The Treasury

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[40]	Not in scope	

In preparing this Information Release, the Treasury has considered the public interest considerations in section 9(1) and section 18 of the Official Information Act.

Cost Benefit Analysis Template

Section A Descriptive Information

Vote	Health
Responsible Minister	Hon Dr Jonathan Coleman
Initiative title	Primary Care- additional support

Funding Sought ($m)	2016/17	2017/18	2018/19	2019/20	2020/21 & outyears	TOTAL
Operating	-	9.585	9.585	9.585	9.585	**38.34**
Capital	-	-	-	-	-	**-**

Problem Definition

A description of the problem or opportunity that this proposal seeks to address, and the counterfactual.

Primary health care plays a key role in the health and social sector

Primary health care services play a key role in providing health and disability support to all New Zealanders, as well as providing a key point of contact for social support to vulnerable families. Working alongside other health and social service providers, primary health care professionals can potentially play a key role in meeting the Governments goals for improving the lives of vulnerable people through better integration across the social sector. Primary health care professionals have been central to meeting the Better Public Services immunisation result; they could play a greater role in others such as reducing long-term welfare dependence. Primary care is also a lynch pin in delivering better integrated services, closer to home, as outlined in the New Zealand Health Strategy.

The Ministry of Health holds funding for particular schemes intended to improve access to primary health services for high needs groups (including children)

A high proportion of NZers have unmet needs due to barriers to accessing care, including the financial barrier of paying a copayment. The NZ Health Survey estimates that 14% of adults have foregone a GP visit due to cost.[1] To help address this the Government provides funding over and above that which they receive from DHDs, to primary care practices which undertake to provide free visits for children under 13, and to practices which sign up to cap copayments at $17 (the 'Very Low Cost Access', VLCA, scheme).

There is also a supply side issue arising from the capitation formula used to allocate funding from DHBs to general practice. While the formula is designed to incentivise prevention, it does not recognise the additional and unavoidable costs faced when providing appropriate level of care to people with chronic conditions. To help address this, PHOs are paid additional funding for each enrollee with chronic health conditions under the scheme 'Care Plus'.

This initiative directly addresses cost and volume pressures associated with these schemes

The sources of volume pressures include:

- Increased utilisation of free services by under 13 year olds (we expect this to plateau, after an initial rise following the introduction of the free care for under 13s scheme)[2], and natural population increase.

[1] Annual Update Key Results, 2014/15, New Zealand Health Survey p.34 http://www.health.govt.nz/publication/annual-update-key-results-2014-15-new-zealand-health-survey, accessed 12 December 2016.

[2] During the first year of providing free care for children aged 6 – 12 (inclusive), average utilisation of GP services in this age group increased from 1.8 visits per child to 2.1

- Natural population increase in VLCA practices
- Increase number of people eligible for Care Plus payments, with increasing incidence of long term conditions and population aging.

In addition to the usual sources of price pressure, arising through price inflation and wage settlements, primary health care organisations are constrained in their ability to raise revenue by increasing prices.

- The fees ("copayments") they are able to charge all patients are regulated under an annually negotiated fees framework. Copayments comprise about one third of the revenues of most practices. (Most primary care practices have a business model which relies on fee for service revenue, generated by a copayment on each appointment. This comprises about a third of their revenue.[3]
- When they enter the VLCA or free care for under 13s schemes, practices undertake to cap their co-payments at zero for children and, if a VLCA practice, at $17.50 for adults. To compensate practices for this, the primary care contract (PSAAP) specifies: "We agree that the Ministry will increase, on an annual basis, the payment rates for very low cost access… zero fees for under 13s… by the amount required to compensate practice providing those Services for not being able to increase their patient co-payments, and that such amount will be no less than the reasonable fee increase amount specified in the Annual Statement"[4]. It is important to note that additional utilisation following the introduction of free care for under 13s, while a good thing, comes at the expense of appointments for which a co-payment can be charged, for practices operating at full capacity.

This initiative also addresses morale and engagement

By compensating for reasonable cost pressures, this initiative also indirectly addresses morale, and the capacity and willingness of primary health care professionals to support wider government initiatives. Commentators report increasing concern among general practitioners (GPs) that their businesses are not viable and that government is not complying with its contractual obligation to "work with the sector to ensure the sustainability of general practice"[5]. This obligation matters, both formally and informally, since it is a sign of good faith to the primary care professionals on whose goodwill we rely for participating in new initiatives and in meeting Government priorities.

Initiative Description
A description of what the initiative will provide or produce and how this will address the problem or opportunity.

This initiative will provide cost pressures funding that meets contractual obligations (in the PHO Services Agreement) to increase funding rates, and to meet increased volumes as outlined above.

The funding pool available for performance payments (the "System Level Measures") is tied to enrolment numbers. An additional 110,000 are expected to enrol in PHOs in 2017/18, needing an additional $582,000 in the performance payments pool.

The following table breaks down the various components of the cost pressures.

[3] Dovey, S., et al. (2011). "Public and private funding of general practice services for children and adolescents in New Zealand." Health Policy **103**(1): 24-30.

[4] PHO Services Agreement, Part F, 3. Page 86, http://psaap.org.nz/contract-documents/pho-services-agreement/

[5] PHO Services Agreement, Part F, 2b Page 85, http://psaap.org.nz/contract-documents/pho-services-agreement/

Budget exercise	Budget 17
GG decision	Supported

Row Labels	Appropriation	Type	Detail	17 18	18 19	19 20	20 21
Service Commissioning							
Primary care - Care Plus	Primary Health Care Strategy	Volume-driven (non-personnel)	Estimated growth in Care Plus eligible (mainly driven by ageing population)	3.229	3.229	3.229	3.229
Primary care - Care Plus	Primary Health Care Strategy	Price-driven	Estimated annual price increase (estimated at 2%)	1.342	1.342	1.342	1.342
Primary Care - Free Under-13s	Primary Health Care Strategy	Price-driven	Estimated funding increase of 2.84% to 2.99% to compensate practices for not being able to increase Under 13s co-payments (to be negotiated through PSAAP in March 2017)	0.882	0.882	0.882	0.882
Primary Care - Free Under-13s	Primary Health Care Strategy	Price-driven	Estimated annual price increase of 2% per annum (to be negotiated through PSAAP in March 2017)	0.604	0.604	0.604	0.604
Primary Care - System Level Measures	Primary Health Care Strategy	Volume-driven (non-personnel)	Based on projected increase in total enrolled populations annually for PHOs	0.582	0.582	0.582	0.582
Primary Care - VLCA/U6s	Primary Health Care Strategy	Volume-driven (non-personnel)	Based on projected increase in total enrolled populations annually for PHOs	0.203	0.203	0.203	0.203
Primary Care - VLCA/U6s	Primary Health Care Strategy	Price-driven	Estimated funding increase of 2.84% to 2.99% to compensate practices for not being able to increase co-payments above maximum co-payment levels (to be negotiated through PSAAP in March 2017)	1.569	1.569	1.569	1.569
Primary Care - VLCA/U6s	Primary Health Care Strategy	Price-driven	Estimated annual price increase of 2% per annum (to be negotiated through PSAAP in March 2017)	1.174	1.174	1.174	1.174
Service Commissioning Total				**9.585**	**9.585**	**9.585**	**9.585**
Grand Total				**9.585**	**9.585**	**9.585**	**9.585**

Alternative Options Considered

Status quo: This is not an option, given contractual obligations to meet cost pressures and the increasing level of need in vulnerable groups – the consequences of not meeting contractual obligations include the formal penalties but also the risk that primary care professionals will disengage from key integration initiatives and, over time, from the schemes.

Reprioritise funding from other primary health care programmes: Already absorbing considerable pressures across the Ministry's NDE appropriations.

Allow GPs to maintain revenue by increasing co-payments

- One option is to allow GPs to increase co-payments charged to patients in the schemes – for example, to raise the VLCA threshold from $17.50 to $20, or to allow a $5 charge on visits by under 13 year olds. This was rejected on equity grounds, in that it would further increase hardship/reduce access for those currently in the schemes.
- Another option is to allow GPs to increase co-payments for patients not in these schemes which would entail changing the current fees regulation scheme. Again, this was rejected because of its impact on the people in these practices who are high needs but not in a VLCA practice.
- Moreover there is no evidence that increasing copayments is associated with increased efficiency[6] or that it would discourage "frivolous" use. We would expect it to be associated with the types of impact discussed in Section B below, including increased Emergency Department attendance and increased Avoidable Hospitalisations.

Section B Impact Analysis

Impact Analysis

An explanation of who is impacted (winners and losers), what the impacts are (costs and benefits), and when the impacts will be realised and for how long. The impacts should be quantified and monetised if possible.

6 New Zealand Treasury, 2013, Health Projections and Policy Options, Background Paper For The 2013 Statement On The Long-Term Fiscal Position. http://www.treasury.govt.nz/government/longterm/fiscalposition/2013/pdfs/ltfs-13-bg-lhppo.pdf, accessed 11 December 2016

Experts advise that meeting these cost pressures is necessary if GPs are to continue participating in the schemes. The advice is that without compensation for cost pressures 10% of GPs might leave these schemes within 12 months, and that this proportion will escalate over time. (We model this more conservatively, assuming 10% leave after four years, to show the significant impact this would have. And rather than directly modelling GPs leaving the scheme we model the impact if 10% of the population is no longer covered by the schemes.)

There is a general proven relationship between income, and recruitment and engagement.[7] However there is also evidence that health professionals are not motivated primarily by financial rewards, although appropriate payment is an important part of a recruitment, retention and motivation strategy[8]. For self-employed professionals, such as most GPs, appropriate payment is also essential to the viability of their business.

Disputes between health professionals and the government affect public trust in and perception of the health and public sector more generally.

We expect the demand side impacts of no longer providing lower co-payments to include:

- People shifting demand to free-at-point of use services (ie an increase in Emergency Department attendances).
- People delaying visits to a primary care professional (or not visiting them at all when symptoms emerge) leading to an increase in avoidable hospitalisations. This may lead to an increase in potentially avoidable mortality, but we do not have an evidence base for this.
- People delaying and making less frequent visits to primary care professionals, leading to a decrease in preventative activity and an increase in poorly managed long term conditions. We illustrate this effect by modelling an increase in costs attributable (and QALYs lost from) diabetes and cardiovascular disease.
- People paying privately for visits to the GP or primary care professional – we have modelled this at a lower rate of utilisation than when visits are subsidised by these schemes. (We use as utilisation rates those observed after the introduction of free care for under 13 year olds, i.e. an average of 1.8 visits for visits at the usual, lower subsidy compared with 2.1 under the schemes covered in this initiative).

We expect the supply side impacts of not compensating for cost pressures to include:

- As noted above, practices are expected to opt out of the schemes. We have modelled this in terms of the demand-side impacts.
- Those practices that do not leave the schemes will be less able to provide services that do not carry co-payment revenue. We have not modelled this impact. It might be evident in, for example, longer time lapses between routine regular appointments to support people with long term conditions.
- Disaffection, decreased morale and less engagement. We would expect this to be evident in lower willingness to participate in wider government initiatives such as supporting people off benefits and back to work. We have illustrated this in the model, with very conservative assumptions about the impact on welfare expenditure.

Modelling assumptions

The approx. size of the populations covered by each of the schemes are shown in the following table. Overlap in the people who are in each scheme has been accommodated as follows:

- There is no additional benefit to being in VLCA and being under 13, so we count only the net population.
- However we assume additive benefit from being in VLCA / under 13 or in Care Plus, so count as "two" any individual who is in both.

Scheme	**Approx no. people covered**
Free Care for under 13s	800,000 (of whom 273,000 are in VLCA practices)
Very Low Cost Access	1,373,000
Careplus	260,000
Total number enrolled in each scheme	**2,433,000**
Target population in the model	2,160,000 (assume no attrition over time)

[7] Kreps, 2014.

[8] Scott, 2001; Scott et al. 2013.

Impacts - Identify and list $m present value, for monetised impacts	Option 6%	 3%	Assumptions and evidence (quantify if possible, and use ranges where appropriate)	Evidence certainty
Estimated impact on key outcomes				
See below				Low
Cost of the Initiative				
Increase in fees paid to primary care to meet cost pressures in particular schemes	(121)	(179)		High
IMPACT 1 Reduction in people on General Supported Living Allowance	61	130	In the absence of the initiative decline in number of people coming off benefit and returning to the workforce, because chronic conditions less well managed and GPs less able to engage in meeting Government priorities. Conservatively assume a very small impact, ie a 25% chance of an additional 100 people (0.005% of target population) on benefits for average 25 years.	Low
IMPACT2 Reduction in hospital admissions	149	340	In the absence of this initiative, over time primary care less able to provide timely preventive services and manage care closer to home, reflected in an increase in acute admissions in this vulnerable population from 0.7% to 1%. (Assumes that in a fully integrated DHB, acute medical admissions (age standardised) are 0.7% (7 per 1000 people; compared with 1% (10 per 1000 people across the country as a whole).[9] Assume effect starts after 4 years, with 25% likelihood, costs are average inpatient cost.	Low
IMPACT 3 Reduce ED attendances	13	23	Over time, practices unable to continue providing free care for under 13s and participate in the Care Plus & VLCA schemes. Assume in four years, 10% of the people currently cared for under the scheme no longer have access, and that 5% of that 10% have an ED attendance each year. [10] Assume 25% likelihood.	Low
IMPACT 4 Reduction in poorly managed / complications from chronic conditions including diabetes	1,626	3,706	Over time, practices unable to continue providing free care for under 13s and participate in the VLCA scheme, moreover PHOs no longer receive Care Plus funding. Assume in four years, 10% of the people currently cared for under the schemes no longer have access, and that 5% of that segment develops diabetes or has poorly managed diabetes which would previously have been either prevented or well managed. Assume 25% likelihood.	Low

[9] Kings Fund Report, p.56.

[10] In the first year of the Free Under 13s scheme, there was a 4.7% reduction in low severity presentations across the whole group (HR20161556). And Kings Fund estimate that following the improvement in integration in one DHB there was a reduction of 2 – 4% in ED attendances in people aged over 60. (p.37)

IMPACT 5 Reduced incidence of Cardiovascular Disease	154	350	In the absence of the initiative, an additional 10,000 people per year who are eligible will not receive Care Plus funding. Assume that this limits PHOs ability to engage in prevention and early intervention of chronic conditions (proxied by Cardiovascular Disease), so 25% likelihood that 5% of this additional group develop the condition.	Low
IMPACT 6 Reduction in Ambulatory Sensitive Hospitalisations	50	113	Ambulatory Sensitive Hospitalisations (ASH) are a measure of system integration. In the absence of this initiative, assume that over time, primary care becomes less engaged with the rest of system, and one impact of this is a 25% likelihood of a 5% increase in ASH in vulnerable population from year 4 (from 2,000/100,000 to 2,100/100,000).[11]	Low
Total Quantified Government Impact	**2053**	4662		Low
Impact 8 Increase in QALYs	196	346	Due to complications and progression of chronic diseases averted a considerable number of QALYs are likely to be gained. Conservatively estimated here to be a 25% probability of an additional 0.01 QALY over lifetime of the people assumed to avoid CVD or diabetes.	Low
Impacts 7 & 9 Reduction in privately funded GP visits	229	523	We assume that in the absence of this initiative, after 4 years 10% of practices would withdraw from the schemes (25% likelihood), and so no longer provide the free or lower co-payment services. This means that most patients would need to pay the usual co-payment for primary care visits. We assume that this is $40, and that they would have previously paid $17.50 under VLCA (this ignores the impact on children), and include as the counterfactual the net increase in co-payment. We assume the lower utilisation rate discussed above, ie fall in average visits from 2.2 to 1.55 per year. We also abstract from the different utilisation rates and co-payment rates for different types of visit to different types of primary care professionals.	Low
Net Present Value of Total Quantified Societal Impacts	**2,357**	**5,352**		Low

[11] cf Health and Independence Report 2015, ASH rate in whole population is about 2,000/100,000, unchanged overall since 2010

Section C Conclusions

Conclusions *What is being recommended and why?*
The initiative recommends funding primary care in a way which meets volume pressures and maintains the value of funding paid to primary care professionals. This will support primary care activity, honour contractual obligations, and contribute to the engagement of health professionals who are key to realising the goals of the New Zealand Health Strategy.

Overall Ratings	
Value for Money	**Strategic Alignment**
5	5
Rating from 0-5. Consider monetised and unquantified impacts and evidence base. 5 High value / return confident, 4 High/medium return likely, 3 medium/break even confident, 2 medium/break even likely, 1 low/break even unclear, 0 no returns / value loss	Rating from 0-5. Consider alignment with government strategic direction and priorities, and cross-government action. 5 Strong alignment, 4 High alignment, 3 Some alignment, 2 Limited alignment, 1 Low alignment, 0 No alignment

Summary of monetised results		
Use ranges for values where appropriate	**Discount Rate**	
	6% real (default)	**3% real (sensitivity)**
Net Present Value (NPV)[12]	2,357	5,352
Benefit Cost Ratio (BCR)[13]	20.4	30.8
Return on Investment (ROI) – Societal Total[14]	20.4	30.8
Return on Investment (ROI) – Government[15]	18.8	28.9

[12] **Net Present Value (NPV**) - The NPV is the sum of the discounted benefits, less the sum of the discounted costs (relative to the counterfactual). This gives a dollar value representing the marginal impact on the collective living standards of all New Zealanders of the initiative, in today's dollar terms.

[13] **Benefit Cost Ratio (BCR**) - The BCR is the ratio of total discounted benefits to the total discounted costs. A proposal with a BCR greater than 1.0 has a positive impact, because the benefits exceed the costs. The BCR is the same as the Return on Investment Societal Total, unless there are negative impacts in addition to the fiscal cost of the initiative. All negative impacts are included in the denominator for the BCR measure.

[14] **Return on Investment (ROI) - Societal Total** - Calculate the ROI by dividing the discounted net change in wider societal impact, including benefits to government, by the discounted cost of the initiative. This can be interpreted as the impact for New Zealanders per dollar the government spends on the initiative, eg, for every $1 the government spends on this programme, New Zealanders receive benefits of $3.

[15] **Return on Investment (ROI) – Government** – Calculate the ROI by dividing the discounted net change in impact for the government by the discounted cost of the initiative. This measures the discounted net marginal (fiscal) benefits to the government.

Supporting Evidence

ie, the bibliography

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Ex-post Impact Evaluation Plan

How will you evaluate (after the programme has been rolled out) what the effect of the programme was, particularly on the impacts listed in Section B?

Data collection and impact evaluation method NA because BAU
Funding of evaluation
Completion dates, publication, and dissemination of findings to key stakeholders

Appendix 1 One-page Intervention Logic

Intervention	Outputs	Outcomes	Impacts (relative to counterfactual)
Maintain the value of payments which improve access to primary care for vulnerable populations	Maintain utilisation of primary care by the high needs populations	Patient experience is optimised (Care Closer to Home), reduced rate of growth of chronic health conditions such as Cardiovascular Disease and Diabetes.	Maintain (do not increase) avoidable Emergency Department Attendances and Inpatient events, reduce
	Honour contractual obligations to maintain the real value of primary care funding		Trusted by primary care professionals, who are better able to participate in integration initiatives, including across the social sector.

Appendix 2 Attach CBAx Outputs Summary