133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

3 June 2022

s 9(2)(a)

By email: s 9(2)(a)
Ref: H202205430

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) on 18 April 2022. You specifically requested:

> *In regard to the refinement of this request (H202204227), I am hoping to see if the following request would be suitable to resubmit. For context, I am hoping to analyse existing information (documents, reports, legislation, communications) surrounding the pharmaceutical co-payment in order to understand the context in which it has been situated over the previous ten years or so (2011 to present). I am particularly interested in the reasoning behind policy decisions and changes to the pharmaceutical co-payment during this time and material that considers issues of equity and the reduction of inequities, in addition to, access to healthcare and the reduction or management of barriers to healthcare.*
>
> *My initial request is shown below:*
>
> *"All information concerning the pharmaceutical co-payment from 1st January 2011 until the present date.*
>
> *This includes all correspondence, including letters, memoranda, emails, fax communications, texts and recordings or minutes of any electronic conferences, files notes, agendas, briefings, advice, reports, internal policy documents, guidelines and legislative drafting instructions by the Ministry (Minister and their office) from 2011 until the present date.*
> *Including internal communications and communications made externally, such as fax message communications sent from the Ministry to pharmacies or organisations."*
>
> *I would like to propose the following request as a refined version, in order to meet your requirements.*
>
> *All formal reports, policy briefings or advice, cabinet minutes, investigations, and meetings or consultations with key stakeholders that concern the pharmaceutical co-payment from 1st January 2011 until the present date. Specific focus on events where the co-payment has faced reform (including cost reduction, increase, or removal) and reasoning behind these decisions for change or no change, including consideration of inequity and access to care.*

On 1 May 2022 you sent an amendment to your request:

> *In addition to my existing request (H202205430), I would like to request information held regarding the number of community pharmacies that offer discounted prescriptions or do not charge the prescription co-payment. I do not require the pharmacy names or contact details but an approximate number per DHB or in relation to geographical location would be appreciated. For context, in 2019 the Commerce Commission stated that pharmaceutical co-payment discounting was not widespread, hence, I would like to know if this still stands true.*
> *Thank you for your assistance, happy to discuss this further if needed.*

The decision not to collect the prescription co-payment is a commercial decision for each pharmacy contractor. The Ministry of Health (the Ministry) does not hold data on which pharmacies collect the prescription co-payment. For information on which pharmacies offer 'free prescriptions' please visit the following link: www.healthpoint.co.nz/.

The Ministry has identified six documents within scope of your request. These are itemised in Appendix 1 of this letter, and copies of the documents are enclosed. Where information has been withheld this is recorded in Appendix 1. I have considered the countervailing public interest in release in making this decision and consider that it does not outweigh the need to withhold at this time.

I trust this information fulfils your request. Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry of Health website at: www.health.govt.nz/about-ministry/information-releases.

Nāku noa, nā

Adeline Cumings
Group Manager
Primary Health Care System Improvement and Innovation
Interim Health New Zealand

Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	22 November 2012	Future policy direction on pharmaceutical co-payments: SOC paper	Released with some information withheld under the following section 9(2)(a) of the Act to protect the privacy of natural persons, including deceased natural persons.
2	27 September 2013	FAQ: pharmaceutical co-payments	Released in full.
3	27 April 2018	Prescription co-payments	Released with some information withheld under section 9(2)(a) and section 9(2)(f)(iv) of the Act to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials.
4	November 2019	Memorandum: Alternative Options in Primary Care – Prescription co-payment subsidy	Released with some information withheld under section 9(2)(a).of the Act.
5	December 2019	Memorandum: Options for the Prescription Co-payment	Released with some information withheld under the following sections of the Act: • section 9(2)(a). • section 9(2)(ba)(i) to protect information that is subject to an obligation of confidence and making it available would likely prejudice the supply of similar information, or information from the same source.

#	Date	Document details	Decision on release
6	October 2019	Abolition of Pharmacy (prescription) co-payments	Released with some information withheld under section 9(2)(a) of the Act.

Document 1

MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20121670

Action required by: **routine**

File number: **HC13-10-12**

Health report

Hon Tony Ryall (Minister of Health)

Future policy direction on pharmaceutical co-payments: SOC paper

Advice

1. Attached is the report-back Cabinet Social Policy Committee paper on the future policy direction for the pharmaceutical co-payment, and associated documents.

Outline of the paper

2. The Budget 2012 decision increasing the standard pharmaceutical co-payment from $3 to $5 takes effect on 1 January 2013. This provides a rare opportunity to gather data on how co-payments affect consumers and their use of medicines. The Ministry of Health and PHARMAC will carefully monitor any effects and this will provide an evidence base for future decisions on what the standard co-payment should be in the long term.

3. The current co-payment regime is unnecessarily complex, and some immediate simplification is justifiable. The paper proposes that existing $10 and $15 co-payment level paid by people whose prescriptions were written by private prescribers should be aligned with the standard co-payment from 1 July 2013.

4. The Ministry's estimate of the impact of this simplification has changed since an early draft of the paper was provided to you. After discovering an error, officials now estimate that this proposal may cost up to $1.7 million, which can easily be absorbed within PHARMAC's Combined Pharmaceuticals Budget ($1.7 million is about 0.02 percent of that budget). Previously, officials had thought that the proposal would actually generate an unknown (but thought to be small) amount of revenue.

Consultation

5. The Ministry of Social Development and PHARMAC were consulted in the drafting of the paper. The Treasury and the Department of the Prime Minister and Cabinet were informed.

Timing

6. You have indicated that you wish to take this paper to the Committee for consideration on Wednesday, 28 November 2012. A letter seeking the late addition of the paper to the agenda is attached for your signature.

The Ministry recommends that you:

a) **Sign** the attached papers and submit them to the Cabinet Office by 10am Monday 26 November for discussion at the Cabinet Social Policy Committee on 28 November 2012. Yes / No

Don Gray
Deputy Director-General
Policy

Minister's signature

Date

Health Report number: 20121670

Ministry of Health contacts

Oliver Poppelwell		Blaise Drinkwater	
Manager, Sector & Services Policy		Policy Analyst, Sector & Services Policy	
Phone	s 9(2)(a)	Phone	s 9(2)(a)
Cellphone	s 9(2)(a)	Cellphone	—

Minister's feedback on quality of report

Very poor (1)	Poor (2)	Neutral (3)	Good (4)	Very good (5)

Document 2

FAQ: pharmaceutical co-payments

What is the 'pharmaceutical co-payment'?

When you pick up a prescription from the pharmacist, you pay a small amount (usually $5) for each fully-funded prescription item. You pay this amount for each medicine: for example, if you've been prescribed three medicines, you'll usually pay $15. This is the pharmaceutical co-payment, and it's a contribution towards the cost of the medicine.

Why did the co-payment go up to $5?

As part of Budget 2012, the Government decided to increase the standard co-payment from $3 to $5. This took effect on 1 January 2013 and saves the Government about $40 million per year. The result is that more medicines can be subsidised.

Why did I have to pay *more* than $5 for my medicine?

Usually, this means one of three things has happened:

1. *Your pharmacist has provided an extra service* – This could include special packaging or delivery.

   If your pharmacist is going to do this, he or she should always tell you first and get your agreement.

2. *Your medicine might not be fully funded* – The Government pays for most medicines used in the community, and your contribution is just the $5 co-payment. But there will never be enough money to fund all medicines in full. Some medicines are funded in part: you cover the fraction of the price that the Government doesn't. Some medicines aren't funded at all: you pay for the full cost of these. If a medicine isn't funded, it is usually because a funded alternative is already available.

   When your doctor writes a prescription for you, ask if the medicine is funded. If it isn't, ask if there is a fully funded alternative that is suitable for you.

3. *Your prescriber is a private clinician* – If your prescriber is working in a private capacity (like most dentists and optometrists do), you will probably have to pay a $15 co-payment ($10 if you're under 18).

   Most of the time, your prescriber is working for a district health board (DHB) or for a clinic that is part of a primary health organisation (PHO), and your co-payment will only be $5. This covers the vast majority of prescriptions.

   If you're worried about this, the time to ask "will prescriptions cost me $5 or $15?" is when you're booking an appointment. Let them know if you have a Community Services Card or a High-Use Health Card – it makes a difference.

Why did I have to pay *less* than $5 for my medicine?

If the prescription is for an under-6-year-old and the medicine is fully funded, the co-payment is $0: free.

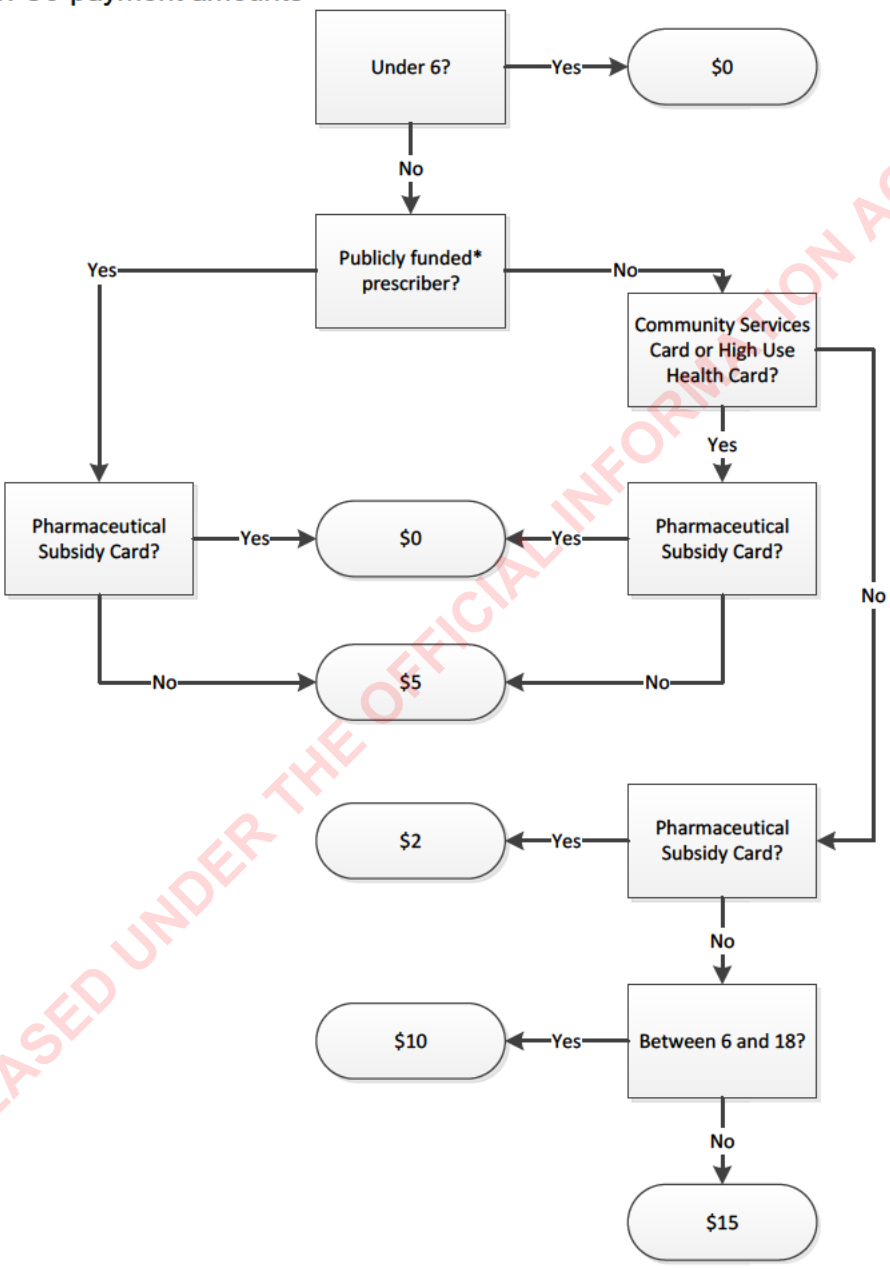
If the prescription is for an adult and you got charged no co-payment, then you most likely have a Prescription Subsidy Card. This means that your family has had more than 20 prescription items this year (since February). You probably won't have to pay another co-payment until next year. (There is one exception: if your prescriber is a private clinician, you *might* have to pay a $2 co-payment for each prescription item, but not if you have a Community Services Card or a High-Use Health Card). Remember to bring your Prescription Subsidy Card to the pharmacy when you pick up your medicine.

There are other reasons your co-payment might be lower: your pharmacist may simply choose to charge less (at their own cost), or one of a number of exemptions may apply to you – your prescriber will let you know.

Co-payments sound complicated. Do you have a diagram?

The Ministry of Health acknowledges that co-payments are a bit more complicated than they might need to be, and is looking to see if simplifying things is something that can be done without costing too much. With that in mind, here is the diagram the Ministry uses:

Diagram 1: Co-payment amounts



* 'Publicly funded prescriber' means a prescriber working for a DHB, or in a clinic that is part of a PHO contracted to a DHB. Examples of *privately* funded prescribers include most dentists, optometrists, and private specialists.

How do I get a Prescription Subsidy Card?

The easiest way is to pick up all your family's prescriptions from the same pharmacy. If you go to a different pharmacy, keep the receipt and bring it to your usual one. Make sure your

pharmacist knows your address and who's in your family, and everything else should be sorted out for you.

Once your family has had 20 prescription items for the year, you shouldn't have to pay co-payments again until the next February. Remember to bring your Prescription Subsidy Card to the pharmacy when you pick up your medicines.

For the purposes of the Prescription Subsidy Card, a 'family' is:

- a married or partnered couple, with or without dependent children, or
- one person with 1 or more dependent children, or
- one person who is not a member of a family of the kinds listed above.

Where can I get more information?

The Ministry's website – health.govt.nz – has more detailed information about the pharmaceutical co-payment, the Budget 2012 change to the standard co-payment, and the Pharmaceutical Subsidy Card.

If you have a specific question that you can't find an answer to there, feel free to ask any pharmacist.

Document 3

MINISTRY OF HEALTH
MANATŪ HAUORA

Health Report number: 20180836

Security classification: In-Confidence

File number: AD62-14-2018
Action required by: Routine

Prescription co-payments

To: Hon Dr David Clark, Minister of Health

Purpose

This report provides you with background to current policy and practice in relation to prescription co-payments and options for reviewing prescription co-payments policy.

Key points

- Currently, the maximum co-payment for standard prescriptions is set at $5. Ministry officials have become aware of sector concerns about some pharmacies charging a lower co-payment and some charging no co-payment.
- You have received correspondence from s 9(2)(a) (C1800430 attached) that expresses concerns with this practice. It also asks how this practice interacts with the prescription subsidy scheme. A Pharmaceutical Subsidy Card (PSC) limits the co-payment of prescriptions for an individual or family to the first 20 items in a year.
- At face value, Ministry officials consider that the practice of some pharmacies charging less or no co-payment may improve access, particularly given the evidence that co-payments may present a barrier for some to access medicines.
- You have indicated your intention to undertake a review of primary health care. The Ministry has provided advice on the potential scope of the review (HR20171863 refers) which suggested it look at reducing barriers to access and addressing practice sustainability.
- The Ministry recommends the policy for prescription co-payments, and broader considerations of access to medicines, be included in the primary health care review.
- Reviewing prescription co-payments as part of the primary health care review will ensure that these issues are considered within the wider primary health care policy settings. We recommend including a focus on access to medicines within the context of barriers to access.
- Based on the outcome of this review, the Ministry would be in a better position to determine whether any further action is required in relation to concerns raised around current pharmacy practice. Based on your feedback on this advice, officals will prepare a response to the recent correspondence about prescription co-payments.
- Offcials can provide you with further advice about how access to medicines and prescription co-payments could be included in a revised scope for the primary health care review.

Contacts:	Caroline Flora, Group Manager, Population Outcomes, Strategy and Policy	s 9(2)(a)
	Andi Shirtcliffe, Chief Advisor – Pharmacy, Office of the Chief Medical Officer	s 9(2)(a)

Health Report number: 20180836

Prescription Co-payments

Recommendations

The Ministry recommends that you:

a) **note** that some pharmacies are charging considerably less than $5 co-payment for prescriptions, and sometimes $0, for standard prescriptions.

b) **advise** the Ministry of your desire to maintain status quo (do nothing) **Yes / No**

OR

advise the Ministry that you would like them to review prescription co-payments (as a standalone project) **Yes / No**

OR

advise the Ministry of your preference to include within the scope of the primary health care review access to medicines and prescription co-payments (recommended option) **Yes / No**

c) **advise** the Ministry if you would like to see a revised draft scope for the proposed primary health care review **Yes / No**

Caroline Flora
Group Manager, Population Outcomes
Strategy and Policy

Minister's signature:

Date:

Health Report number: 20180836

Prescription Co-payments

1. This report provides you with information about recent concerns raised by parts of the pharmacy sector about the discounting of prescription co-payments and outlines options for how the Ministry could proceed.

Context

2. Pharmacist and pharmacy practice, and as a result patient safety, is influenced by a number of levers and controls. The quality of medicines and of pharmacist services are regulated by the Medicines Act 1981 and the Health Practitioners Competence Assurance Act 2003.
3. Some of the concerns being raised in relation to co-payments are likely to be contributed to by other changes occurring in the pharmacy sector, including a new pharmacy contract, and increased corporate investment in pharmacy.
4. DHBs are currently consulting on a new pharmacist services contract (Integrated Pharmacist Services in the Community Agreement - IPSCA) for implementation from 1 July 2018. The intention is to shift from a 'one size fits all' approach to a tiered contracting model. This will provide national contracts for the supply of medicines and standardised services, while allowing DHBs greater flexibility to commission services locally to meet their specific population needs. DHBs are also offering a one-year extension to the current Community Pharmacy Services Agreement 2012 for those contract-holders who do not wish to sign the IPSCA from 1 July 2018.
5. Some parts of the pharmacy sector are concerned about the influence of corporations in the pharmacy market. The Medicines Act 1981 requires majority ownership and effective control by a pharmacist, but allows non-pharmacists and corporations to have shareholdings of up to 49 percent. s 9(2)(f)(iv) [redacted]

Current policy

Co-payments across the primary health care system

6. A co-payment is a type of user charge, where an individual pays part of the cost of a service and the remaining share is met by another party (eg the government).
7. Co-payments can serve a useful function by:
   a. reducing the cost to the public purse of publicly funded services (eg prescription co-payments)
   b. contributing to service providers' revenue (eg general practice co-payments)
   c. reducing demand for low-priority use of health services.
8. Co-payments drive different consumer and provider behaviour depending on the way they are configured. For example, general practice co-payments contribute to providers' revenue, but prescription co-payments do not. Instead prescription co-payments reduce the cost to the health system of pharmaceuticals by collecting a fee on subsidised medicines.

Prescription co-payments

9. When people get a prescription filled at a pharmacy they pay a small amount towards the cost of each government-subsidised medicine on their prescription. This is the prescription co-payment that is set by the government. The maximum co-payment is set at $5. Surcharging over the $5 co-payment is prohibited under the national contract.
10. The money from prescription co-payments offsets some of the subsidy paid by district health boards (DHBs) for medicines and dispensing fees.

11. This reduces the cost to the government of subsidising community pharmaceuticals. This co-payment does not contribute to pharmacy revenue – it is wholly collected by government.

12. In 2016/17 DHBs paid approximately $427 million to community pharmacies to dispense and advise on 69 million prescriptions. Around $100 million was collected in prescription co-payments.

13. Standard co-payments are defined in the Community Pharmacy Services Agreement (CPSA) as a patient contribution by a person who is eligible for publicly funded health services in New Zealand under the Eligibility Direction, on prescriptions for fully subsided medicines if the prescription is issued by:
    a. a prescriber employed by a DHB (eg hospital or DHB based community services)
    b. a provider/prescriber with an agreement with the Ministry of Health, a DHB, or PHO
    c. an after-hours provider with an access or service agreement with a DHB or PHO
    d. a provider providing a fully publicly funded service under a Section 88 notice alone.

14. Under the contract, pharmacies will charge a co-payment of $5 in most cases (this was raised from $3 in 2013) for dispensing medicines. However, co-payments between $0 and $15 may apply depending on a number of other factors:
    a. the patients age – for example standard prescriptions for Under 13s are exempt from the $5 co-payment
    b. a prescription written by a non-DHB and non-PHO prescriber is $15 – most dentists, optometrists and private specialists, although this cost may be reduced if the patient has a Community Services Card (CSC) or High User Health Card (HUHC)
    c. the number of prescriptions redeemed by an individual or family in any February–January year – a Pharmaceutical Subsidy Card (PSC) reduces the co-payment for fully subsidised medicines to zero for the remainder of the year once 20 items are reached.

    If the medicine is not subsidised, or only partially, subsidised by the Government the patient will be required to pay the remaining cost of the medicine.

15. Recently there have been a number of concerns raised by the pharmacy sector and government agencies around the current pharmacy practice and impact of co-payments on access to medicines.

Current practice

16. There are reports from the sector that some pharmacies are charging considerably less than the $5 prescription co-payment. For example Chemist Warehouse is anecdotally charging $0, and Countdown is charging $2.50.

17. A pharmacy charging less than a $5 co-payment will be doing so at their own cost. This is a choice that pharmacies can make. Some parts of the sector see this as a tactic for generating business, and are concerned this may draw some patients away from their 'home' pharmacy – interrupting the therapeutic relationship between pharmacist and patient. An attempt in 2014 to include a "no discounting" clause in the contract resulted in a warning from the Commerce Commission.

18. You have recently received correspondence from s 9(2)(a) (C1800430) seeking clarification as to whether items for which there is $0 co-payment are eligible for the PSC.

19. The Health Entitlement Cards Regulations (S23(1)) state that:
"A family unit shall be eligible to receive a pharmaceutical subsidy card for a pharmaceutical year if that family unit has received, and been charged for, 20 prescription items since the beginning of the pharmaceutical year".

20. This means that while co-payments larger than $0 will be eligible for the PSC, those charging $0 will not. It also means that people who have a PSC may have contributed different amounts towards their medicines, as it is based on 20 items, as opposed to a dollar amount (eg $100). This would not always be determined by need, but by competitive practice between pharmacies to discount co-payments.

21. The practice of pharmacies discounting the co-payment raises questions about the eligibility for the PSC. These include:
    a. whether we should require a patient (or their family) to pay a contribution towards the cost of their medicine as a co-payment, or whether this can be fulfilled by third parties (i.e. the pharmacy or an NGO)
    b. whether the policy for the PSC criteria did, or should, consider the potential that some pharmacies might charge different amounts.
22. Ministry officials consider that a pharmacy choosing to charge less than $5 can potentially improve access. There does not appear to be any reason to oppose this behaviour, as the fiscal impact benefits patients, and there is no change for Crown revenue as the cost sits with the pharmacy. However, as this lower co-payment is only available in some areas it could be considered to create or contribute to equity issues, both generally and in relation to the PSC.
23. The Commerce Commission has recently filed civil proceedings against Prices Pharmacy 2011 Limited and their directors for alleged price-fixing (a breach of Part 2 of the Commerce Act) in 2016 with co-payments, by agreeing with competing pharmacy owners to introduce a $1 margin charge in addition to co-payment of $5 on fully-funded prescription items. A number of other pharmacies in Nelson have been issued with a warning from the Commission. This behaviour took place in 2016 and stopped when government funding through the contract increased.
24. Surcharging over the $5 co-payment is prohibited under the CPSA, and this behaviour would constitute breach of contract. Ministry officials understand that surcharging is a historical issue and are not aware of pharmacies charging above the co-payment amount at present.

The impact of prescription co-payments on access

25. There is evidence that, while most New Zealanders are able to access community pharmaceuticals, co-payments are having a negative impact on access, with a disproportionate impact falling on high needs groups. The New Zealand Health Survey 2016/17 found that in the past 12 months:
    a. about 268,000 adults (7 percent) did not collect one or more prescription items due to cost
    b. fifteen percent of Pacific adults and 14 percent of Māori adults had not collected a prescription due to cost. Pacific and Māori adults were 2.2 times more likely than non-Pacific and non-Māori adults, respectively, not to have collected a prescription due to cost after adjusting for age and sex differences
    c. adults living in the most socioeconomically deprived areas were over three times more likely to have been unable to collect a prescription due to cost than adults living in the least deprived areas, after adjusting for age, sex and ethnic differences.
    d. about 37,000 children (3.9 percent) had a prescription that was not collected due to cost, down from 6.6 percent in 2011/12.
26. PHARMAC has also recently released a report "*Variation in medicines use by ethnicity: a comparison between 2006/07 and 2012/13*" which shows:
    a. Māori are continuing to receive medicines in the community at a lower rate than non-Māori.
    b. Māori access to medicines remains lower despite their health need being higher – leading to greater inequities in health. This was seen in chronic conditions like diabetes, heart disease and respiratory conditions like asthma and Chronic Obstructive Pulmonary Disease (COPD).

Choices/options

27. Ministry officials consider further work is required to determine whether prescription co-payments are set at the right level, targeted appropriately and drive the desired behaviour. Prescription co-payments should also be considered in the context of how to reduce inequities and optimise access to primary health care services, including medicines.

28. Any review of the policy needs to be firmly grounded on the reasons for having a co-payment in the first place:
    a. ensuring patients have access to safe and appropriately funded medicines
    b. improving health outcomes by improving patient buy-in to courses of treatment
    c. reducing costs to taxpayers.
29. On the other hand the Ministry would also want to consider the broader health system, including:
    a. how co-payments impact on access to medicines
    b. whether co-payments deter necessary use of medicines
    c. the role of co-payments where it exceeds the cost of a medicine
    d. whether any proposed changes to co-payment policy would impact government expenditure in other areas of the health system or broader government (eg Disability Allowance)
    e. the impact of universal versus targeted subsidies and exemptions.
30. Ministry officials have identified three options for how you might like to respond to this issue (outlined in Appendix One). They include:
    a. maintaining status quo
    b. reviewing prescription co-payments as a standalone project
    c. considering this issue within the proposed primary health care review (recommended option).
31. You have indicated that there will be a review of primary health care. The draft terms of reference for the review (HR 20181863 refers) suggested that the purpose of the review is to identify practical recommendations to:
    a. reduce health inequalities including reducing barriers to access
    b. re-orientate settings to ensure that primary health care secures better health outcomes for New Zealanders and maintains long term sustainability.
32. Ministry officials recommend that access to medicines be included within the scope of the proposed review. This would allow a discussion of co-payments more generally (from a consumer perspective, as provider revenue, and source of Government revenue) with the aim of reducing barriers to access.
33. Reviewing prescription co-payments as a stand-alone project risks it being considered in isolation of other issues that may impact on access within broader primary health care; for example, general practice co-payments. This is also a risk that the options would be limited to those relating to the co-payment level, when there may be other more suitable and targeted options available as part of the wider primary health care system. Reviewing the policy as part of the primary care review will ensure it can be contextualised within the broader focus of how to reduce cost-barriers to access.
34. Including these issues in the scope of the review may have implications for the timing and resourcing of the primary health care review. It may also have implications for the membership of the review group, or necessitate additional working groups, to contribute meaningfully to this issue.

Next steps

35. Ministry officials can provide you with further advice on how access to medicines and prescription co-payments could be included in a revised scope of the proposed primary health care review.
36. Based on your feedback on this advice, officals will prepare a response to the recent correspondence about prescription co-payments.
37. Ministry officials are available to discuss this matter with you.

END.

Health Report number: 20180836

Appendix One: Options to address prescription co-payment concerns

Option	Benefits	Risks	Overall impact
1. Status quo (do nothing)	• No additional resourcing required to review this policy	• Scrutiny from the sector • Any access issues will continue	
2. Review prescription co-payments as a standalone project	• This would provide a basis for future intervention to increase access to medicines • It would provide a clear rationale for responding to sector concerns regarding pharmacy practice (i.e. prescription co-payment discounting)	• Doing this work in isolation may mean that prescription co-payments are not considered in terms of the whole system In isolation this may not consider the unintended consequences of change	
3. Consider as part of the proposed primary health care review (recommended option) While co-payments for prescriptions are different to general practice co-payments, they may represent a barrier for New Zealanders. The role of co-payments for prescriptions and access to medicines should be considered as part of the aim to reduce cost-barriers to primary health care **RECOMMENDED OPTION**	• This will allow prescription co-payments to be considered within the broader context of barriers to access • This would also provide a way of ensuring that the review consider the patient pathway through the system such as seeing a GP and being prescribed a medicine through to getting that prescription filled • This issue can be discussed as part of a system of co-payments (e.g. what is our rationale for co-payments more generally in primary health care) • Allows the consideration of how the different health entitlements (e.g. Pharmaceutical Subsidy Card, Community Services Card, High User Health Card) impact upon prescription co-payments and the rationale or intent behind these • Could include consideration of how to simplify the policy	• The outcome of the review will take time • Including this within the scope of the review are likely to have timing and resourcing implications	

Document 4

MINISTRY OF HEALTH
MANATŪ HAUORA

Memorandum

Alternative Options in Primary Care – Prescription co-payment subsidy

Date due to MO:	4 November 2019	**Action required by:**	11 November 2019
Security level:	IN CONFIDENCE	**Health Report number:**	**20192137**
To:	Hon Dr David Clark, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Gabrielle Roberts	Manager Primary Care, Health System Improvement and Innovation	s 9(2)(a)
Patricia Farrelly	Pharmacy Manager, Health System Improvement and Innovation	s 9(2)(a)

Action for Private Secretaries

N/A

Date dispatched to MO:

Ministry of Health
12 NOV 2019
DISPATCHED

MINISTRY OF HEALTH
MANATŪ HAUORA

Alternative Options in Primary Care – Prescription co-payment subsidy

Purpose of report

1. This memo responds to your request for further information about alternative options for the primary care $10 off initiative for Budget 2020.

Background

Prescription co-payment

2. The prescription co-payment (prescription charge) was introduced on 1 February 1985. The prescription co-payment is the patient's contribution to the cost of their medicine – the remainder of the cost of each subsidised medicine is paid for by the Government.

3. Currently most people who are required to pay the prescription co-payment pay $5 per dispensed item. However, co-payments between $0 and $15 may apply depending on several factors:

   a. the patient's age – standard prescriptions for Under 14s are exempt from the $5 co-payment

   b. specific exemptions, for example, people living in the Hokianga and mental health patients under a Compulsory Treatment Order are exempt from the $5 prescription co-payment

   c. a prescription written by a non-district health board (DHB) and non-Primary Health Organisation (PHO) prescriber (dentists, optometrists and private specialists providing services outside a DHB-funded contract) is either $10 (youth aged 14 – 17 years) or $15 (adults 18 years and over). This cost reduces to $5 if the patient has a Community Services Card (CSC) or a High User Health Card (HUHC).

4. Prescription Subsidy Card (PSC). From 1 February each year, once an individual or family has paid the co-payment for twenty prescriptions, (usually $100), they are exempt the co-payment for the remainder of that year.

5. The money from prescription co-payments offsets some of the subsidy paid by DHBs for medicines and dispensing fees. This reduces the cost to the Government of subsidising community pharmaceuticals.

6. The prescription co-payment does not contribute to pharmacy revenue – it is wholly collected by DHBs.

7. In 2017/18 DHBs paid approximately $440 million to community pharmacies to dispense and provide advice on around 71 million prescriptions.

8. Around $126 million in prescription co-payments was collected back by DHBs in 2017/18.

Impact on access to medicines

9. There is evidence that, while most New Zealanders are able to access community pharmaceuticals, prescription co-payments are having a negative impact on access to health care for some high needs groups. This contributes to inequity and suboptimal health outcomes, despite visits to doctors and nurses becoming more affordable.

10. The New Zealand Health Survey 2017/18 found that in the past 12 months:

    a. about 257,000 adults (6.6 percent) did not collect one or more prescription items due to cost

    b. Māori and Pacific adults and children were more than twice as likely not to have collected a prescription due to cost than non-Māori and Pacific adults and children, after adjusting for age and gender differences.

11. The introduction of the Zero fees for Under 13s prescription policy in 2015 showed that, compared to the same period the previous year, the number of prescriptions dispensed for children aged 6-12 years increased by 23.9 percent. This indicated that the removal of the cost barrier increased access to medicines for this age group.

12. Hut Valley DHB and the Ministry of Social Development (MSD) have a trial underway,[i] paying the first 20 co-payments (usually $100) per family per year to a nominated pharmacy. The trial results showed a 22 percent increase in medicines dispensed for the families in the study, accompanied by reduced Emergency Department presentations and inpatient admissions. This has the additional benefit of improving the relationship between the consumer and the pharmacist and people not doing the rounds of pharmacies to avoid any debt.

13. Counties Manukau DHB, which has a number of Chemist Warehouse pharmacies that are fully discounting the $5 prescription co-payment, has seen a strong and continued growth in prescription numbers over recent quarters. The growth is sufficiently strong to support the notion that the DHB is seeing prescriptions being filled that patients would previously have elected to delay or miss out on altogether, because of cost.

14. It is noted however, because this lower co-payment is only available in some areas (mostly main urban centres) it could create or contribute to equity issues as not all New Zealanders (including those for whom prescription costs are a barrier to access) have the option to get their prescriptions dispensed by a 'discounting' pharmacy.

Pharmacy Sector analysis

15. Some analysis has been conducted by the pharmacy sector suggesting that the current co-payment policy increases net government expenditure.

16. This analysis requires further scrutiny as it relies heavily on a single piece of Canadian research from 2001, carried out in one location only, with no control group.

17. The Ministry can provide you with further advice about the analysis in a separate paper if you wish to progress this option.

Prescription co-payment subsidy as an alternative option in primary health care investment

18. Because co-payments for general practitioner visits have already been reduced via Zero fees for Under 14s and the CSC scheme, an alternative option is to focus on removing

prescription co-payments to help improve patient access to medicines and reduce inequity.

19. This option could be introduced as a universal removal, could be targeted or scaled at CSC holders only, or targeted at the 15-24 year age group. This would help address inequitable access to medicines due to affordability issues. The latter would support the government's focus on both youth and mental health.

20. Removing prescription co-payments may be positioned as part of the *improving access to primary health care by reducing patient fees ($10 off)* Budget 20 bid, or as a stand-alone Budget bid.

21. Please indicate whether you wish to further discuss this option with officials.

END.

Keriana Brooking

Deputy Director-General

Health System Improvement and Innovation

[i] Jay, C. & Fraser, K. (2016) Improving Financial Access to Community Medicines for Patients in the Hutt Valley. Hutt Valley DHB/ MSD.

Document 5

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MINISTRY OF HEALTH
MANATŪ HAUORA

Memorandum

Options for the prescription co-payment

Date due to MO:	28 November 2019	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20192285
To:	Hon Dr David Clark, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Monique Burrows	Group Manager, Primary Health Care System Improvement and Innovation	s 9(2)(a)
Trish Farrelly	Pharmacy Manager, Primary Health Care System Improvement and Innovation	s 9(2)(a)

Action for Private Secretaries

N/A

Date dispatched to MO:

Ministry of Health
03 DEC 2019
DISPATCHED

Options for the prescription co-payment

Purpose of report

1. This memo responds to your request for advice on options for universal or targeted removal of the prescription co-payment and the impact of making it mandatory for pharmacies to collect the full prescription co-payment from everyone who is not exempt.

Background

2. The arrival of discounting chains such as Chemist Warehouse in New Zealand has seen an increasing number of pharmacies fully absorbing (discounting) the cost of the $5 prescription co-payment.

3. While this means that some New Zealanders now have access to cheaper prescriptions, it has the potential to widen inequities in some populations and some parts of the country, as discounting pharmacies tend to concentrate in urban areas where there is strong market competition.

4. Sector representatives s 9(2)(ba)(i) and individual pharmacy owners believe that the current prescription co-payment policy is not fit for purpose, is contributing to inequities in medicines access and is posing a threat to the sustainability of community pharmacies.

5. In October 2019 the s 9(2)(ba)(i) presented a policy analysis paper to the Ministry, recommending that the current prescription co-payment policy be altered to improve access to primary health services. The paper outlined a range of options for universal or targeted removal or reduction of the co-payment, with the three preferred options being;

   a. universal removal of the prescription co-payment

   b. targeted removal for Community Services Card (CSC) holders and their dependents, or

   c. targeted removal for Māori and Pasifika populations.

6. On 12 November 2019 you requested the development of a Budget 20 new initiatives bid for options to remove the prescription co-payment as part of the suite of primary health care bids.

Options for removal of the prescription co-payment

7. The Budget 20 initiative proposes three options for removal of the prescription co-payment.

Targeted removal of the prescription co-payment for CSC holders and their dependents (preferred option) (cost approximately $42M per annum)

8. According to the latest New Zealand Health Survey, 207,000 adults (5.3 percent) did not collect at least one prescription medicine in 2018/19 due to cost. Cost was a greater

barrier to medicines access for Māori (11.8%), Pasifika (14%) and people living in high deprivation areas.

9. Extending CSC eligibility to a wider group of people on lower incomes and removing the prescription co-payment for CSC holders and their dependents could remove barriers to accessing medicines for more than a million New Zealanders.

10. This option is less expensive than universal removal of the prescription co-payment; however, it is more complex to implement at a systems level and requires substantive changes to Ministry payment systems and pharmacy vendor systems.

Universal removal of the prescription co-payment (alternative option) (cost approximately $148M per annum)

11. Universal removal of the prescription co-payment means that all people entitled to government-funded health services would receive fully funded community pharmaceuticals at zero cost.

12. While this option is likely to find favour with many New Zealanders, it is the most expensive and has the potential to increase inequities as it is not specifically focussed on addressing the financial barriers that prevent Māori, Pasifika and people on low incomes from accessing medicines.

13. This option could enable the Prescription Subsidy Card (PSC) scheme to be phased out. The scheme makes medicines more affordable for individuals and their families by exempting them from the prescription co-payment once they have paid for 20 prescription items.

14. Eligibility for the PSC is determined by the number of prescription items dispensed for an individual or family, rather than financial need. It is poorly understood by the public, meaning that some people continue to pay the prescription co-payment after they have reached the eligibility threshold. Conversely there is anecdotal evidence that a growing number of pharmacies are issuing the PSC to people who may not meet the eligibility criteria.

15. Current Ministry systems do not easily support auditing compliance with PSC eligibility rules.

Targeted removal of the prescription co-payment for people aged 14 – 24 years (minimum viable option) (cost approx. $14M per annum)

16. The New Zealand Health Survey 2018/19 found that around 39,000 young people aged 15 – 24 years were unable to collect one or more prescription items due to cost. This includes those living in high deprivation areas, Māori and Pasifika and those with a high number of co-morbidities.

17. This option expands the Free Under 14s policy and would mean that all children and young people from birth to 24 years have improved access to vital medicines.

Cost vs. benefit of removing the prescription co-payment

18. Removing the prescription co-payment is expected to increase access to prescription medicines. For example, the expansion of the Free Under 6s policy to Free Under 13s resulted in a 24 percent increase in the number of prescriptions dispensed for 6 – 12-year olds in the first year.

19. Increased access to medicines is expected to contribute to improved medicines adherence, resulting in reduced hospital presentations and admissions, although the financial benefit of this is difficult to quantify.

20. The Hutt Valley study 'Improving Financial Access to Community Medicines for Patients in the Hutt Valley' evaluated the impact of removing the prescription co-payment for high needs patients at risk of non-collection of prescription medicines due to cost.

21. The study found that removal of the prescription co-payment led to a significant reduction in emergency department (ED) presentations, inpatient admissions and bed days, and improved medicines adherence.

22. s 9(2)(ba)(i) policy analysis concluded that all proposed options for change, including universal removal of the prescription co-payment, would generate a net fiscal benefit to the health system, rather than a cost, through a reduction in avoidable hospital events.

23. s 9(2)(ba)(i) analysis does not translate directly to the New Zealand setting. It relies heavily on a 2001 Canadian study which considered the impact of high out-of-pocket prescription costs in a narrow, high needs population group. No sensitivity analysis was performed, and the study results, in particular the fiscal benefits, cannot be reliably extrapolated to the New Zealand system.

Mandatory collection of the prescription co-payment

24. You have asked for advice on the impact of making it mandatory for all pharmacies to charge the full prescription co-payment to everyone, except those who are exempt.

25. s 9(2)(ba)(i) are focussed on targeted or universal removal of the prescription co-payment to address access and equity issues and prevent market distortionary effects. However, there have been some informal comments from sector representatives that, in the absence of a policy change to remove the prescription co-payment, then charging the full co-payment should be mandatory.

26. Under the current Integrated Community Pharmacy Services Agreement (ICPSA) it is not mandatory for pharmacies to charge the full $5 prescription co-payment for example discounting of some, or all, of the co-payment is permitted.

27. It is likely that the Commerce Commission would deem any move to make it mandatory for pharmacies to charge the co-payment to be anti-competitive.

28. This is based on a Commerce Commission finding that "no discounting" clauses in the 2012 CPSA were likely to have breached Section 27 of the Commerce Act 1986. The clauses were removed in early 2013, on receipt of a warning letter from the Commerce Commission to district health boards (DHBs) that the contractual arrangement between DHBs and community pharmacies was found to be anti-competitive.

29. As payments to community pharmacies are by contract, rather than by legislative instrument such as a Section 88 notice under the New Zealand Public Health and Disability Act 2000, it would not be possible to fix the co-payment amount through current existing legislative means.

30. Options would have to be considered such as exemptions under the Commerce Act, which are likely to be long (12 + months) and expensive (an estimated $100k plus in legal fees) processes with no guarantee of success.

31. The Ministry has previously provided advice to s 9(2)(ba) on steps it can take to make collection of the full prescription co-payment mandatory; these include s 9(2)(ba) itself applying to the Commerce Commission for an exemption under the Commerce Act.

Keriana Brooking
Deputy Director-General
Health System Improvement and Innovation

Abolition of pharmacy (prescription) co-payments

Category			
Priority	E – Other This initiative aligns with Priority E and Sub Priority 2. The initiative supports elimination of health inequities through its focus on removal of a cost barrier that currently prevents some New Zealanders from accessing prescribed medicines. It also aligns with Priority C Sub Priority 1 as evidence shows that poor health outcomes, which can result from reduced access to medicines, can have a negative impact on educational attainment, income levels and future employment.		
MoH priority alignment	A strong and equitable health and disability system	**Government Commitment:**	Yes

Description: This initiative would remove the $5 prescription co-payment for all eligible New Zealanders from 1 July 2021, or a date to be determined. The initiative is intended to help improve patient access to medicines, improve medicines adherence, contribute to continuity of pharmaceutical care, improve health outcomes, and reduce inequity.

The first year will cover the necessary information technology (IT) systems transformation to allow the change ($1.1m in 2020/21) and from 2021/22 the co-payments will be removed at an ongoing cost of $147m per annum.

Funding ($m)	2019/20	2020/21	2021/22	2022/23	2023/24 & outyears	TOTAL
Operating			147.623[i]	147.623	147.623	**441**
Capital		1.1				**1.1**

This initiative buys:

☑ **Removal of prescription co-payments for all New Zealanders**

The prescription co-payment is a person's contribution to the cost of their medicine. The remainder of the cost of each subsidised medicine is paid by the Government. Currently most people pay a prescription co-payment of $5 per medicine, although co-payments vary between $0 and $15 depending on a range of factors.

The New Zealand Health Survey 2018/19 found that in the past 12 months about 207,000 adults (5.3 percent) did not collect one or more prescription items due to cost. For Māori and Pacific people, prescription costs were a barrier to access for 14 percent and 11.8 percent of adults, respectively. Those living in the most socioeconomically deprived areas were more than four times as likely to have been unable to collect a prescription due to cost than those living in the least deprived areas. Cost is also cited as a barrier to younger age groups (less than 55 years) accessing medicines.

Foregoing or delaying collection of medicines increases the risk of suboptimal health outcomes, increases health inequity based on ability to pay, and creates higher net health costs (for individuals, families and the health system).

An increasing number of pharmacies, usually concentrated in urban areas where there is high market competition, are choosing to absorb the cost of the prescription co-payment completely. Removing the co-payment serves as a 'loss leader' to increase pharmacy foot traffic. Removal of the co-payment at these 'discounting pharmacies makes prescriptions more affordable for some New Zealanders but can create or contribute to inequity for people living in parts of New Zealand not serviced by these pharmacies. This can increase the risk of inequities for our most underserved population.

☑ **Assumptions**

We know:

1. The population of New Zealand is 4,699,755 (2018 NZ census)
2. The total revenue collected from the $5 prescription co-payment in the period 2018/19 is $133,881,642

It is assumed that:

- The volume pressure for increase in number of prescriptions annually is 2.33%

- That patients not collecting a prescription due to cost will collect their prescriptions if the prescription co-payment is removed as a result of implementation of this initiative. The New Zealand Health Survey 2018/19 showed that 5.3% of the adult population reported not collecting a prescription due to cost in the past year.
- The average number of prescriptions collected in New Zealand in the past year is similar to the average number of prescriptions CSC holders and their dependents would collect
- Funding sought has not included the additional fiscal savings from existing pharmaceutical support benefit costs currently paid to beneficiaries
- The removal of prescription co-payments for all eligible New Zealand would mean the winding up of the prescription subsidy card (PSC) scheme (Health Entitlement Card Regulations 1993)
- The funding will compensate DHBs for the financial loss of reduced prescription co-payment revenue created by removing the prescription co-payment for all eligible New Zealanders.

Workforce implications:

- To support the removal of co-payments, changes will need to be made to pharmacy management systems and the Ministry's pharmacy payments system. It would take approximately six months to implement these changes, hence the lower cost figure for the 2020/21year.

The expected impacts of the initiative are:

Removing the prescription co-payment is expected to increase equity of access to medicines by reducing cost barriers to collecting prescriptions. The expansion of the free Under 6's policy to provide free prescriptions for children under 13 on 1 July 2015 saw the number of prescriptions dispensed for 6-12 year olds increase by 24 percent, indicating that the removal of a cost barrier had improved access to medicines.

In the medium term the initiative is expected to improve health outcomes for high need populations (including Māori, Pacific, people living in deprivation quintile 5), through improved access to medicines, improved medicines adherence and reduce inequity in health outcomes through better management of health conditions, with reduced acute general practice and hospital emergency department visits, and reduced avoidable hospitalisations.

In the longer term the benefits of improved health outcomes include:

- Increased ability to participate in employment, education and community opportunities
- Long-term savings on the Disability Allowance for the Ministry of Social Development
- Improved subjective wellbeing
- Improved work productivity and incomes.

- DHBs will experience a loss in revenue through the removal of prescription co-payment revenue. Additional funding to DHBs will be required to compensate for this financial loss.
- With the increased uptake of medicines, the cost of medicines in the DHBs' community pharmaceuticals budget will increase. We have not been able to quantity this increase in the cost of medicines.
- Some reduction in the cost of acute admissions to hospital (ambulatory sensitive hospitalisations or ASH), although it is hard to predict the exact amount. In 2019 ASH cost an estimated $556m for people aged 0-74, including $140m (25%) for Māori and $69m (12%) for Pacific people, with cellulitis (skin infections) as major contributor at $54m.

Key Messages:

- Removal of the prescription co-payment will increase access to medicines for all eligible New Zealanders, but will likely have a greater impact on Māori, Pacific peoples and those living in high deprivation quintile 5.
- Increased access to medicines will improve health outcomes for all eligible New Zealanders, through better management of health conditions, with reduced acute general practice and hospital emergency department visits, and reduced avoidable hospitalisations.
- DHBs will need to receive funding to compensate from the loss of revenue with the removal of the prescription co-payment.

Responsible Minister:	Deputy Prime Minister - Rt Hon Winston Peters Minister of Finance - Hon Grant Robertson
Ministry contact:	Kathy Rex, Acting Group Manager Primary Health Care System Improvement & Innovation; s 9(2)(a)

[i] Ministry of Health. Improve Access to medicines by removing the prescription co-payment for the eligible population. Budget bid 2020/21.