The Treasury

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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.

Free and Frank advice on increasing the pharmaceuticals co-payment

1) This note provides information on the possible impacts of increasing the pharmaceutical co-payment. Given the short turnaround and a lack of availability of accurate data, figures are indicative.

2) If the co-payment were increased and the dispensing fee remained at $5.31, then the following savings could potentially be realised:

co-payment	Potential savings	Savings with CSC holders exempted	Savings with under 18s and over 65s exempted	Savings with under 18s, over 65s, and CSC holders exempted
$5.00	$45-50 million	$23-28 million	$20-25 million	$18-22 million
$7.00	$90-100 million	$47-57 million	$41-51 million	$34-44 million
$10.00	$160-170 million	$75-99 million	$65-89 million	$54-78 million
Note: this assumes that access rates remain the same				

3) Pharmacists can claim payment from the Ministry of Health whenever the cost to the pharmacy (the dispensing fee + mark-up + drug cost) of a prescribed item is greater than the co-payment paid by the member of the public. The amount claimed is the difference between the cost to the pharmacy and the co-payment amount. Note: presently the co-payment ($3) is less than the dispensing fee ($5.31) so pharmacies can claim whenever they dispense.

4) Increasing the amount of the co-payment would decrease the cost to the Crown by shifting it to the public, so long as the DHBs' Community Pharmaceutical and Dispensing Budget was reduced by the amount that the Crown expects to save.
   a) Some transactions would become entirely private (that is, no claim would be made because the co-payment would cover the entire cost to the pharmacy).
   b) For other item, the amount claimed by the pharmacist would reduce by the amount of the increase in co-payment.

5) Through the Community Pharmaceutical Services Agreement, DHB are currently negotiating a reduction in total expenditure on dispensing. The future cost growth across the sector is expected to reduce from an average of 8 percent per annum over the last decade to 0 percent in 2012/13, and to 1.5 percent in each of 2013/14 and 2014/15.

6) Implementation issues. There are significant implementation issues which will need to be considered.
   a) Returning the funding:
      - As noted above, pharmacists collect the co-payment and bill any cost above that to the Government. That cost is met from the DHBs' Community Pharmaceutical and Dispensing budget held by DHBs. Any savings in dispensing and community pharmaceutical budget will occur in these budgets held by DHBs.
      - This makes it difficult to return the funding to the Crown without reducing DHB budgets, unless pharmacists could somehow return the additional co-payment (fully or partially) to the Crown and bill DHB's for their cost.

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- If the co-payment is greater than the cost then pharmacists don't need to claim. There is no incentive for them to return the additional co-payment as they would lose any windfall against cost.
- DHBs would then need to reimburse the Crown for the co-pay collected on its behalf. There is currently no system for this.
- If pharmacies were to pay the increased co-payment to the Crown (via the Ministry of Health) this could not be offset against payments, as receipt will be the Crown and payments DHBs. A collection/payment system would need to be established.

b) There are significant system issues involved with changing both Pharmacy and Ministry systems.
c) Pharmacist may not co-operate when there is little incentive
d) The current Pharmaceutical dispensing agreement, which has been agreed with the Pharmacy Guild, will need to be renegotiated to reflect the changes.
e) A smaller universal ($5 or under) fee would be easier to implement, in terms of agreements with pharmacists and changes to systems.

Benefits

7) **Price Competition.** Increased co-payments could lead to pharmacies competing to secure high needs patients and therefore offering discounts to them.

8) **Reduced wastage.** Increased cost may lead to an increase in the perceived value of the medications and therefore to decreased wastage. Consumers may shift to purchasing some medicines (for example paracetamol) over the counter rather than getting them on prescription.

Risks

9) **Complexity.** Changing the co-payment quickly, especially if changes to setting is included, would be risky. The environment and systems involved are complex and there could be unintended consequences or expected benefits may not arise. Therefore we advise a six month implementation period.

10) **Increased uptake of Pharmaceutical Subsidy Card.** These cards, as currently implemented, reduce the co-payment to zero for consumers whose family group have had already had 20 prescribed items dispensed to them in a 12 month period (starting February each year). Uptake of these cards is currently low, as their existence is not well publicised[1], but may increase sharply if co-payments increase.

11) PHARMAC's information indicates that the average adult (aged between 20 and 50) has between 5 and 12 prescriptions filled per year and children have about 5 prescriptions filled per year. A family with two adults and two children therefore fills about 25 prescriptions per year and each of these could be for multiple items.

12) If uptake of the cards increased, then savings to the government would decrease, because pharmacies would claim the items beyond the first 20 and no co-payment would be paid.

[1] Also the return on using a card, given the current $3.00 co-payment, would be relatively low and potentially not considered to be worth the effort of either keeping receipts or using a single pharmacy to fill all of the family's prescriptions.

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13) *Mitigation:* the rules around the Pharmaceutical Subsidy Cards could be changed, but this would have negative impacts on high users, whom the card is intended to assist.

14) **Systems costs for sector and Ministry of Health.** Pharmacy, GP, and Ministry systems would have to be updated. The systems are "rules based" with the costs coded into each rule. Just changing the co-payment is not, therefore, a small undertaking. Changing the co-payment and changing or adding complexity to the entitlements would be a bigger undertaking.

15) The exact cost is not quantified at this stage. Pharmacies and GPs may ask for funding to cover these costs.

16) **PHARMAC loss of information.** PHARMAC uses claims information to inform their bargaining and purchasing; reducing information to them will weaken their bargaining position. The bigger the increase, the larger the reduction in information. This could be mitigated by providing pharmacy's with an incentive to enter information on unclaimed items, but this would have a cost (currently un-quantified).

17) **Change to nominal Community Pharmaceuticals Budget.** The nominal Community Pharmaceuticals Budget for 2012/13 has already been agreed and would need to be changed. This would require Ministerial sign-off.

18) **Community Pharmaceutical Services Agreement.** The new pharmacy agreement has not been finalised. The changes could impact pharmacy accepting the new agreement. M*itigation:* officials note, however, that pharmacy has typically been positive about increases to co-payments.

19) **Potential increased costs to Ministry of Social Development (MSD).** Some of the cost of increased co-payments could effectively transfer to MSD because of those entitled to sickness or disability allowances claiming the costs. Officials do not know the extent of this risk. It could be mitigated by exempting Community Service Card holders from the co-payment increases.

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