The Treasury

Budget 2012 Information Release

Release Document

June 2012

www.treasury.govt.nz/publications/informationreleases/budget/2012

Key to sections of the Official Information Act 1982 under which information has been withheld.

Certain information in this document has been withheld under one or more of the following sections of the Official Information Act, as applicable:

[1] 6(a) - to prevent prejudice to the security or defence of New Zealand or the international relations of the government

[2] 6(c) - to prevent prejudice to the maintenance of the law, including the prevention, investigation, and detection of offences, and the right to a fair trial

[3] 9(2)(a) - to protect the privacy of natural persons, including deceased people

[4] 9(2)(b)(ii) - to protect the commercial position of the person who supplied the information or who is the subject of the information

[5] 9(2)(d) - to avoid prejudice to the substantial economic interests of New Zealand

[6] 9(2)(f)(iv) - to maintain the current constitutional conventions protecting the confidentiality of advice tendered by ministers and officials

[7] 9(2)(g)(i) - to maintain the effective conduct of public affairs through the free and frank expression of opinions

[8] 9(2)(h) - to maintain legal professional privilege

[9] 9(2)(i) - to enable the Crown to carry out commercial activities without disadvantage or prejudice

[10] 9(2)(j) - to enable the Crown to negotiate without disadvantage or prejudice

[11] 9(2)(k) - to prevent the disclosure of official information for improper gain or improper advantage

[12] 9(2)(ba)(i) - to prevent prejudice to the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied.

Where information has been withheld, a numbered reference to the applicable section of the Official Information Act has been made, as listed above. For example, an [4] appearing where information has been withheld in a release document refers to section 9(2)(b)(ii).

In preparing this Information Release, the Treasury has considered the public interest considerations in section 9(1) of the Official Information Act.

From: [3]
Sent: Wednesday, 11 April 2012 4:08 p.m.
To: ^MOF: Andrew Craig
Cc: Ruth Isaac; John MacCormick; [3]
Subject: pharms copays savings
Attachments: MoH pharms copays costings 11/04/12

Hi AC,

We've spoken to the Ministry about their latest copays costings (attached).

[7] favours a flat-rate increase to $4 or $5 without exemptions. We are comfortable with the costings for this, which are conservative. Increasing to $5 is estimated to generate $40.9m per annum in savings. The variable numbers (para 4) assume a low dispensing fee and do not account for the new service fee and are therefore low.

FM's table of budget options estimates a saving of $47m per year from copays, and does not assume a part year impact for 2012/13 (MoH is working towards a 1 Jan implementation date, giving a half year impact for 2012/13). This creates a savings gap:

	2012/13	**2013/14**	**2014/15**	**2015/16**
FM table	47	47	47	47
MoH costings	20?	40.9	40.9	40.9
gap	27	6.1	6.1	6.1

There are still options to bridge some or all of this gap:

- Press for faster implementation (1 Oct should be achievable; 1 July likely ambitious)
- Changes to eligibility for subsidy cards eg. making family threshold higher than that of individuals [7] nd we don't have a savings estimate)
- Increasing the flat-rate copay slightly above $5 (eg. to $5.50 or $6) will make a big difference

We recommend that MoH still be given a savings target (eg. $50m) and be required to report back with the detail. This will ensure that they have the incentive to pursue the above options.

When this goes to Cabinet (either as a separate urgent paper or in budget cabinet papers), we would recommend that Ministers direct some further reports from the Ministry of Health:

- [within weeks] Detailed advice on implementation of the changes including new clauses required in the new pharmacy agreement (these are needed to ensure pharmacists don't capture the increase and to preserve Pharmac bargaining power). The new pharmacy agreement needs to maintain flexibility for the government to make further changes to copays later.
- [within months] Policy advice (which we would have liked to see in developing this proposal) on how to maximise the cost effectiveness of pharmaceutical subsidies in future, including what the maximum co-payment should be, whether it should differ by type of pharmaceutical, and what the targeting/exemption regime should be.

Note that these increases to co-payments are very modest, only restoring copays to mid 2000s level in real terms. For comparison, in Australia the maximum co-payment is A$34.20 for each prescription item and patients holding concession cards pay A$5.60 per prescription item.

Cheers,
[3]

[3] Analyst, Health and Housing | **The Treasury**

[3]

Free and Frank advice on increasing the pharmaceuticals co-payment

1) This note provides further information on the possible impacts of increasing the pharmaceutical co-pay.

2) These figures have been modelled on Pharmac data and information.

3) **If the co-pay were increased as a flat amount then the following savings could potentially be realised:**

co-payment (HUHC and PSC as present)	Savings with under 6's exempted (current status)	Savings with under 18s and over 65s exempted	Savings with under 18s, over 65s, and CSC holders exempted
$4.00	**$20.4 million**	**-**	**-**
$5.00	**$40.9 million**	**-**	**-**
$7.00	**-**	**$49.2 million**	**$36.5 million**
$10.00	**-**	**$86.1 million**	**$63.9 million**
	Note: this assumes that access rates remain the same		

4) If the co-pay were increased as a variable amount, that is to the total cost to the pharmacist (dispensing fee, drug cost and 4% mark-up) then the following savings could potentially be realised:

co-payment (HUHC and PSC as present)	Savings with under 6s exempted	Savings with under 18s and over 65s exempted	Savings with under 18s, over 65s, and CSC holders exempted
$4.00	$13.5 million	-	-
$5.00	$27.1 million	-	-
$7.00	-	$30.1 million	$22.3 million
$10.00	-	$43.7 million	$32.4 million
	Note: this assumes that access rates remain the same		

- **the effects on Pharmac's purchasing power and data**

Unless changes were made to the current contract with Pharmacies and in the agreed option the co-pay exceeds the drug-cost + mark-up + dispensing fee, pharmacists would not need to submit a claim to the DHB to recover their costs (so we would see a reduction in the volumes of treatments in the data we receive).

Because of this, the DHBs would still pay the full drug and distribution cost of the new treatments that we would fund (this may be offset in part by the increased value of co-

pays). The net effect would be a larger private market (where the Crown's agents are not involved in setting the terms of supply and where Pharmac is not able to obtain data on the number of sales) and a decrease in the value for money of subsidised pharmaceuticals and lower health gain.

Pharmac would potentially be unable to manage stock supply issues as efficiently as at present, if a large private market existed with multiple suppliers operating without agreed terms of supply with Pharmac. At present, whether sole or dual supply, Pharmac is able to work with suppliers on stock management issues.
Purchasing power may be diminished over time if a large private market meant that the size of the subsidised market diminishes and therefore the benefits to potential suppliers reduce.
However , this paper recommends possible changes to the payments systems and contracts that will protect the operation of Pharmac and information flows, except where an OTC is available and could be substituted.

- **Options initially assessed around Implementation**

Proposal 1

- Removing funding and savings from DHB baselines. As the cost is also being removed the reduction can be justified on that basis, the reduction has no impact on the DHB operating or any impact on their activities.
- It could also be that the DHB appropriated baseline be backfilled by devolving other activity ie part of electives funding to maintain appropriated baseline.
- This proposal however does reduce DHB baselines and affects the fully funding argument being used to protect funding levels.
- However this is the easiest option in terms of bureaucracy.

Proposal 2

- The pharmacies collect the additional co-pay and return to the DHBs as part of their billing / payment mechanism.
- Significant system changes may be required to implement. DHBs then would retain the revenue and credit the Community Pharmacy account.
- This method has no impact on Pharmac as the Purchasing, data and payment regimes remain as they are now.
- This method as it is a user pays charge would not be regarded as taxation.
- The amount will also not affect the DHB (except for systems changes and maybe some collection activity), the community pharmacy budget and amount of revenue in the DHB books would be unchanged. This is because one source of revenue (rebates) is being substituted by the rebate.

- The Government as part of this arrangement would require Pharmac to repatriate to the Crown an agreed amount of pharmacy rebates (equivalent to extra user pays fee collected).
- This would essentially be revenue to the Crown in return for purchasing arrangements with Pharmacy companies reflecting bulk purchasing arrangements.
- Rebates are only paid out by the pharmaceutical companies once or twice a year and were previously partially returned to the Crown.
- There would be no net impact on CPB , and no impact on CPSA.

Systems changes:

The system changes required in the up-to cost scenario are less complex than the flat fee scenario, due to the rules based design of the current systems. It is likely that **pharmacists will seek funding to enable the changes** to their systems, they currently use two main systems Healthsoft and Toniq. It needs to be noted that if one flat fee scenarios applies - there will be an effective increase in the price of delivery of community pharmacy services.

5) **It is recommended Ministers discus :**

a)	The level of the co-pay to be set
b)	The implementation preference - either option 1 or 2
c)	The Implementation date of any decision, noting that at least 6 months is required for the Ministry and Pharmacies to make system changes.