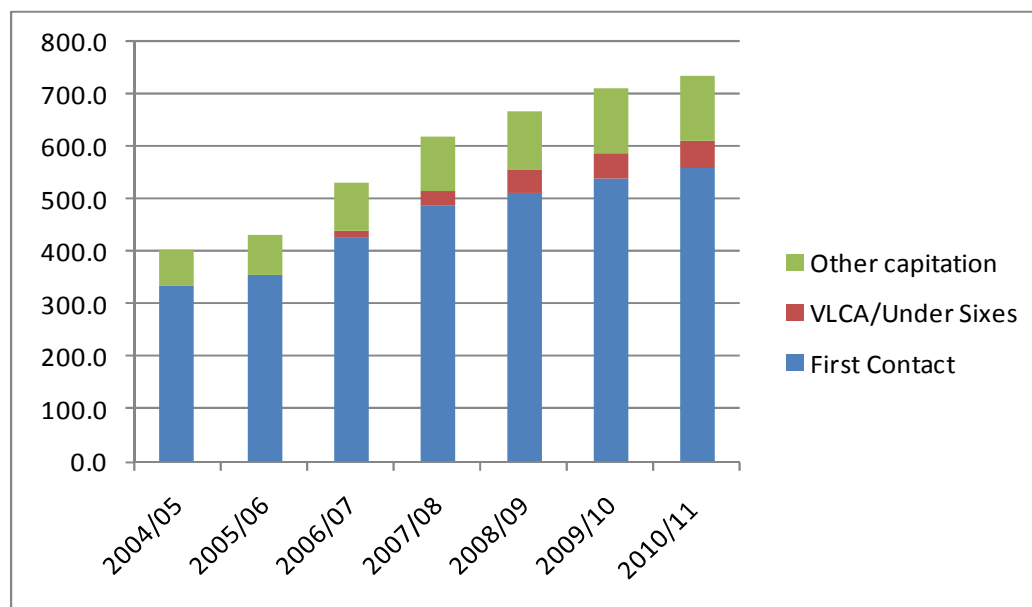
¹¹ More detail is provided about these funding streams in Annex 1. There are also a number of primary care funding streams paid to DHBs and distributed to providers on a fee-for-service basis, which are summarised in the Annex.

- Care Plus, Services to Improve Access, and Health Promotion are aimed at particular population groups; and
- Management Fees for PHOs to provide or purchase management services.

57. Funding for each BSMC Alliance is derived from pooling the funding from Care Plus, Services to Improve Access, Health Promotion and Management Fees, to create a 'flexible funding pool', and is monitored through contracts. This approach could be extended to other primary care practices [CBC (10) 56 refers].

58. Primary care funding has increased substantially over the period from 2004/05 to 2010/11 as shown in Figure 5.

Figure 5: Primary Care Capitated Funding Streams, 2004/05 to 2010/11



*Other capitation includes Care Plus, Services to Improve Access, Health Promotion, and Management Fees.

59. Patient co-payments continue to represent a substantial proportion (around 30% to 40%) of the revenue of general practices. The implementation of the PCHS resulted in a decrease in patient fees. However, the reduction in fees was not as large as hoped and there is evidence that GP incomes have increased significantly in the past decade.¹² The mechanisms to control fee increases are weak and raise questions about the value for money and sustainability of primary care funding.

60. Table 4 shows the distribution of co-payments charged for different groups in 2011.

Table 4: Summary of GP fees in New Zealand, by age group 2010/11

	Age group					
	0 to 5	6 to 17	18 to 24	25 to 44	45 to 64	65+
25th Quartile	\$0.00	\$11.50	\$17.00	\$17.00	\$17.00	\$17.00
Median	\$0.00	\$24.00	\$32.00	\$33.00	\$33.00	\$32.00
75th Quartile	\$0.00	\$30.50	\$37.00	\$38.50	\$38.63	\$37.00
Non VLCA practices	\$3.00	\$27.84	\$34.81	\$36.61	\$36.68	\$35.39
VLCA practices	\$0.00	\$7.57	\$14.62	\$14.82	\$14.70	\$13.57

¹² Raymont and Cumming (2009)

61. In 2010/11 4.17 million New Zealanders were enrolled with a PHO. The average number of consultations per enrolled patient was 2.87. The average subsidy per consultation through the First Contact stream was \$46.65.¹³

Primary care – options to target subsidies

There are options to reduce and better target funding in primary care

62. We consider that changes to the primary care system are needed, alongside changes to the overall health system, to strengthen accountabilities and align incentives [report T2011/1776 refers]. However, even in the absence of broader changes, consideration of options to improve the targeting of primary care funding within the current model is warranted.
63. The current primary care funding system is based on a principle of universal subsidies, which are designed to ensure everyone has access to health services and to encourage take-up.
64. Given budget constraints, however, there is a tension between providing universal subsidies and a high level of subsidisation for needy populations. Universal subsidies invariably mean that a large amount of funding is captured by middle and high income earners who would be likely to visit the GP anyway.¹⁴ Moreover, an evaluation of the PHCS by Victoria University found that there was no consistent increase in consultation rates following capitation, and that rates continue to be lower in areas of higher health need.¹⁵
65. We consider there is a case for more targeting of subsidies based on health and financial need. With limits on the amount of new money available for health, targeting will help protect the disadvantaged. Targeting can generate fiscal savings and is also likely to improve the value for money of primary care funding.
66. The options below give a broad indication of the impact of funding changes on government finances and patient co-payments. Under the capitated funding model it is difficult to predict what impact changes in government funding will have on patient co-payments as GPs have control over the fees they charge.
67. Subsidies could be targeted at:
- Low income and high-risk people to enable them to use more health care than they would otherwise; and
 - Health services with high marginal benefit which may otherwise be underused.
68. Targeting based on need should be carefully designed to ensure that it reaches the target population. For example, in the early 2000s, around 21% of adults eligible for a subsidy card did not have one.¹⁶ There is also a trade-off with the wider objectives of the PCHS: increasing the share of GPs' revenue from co-payments further weakens the effects of capitation.

¹³ Note this assumes all First Contact funding was spent on GP consultations, and none on nurse consultations.

¹⁴ Pauly (2007)

¹⁵ Raymond et al. (2010)

¹⁶ Cumming and Mays (2009)

69. If you are interested in pursuing changes to target primary care funding, further analysis should consider:
- impacts on the use of health services, and how impacts on health outcomes can be mitigated and monitored;
 - impacts on the financial incentives faced by GPs; and
 - impacts on the wider health system, including secondary demand and ACC.

...through reducing First Contact funding...

70. Table 5 outlines options to reduce First Contact funding which would result in direct savings for the Government. Slowing the growth in First Contact funding would also help manage down costs. Small increases for cost pressures (around 2%) have occurred in the last couple of years.

Table 5: Annual savings from reductions to First Contact funding

		Savings	Average co-payment per consultation (ages 25 – 64)
Reduce average subsidy per consultation (cut First Contact)	by \$5	\$60 million	\$38
	by \$10	\$120 million	\$43
	by \$20	\$240 million	\$53

71. Reducing First Contact funding would likely result in an increase in patient co-payments for GP consultations. How this cost is passed on to patients, and distributed among the patient population, would be at the discretion of GPs. GPs could choose to:
- subsume the cost within their practice, thereby reducing their income;
 - increase fees for all patient categories by an equal amount to cover the loss in income; or
 - allocate the cost across patients in a targeted manner, e.g. by exempting CSC and HUHHC holders from extra fees.
72. The estimated increases in fees in the table above assume that GPs allocated the cost equally across all patients. In order to maintain low or zero fees for some groups the increase would need to be higher for the remaining patients or the savings lower.

...and increasing targeting for low income and deprived populations.

73. Reductions in First Contact funding could be combined with an increased level of targeting towards low income and deprived populations. This could be done on an individual or population basis.
74. One option would be to reduce First Contact funding and introduce a new funding stream targeted at CSC holders. GPs would be required to target the additional funding at CSC holders. Maintaining current fee levels for CSC holders and for under sixes would reduce the savings in the table above by about half.¹⁷

¹⁷ Assuming 40% of over 5 GP consultations are by CSC holders.

- 75. A second option would be to alter the First Contact capitation formula to include income and/or deprivation decile (currently it includes age, gender and frequency of use). This would result in PHOs in poorer areas getting more First Contact funding than PHOs in richer areas. The result, all else equal, would be higher fees for patients in richer areas. Providers could be encouraged to direct any fee increases at those who are better able to pay, for example, through the CSC.
- 76. Another possibility would be to introduce more tiers of funding based on the need of the population. VLCA funding is provided to practices who voluntarily cap their patient fees at or below a threshold set by the Ministry of Health (currently \$0, \$11.50 and \$17 dependent on age).¹⁸ Additional tiers of funding could be introduced in exchange for practices capping their fees. Funding could be withheld from practices that choose to manage their own fees. Practices that cap their fees at low levels would be eligible for more government funding. Admission to the various tiers could be based on the level of need in the patient population (eg. percentage of high-needs populations).
- 77. Table 6 provides an example of how a tiered system could work.

Table 6: Tiered primary care funding system

	Government funding	Max fee
Tier 1 (VLCA)	First Contact + VLCA	\$17
Tier 2	First Contact + half VLCA	\$25
Tier 3	First Contact only	\$40
Tier 4	No government funding	No maximum

- 78. A tiered system would be a larger change to the status quo, and would be a move from individual to population based targeting. It is not clear whether this option would result in savings, but it would be worth considering and may achieve more accountability for primary care funding.
- 79. Primary care funding is more complex than community pharmaceuticals funding, and implementing changes in a short timeframe would be challenging. Moreover, incremental changes may further complicate what is already a complex and fragmented system.
- 80. We recommend that the Ministry of Health considers changes to the funding model and targeting in the context of policy work on the primary care system in 2012. However, should you wish to move more quickly, there are options to generate savings in primary care for Budget 2012.

¹⁸ Subscription to this programme was originally open but was restricted in 2009 to practices with 50% or more high-needs populations.

ANNEX: Primary care funding streams

Table A1 summarises the capitated funding streams which are paid to PHOs to support the management of health outcomes of their enrolled populations. These services are provided differently in different PHOs.

Table A1: Summary of Capitated Primary Care Funding Streams, 2010/11

Funding stream	Description	\$m 2010/11
First Contact	Funding for PHOs to subsidise GP consultations, the main aim of which is to reduce upward pressure on patient co-payments and thus reduce financial barriers to access. Subsidies increase in line with FFT or some measure of cost pressures annually.	558
Very Low Cost Access	Funding for PHOs to subsidise those practices who voluntarily cap their co-payments at or below a threshold set by MoH and DHBs (\$0; \$11.50; \$17, dependent on age). From 2009, registering practices need to have 50% or more high-needs populations. Currently 306 out of the 1100 practices in New Zealand participate in the scheme. Annual VLCA increases are determined by the maximum allowable increases to patient co-payments recommended through the annual fees review process.	41
Zero Fees for Under Sixes	Funding for PHOs to subsidise those practices who voluntarily provide free care patients under 6. Practices cannot be in both Zero Fees and VLCA. Currently 605 out of the 1100 practices in New Zealand participate in the scheme, and 160 practices are in not in either. Annual Zero Fees for Under Sixes increases are determined by the maximum allowable increases to patient co-payments recommended through the annual fees review process.	12
Care Plus	Funding for PHOs to purchase or provide additional services for people who require frequent visits to GPs or nurses because of a chronic condition.	44
Services to Improve Access	Funding for PHOs to purchase or provide additional services (e.g. tailored or outreach services) to reduce inequalities among those populations that are known to have the worst health status: Maori, Pacific people and those living in NZDep index 9-10 decile areas.	42
Health Promotion	Funding for PHOs to purchase or provide appropriate health promotion activities within their communities.	9
Management Fees	Funding for PHOs to provide or purchase management services. Payments are higher for small PHOs.	31
Total		737

Other primary care funding streams are paid to DHBs and distributed to providers on a fee-for-service basis. The table below excludes the amount DHBs spend on community radiology and diagnostics (approximately \$300-\$400m) and on community pharmaceuticals (approximately \$710m).

Table A2: Summary of Other Primary Care Funding Streams, 2010/11

Funding stream	Description	\$m 2010/11
Immunisation Fees	Funding for DHBs to pay GPs for immunisations.	25
General Medical Services + 'clawbacks'	Funding for DHBs to pay GPs for casual and after hours services. Includes 'clawback' mechanism to ensure that funding follows the patient, i.e. if a patient visits a different GP to the one they are enrolled with, the subsidy is taken from their home GPs' capitation funding.	28
PHO Performance Programme	Funding for DHBs to monitor and measure PHO performance against a range of nationally consistent indicators, and to provide performance-based payments to PHOs. Administered by DHBNZ.	18
Primary Mental Health	Funding for DHBs to purchase or provide primary mental health services.	25
Tamariki Ora	Funding for DHBs to purchase or provide WellChild services.	11
B4 School Checks	Funding for DHBs to purchase or provide checkups for children starting school.	9
Diabetes Get Checked	Funding for DHBs to purchase or provide diabetes checkups.	9
After Hours¹⁹	Funding for DHBs to purchase or provide after hours GP services, including rural after hours services.	14
Total		139

¹⁹ This will need to increase to implement free after-hours care for under sixes.