Briefing

Manifesto commitment – Reinstating the $5 prescription co-payment

Date due to MO:	1 December 2023	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	H2023033029
To:	Hon Dr Shane Reti, Minister of Health		
Copy to:	Hon David Seymour, Associate Minister of Health (Pharmac)		
Consulted:	Te Whatu Ora: ☒ Te Aka Whai Ora: ☒		

Contact for telephone discussion

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Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Manifesto Commitment – Reinstating the $5 prescription co-payment

Security level:	IN CONFIDENCE	**Date:**	30 November 2023
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This report provides you with advice on achieving your manifesto commitment to reinstate the prescription co-payment for New Zealanders over 14 years old including targeted exemptions for people on low-incomes and superannuitants, while capping the total amount any person or family will pay for prescriptions in a year at $100.
2. This paper also includes information on the initial impact of removing the standard $5 prescription co-payment on the Community Pharmaceutical Budget.

Summary

3. In your election manifesto you proposed to reinstate the $5 prescription co-payment except for people on low-incomes and superannuitants, while capping the total amount any person or family pays for prescriptions in a year at $100.
4. There are potential savings from reinstating the prescription co-payment and making prescriptions free to people with a CSC and people 65 years and over depending on different levels of growth in filled prescriptions. Our initial modelling, using recent increases of 2.5% in the number of filled prescriptions per year, suggests that savings to Vote Health could be around $425 million over four years. The total savings over four years will vary depending on the number of filled prescriptions per year.
5. These estimates assume that you wish to retain the co-payment free settings for people under 14 years old and those who qualify for the Prescription Subsidy Card.
6. Once we have confirmation from you about the final policy parameters, we will refine our estimates on the savings for the next four financial years.
7. It is likely to take between three and six months to prepare to implement this commitment, to have systems in place by 1 July 2024. Having policy decisions confirmed in December 2023 would help ensure we meet this implementation timeline.
8. Settings on prescription co-payments are a key consideration within the health system. While they may encourage more efficient use of services these costs also create a barrier to some people accessing necessary care. These settings also have important implications for the financial sustainability of the health system. We can provide you with advice on further opportunities to simplify and better target prescription co-payments as part of a future primary and community healthcare policy work-programme.
9. If you agree we will:

- provide you with updated estimates of the savings that would be realised from reinstating the $5 prescription co-payment, subject to your direction on scope and exemptions.
- provide you with a draft cabinet paper
- provide you with further advice on the opportunities to simplify and better target prescription co-payments as part of the primary and community healthcare policy work-programme.

Recommendations

We recommend you:

a) **Note** that this briefing provides information about your manifesto commitment.

b) **Agree** to seek Cabinet approval to reinstate the $5 prescription co-payment for those 14 years and over, with targeted exemptions for people with a CSC and those 65 years and over, and to maintain the current settings for the Prescription Subsidy Card, from 1 July 2024. **Yes/No**

c) **Note** the initial estimates of around $425 million in savings, comprised of prescription co-payment revenue and reduced spending in the Combined Pharmaceutical Budget over the next four financial years, from reinstating the $5 prescription co-payment for people over 14 years old with targeted exemptions for people with a CSC and those 65 years. This is based on an annual increase of 2.5% in the number of filled prescriptions.

d) **Indicate** whether you wish to receive further advice on:

- changing the approach to prescription co-payments for under 14 year olds as part of your policy. **Yes/No**
- options and analysis for how the $100 cap on costs of prescription co-payments in your manifesto commitment could be applied across all prescription co-payments. **Yes/No**
- estimates on targeted exemptions for the proportion of those aged 65 and over with a Combination CSC and SuperGold Card. **Yes/No**
- using the SuperGold Card to target exemptions at people aged 65 and over **Yes/No**

e) **Note** that having policy decisions confirmed in December 2023 would help ensure we can meet the implementation timeline of 1 July 2024.

f) **Indicate** if you would like advice as part of the longer-term primary and community healthcare policy work-programme on the future approach to prescription co-payments and simplifying the policy settings, including on unapproved prescribers, targeting additional population groups, expanding pharmacist prescribing, the prescription subsidy card, and targeting mechanisms such as entitlement cards. **Yes/No**

g) **Note** that we will continue to monitor the impact of the current prescription co-payment settings on the Combined Pharmaceutical Budget to inform future budget processes.

Dr Diana Sarfati	Hon Dr Shane Reti
Director-General of Health	
Te Tumu Whakarae mō te Hauora	**Minister of Health**
Date:1/12/23	Date:

Manifesto Commitment – Reinstating the $5 prescription co-payment

Background

10. Co-payments are part of cost sharing strategies used to reduce government expenditure within tax funded health systems. Using co-payments generates revenue. They may help encourage more efficient use of services; however these costs also create a barrier to some people accessing necessary care.

11. This report provides initial estimates of the savings that could be realised from implementing your manifesto commitment.

Future approach to the prescription co-payment system

12. Over 54 million prescriptions are dispensed in over 1,000 community pharmacies in New Zealand each year. An estimated 74% of the population collect at least one prescription annually, averaging 14 filled prescriptions per person per year. These rates are higher amongst some population cohorts, including people 65 years and over.

13. Prescription co-payments require people to contribute to the cost of obtaining their medicines. There are many elements to the prescription co-payment system, with different policy settings depending on whether prescribers are funded through Vote Health, other Government budgets or private funding, cost differences because of age, and reduced co-payments for people with entitlement cards such as the Community Services Card (CSC) or High Use Health Card (HUHC).[1]

Table 2: Current prescription co-payment settings for eligible persons

	Prescriptions from GPs, hospitals and other approved prescribers [2]	Prescriptions from private specialists and other unapproved prescribers [3] (with CSC/HUHC/care plus)	Prescriptions from private specialists and other unapproved prescribers (no CSC/HUHC/care plus)	Prescription subsidy card
Child under 14	$0	$0	$0	$0
14 – 17 years	$0	$5	$10	$0
Adult 18+ years	$0	$5	$15	$0

[1] Additional charges also apply for partially subsidised or unsubsidised medicines.
[2] Pharmacy Procedures Manual, pp85-86. (Te Whatu Ora, July 2023) Pharmacy-Procedure-Manual-v10.0-July-2023-.pdf (tewhatuora.govt.nz)
[3] Ibid., p78.

14. The Prescription Subsidy Card (PSC) helps to lower the cost of prescription medicines for people who are eligible. The PSC sets a limit on the number of prescriptions that an individual or family has to pay for each year. Once a family has paid for 20 funded prescriptions, they do not need to pay a co-payment for any remaining prescriptions. The year runs from 1 February to 31 January and the PSC is available to those collecting medicines prescribed by unapproved prescribers. In the 2022-23 financial year approximately 42% of prescriptions were dispensed without requiring a co-payment under the PSC.

15. There are several issues with the current PSC. There is no national record of prescriptions by family, and it falls upon individual pharmacies to build an understanding of which people are within the same family unit. If a person or family goes to more than one pharmacy within a year, there is no system to alert other pharmacies that a co-payment was made and so the family is no closer to getting the PSC. The system undercounts a person's eligibility, and it is people with the least health literacy who are likely to overpay the most.

16. The prescription co-payment is not revenue for the pharmacy filling the prescription. The co-payment is deducted from dispensing fees, irrespective of whether a person pays the co-payment when collecting their prescription. Pharmacies can make a commercial decision as to whether they pass on the prescription co-payment to customers and, prior to 1 July 2023, some larger pharmacy groups were not charging any customers co-payments as part of their business strategy, while anecdotal evidence indicates that some independent pharmacies were offering reduced co-payments to some patients on a case by case basis. Discounting pharmacies represent 12.2% of filled prescription market share as of January 2023.

Targeted assistance with paying the prescription co-payment

17. As part of your 2023 Manifesto you committed to reinstating the $5 prescription co-payment with targeted exemptions for people on low-income and superannuitants. You note that the total amount any person or family will pay for prescriptions in a year should be capped at $100. Your manifesto shows that you expect savings from this policy to be between $76.2 and $81.8 million per year over four years; a total saving of $316.8 million on current costs.

18. We understand that your rationale for the commitment is that assistance should be targeted at those who need it most.

19. Your manifesto identifies using the CSC and SuperGold Card to make prescriptions free for people on low income and superannuitants. To achieve the commitment efficiently we have focussed on using the CSC and exempting people 65 years and over by age. Age is linked to a person's National Health Index number which means a pharmacist can automatically see an individual is eligible or not with the system. The current health information systems do not hold information on the SuperGold Card.

20. The majority of prescriptions are now transmitted and dispensed electronically which means, from an efficiency perspective, that the information on eligibility for reduced costs must be available at the time of dispensing rather than payment to avoid further administration and pressure on pharmacists when someone collects their prescription. It is not currently possible for pharmacists to record the SuperGold Card in pharmacy

management systems. SuperGold data is held by The Ministry of Social Development (MSD) and, to use the card, Te Whatu Ora would need to work with MSD to explore possibilities for connecting the data held with the pharmacy management system and health payment systems.

We would welcome your steer on whether you wish to receive advice on using the SuperGold Card to target exemptions at people aged 65 and over.

21. Our assumption is that you wish to retain the co-payment-free prescriptions for those under 14 years old and the PSC, both of which were already in place before the policy change in July 2023.

We would welcome your direction on the exemption for under 14 year olds and we can provide revised cost estimates if required.

Reinstating the $5 prescription co-payment for people 14 years of age and older with targeted exemptions for those on low-income and people 65 years and over

22. This option is based on reinstating the prescription co-payment, using the CSC to exempt people on low-incomes and their dependents, and exempting everyone 65 years and over irrespective of their income, receipt of New Zealand Superannuation or the SuperGold Card.[4]

23. The initial savings estimated for the manifesto commitment presented below represent income earned through co-payment collection from patients and reduction in community medicine expenditure.

24. Removing the $5 co-payment from 1 July 2023 was expected to cost $706 million total over four years. Initial modelling suggests that the additional revenue available to the Government from reintroducing the prescription co-payment with exemptions for those with a CSC and people 65 years and over is $425 million. This based on 2.5% growth per year in filled prescriptions. Total savings over 4 years will vary depending on the growth in filled prescriptions.

Other settings you may wish to consider

25. Using the Combination CSC and SuperGold Card CSC/SGC enables better targeting to those 65 years and over who are on low income ie, those meeting the income requirements for the CSC, and is a potential variation on your manifesto commitment to help target assistance at those for whom cost is a significant barrier to care.[5]

We would welcome your direction on whether you wish to receive estimates based on exempting those 65 and over with a Combination CSC and SuperGold Card.

Annual cap on the amount people pay for prescription each year...

[4] In September 2023 there were 1,044,000 CSC holders and an estimated 864,800 people 65 and over.
[5] In September 2023 there were approximately 337,000 SGC/CSC combination cards on issue.

26. In relation to your commitment to cap the amount a person or family pays for prescriptions during a year at $100, we note that the current PSC should be triggered when an individual or family has reached 20 co-payments. This is a cap of $100 per year for 20 $5 prescriptions, however the card covers prescriptions that attract co-payments of $10 or $15 and means a person or family can spend up to $200 or $300 before the card is triggered. There were approximately 2,560,560 prescriptions from unapproved prescribers in the 2022-23 financial year, representing 4.7% of the total number of prescriptions filled.

We would welcome your direction on whether you intend for the $100 cap to apply across all prescription co-payments, and whether you require further advice on effective mechanisms to limit costs for high volume prescription users.

Limitations to the estimates

27. This paper, with the time available, presents initial financial estimates for reinstating the prescription co-payment with exemptions for the groups targeted. These estimates are subject to uncertainty, and we will refine the estimates subject to your direction on scope and exemptions.

28. Some increases in the proportion of prescriptions dispensed to CSC holders has been incorporated as part of sensitivity analysis but further investigation of this aspect as part of the budget advice will reduce uncertainty.

Implementing your manifesto commitment

29. To implement your manifesto commitment, work is required to integrate the health database that holds CSC information with pharmacy management systems, the systems of software vendors, and Te Whatu Ora payment systems. This will make it as easy as possible for people to get their entitlement and for the sector to administer the system efficiently. As the dependent children of a CSC holder are eligible for reduced healthcare costs but do not have their own cards, we will also need to explore options for automating the process of identifying dependents.

30. Te Whatu Ora will need time to consult the sector on how any changes are implemented and develop a communication plan for the policy. Given concerns expressed by pharmacists with regard to reinstating the co-payment with exemptions, consultation with the sector will be a key element of the implementation plan, while automating the process of checking CSC eligibility will be crucial to minimise pressure on the workforce.

31. Once the policy is agreed it will need to be reflected in the Integrated Community Pharmacy Services Agreement and Pharmaceutical Schedule.

32. As part of implementation, we will also develop a plan to monitor and evaluate the impact of the approach.

Timeline for implementing this manifesto commitment

33. It is likely to take 3 to 6 months to establish the IT systems required to implement your manifesto commitment. It is likely that more time would be needed if it were decided to use the SuperGold Card to target those 65 and over.

34. In order to complete the work required in relation to the CSC to implement changes from 1 July 2024 the Ministry will need policy decisions as soon as possible.

Impact and risks of reinstating the prescription co-payment with targeted exemptions

35. Financial costs are one of the key barriers people face to accessing healthcare and medicines, and a major driver of inequitable outcomes. In 2021/22 an estimated 135,000 people had an unfilled prescription due to cost.[6] These costs hit those on low incomes the hardest. The costs contribute to behaviours that include delaying and not collecting prescriptions, which have negative impacts on the health and wellbeing of those people and their families. It also causes pressure along the health continuum, such as for acute or secondary care. [7] [8]

36. Māori, Pacific people, and people living with a disability are disproportionately affected by having lower incomes and, along with some of those living in areas of high socio-economic deprivation, are amongst those most affected by cost barriers.[9]

37. We anticipate that continuing to exempt people on low incomes and superannuitants from paying the $5 prescription co-payment will help those people achieve better health and wellbeing as they will be able to continue accessing the prescription medicines they need to get well and stay well. While people 65 and over are major users of healthcare services, and maintaining assistance to this group will help enable timely access to care for the proportion who find cost a barrier, we note that younger cohorts are more likely to identify financial costs as a barrier to healthcare.[10]

38. Using the CSC helps some of the most disadvantaged by income. However, using the card will mean that people with income above the eligible threshold, but who nevertheless have very limited income, will have to pay for prescription medicine. This could lead to an increase in people delaying or avoiding collecting their medicine, poorer health outcomes, and increased costs and pressure for the system because of demand for hospital care.

39. Māori experience inequitable outcomes compared to non-Māori, and also experience disease at an earlier age. Barriers to accessing prescription medicine has a direct impact on Māori health inequities. For example, nearly two in three Māori hospitalised for gout did not receive their preventative medication in the six months prior to hospitalisation.

40. Reinstating the co-payment may lead to the patient consultation time pharmacists have available focussing on payment for prescriptions rather than on how to get the maximum benefit from medicine. The pharmacy sector reports positive benefits in

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[6] New Zealand Health Survey 2021-22 (Ministry of Health)

[7] Norris, P., Cousins, K., Horsburgh, S. *et al.* Impact of removing prescription co-payments on the use of costly health services: a pragmatic randomised controlled trial. *BMC Health Serv Res* 23, 31 (2023). https://doi.org/10.1186/s12913-022-09011-0 https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-09011-0

[8] Ibid.

[9] Health for Everyone? Social Inequalities in Health and Health Systems (OECD). Affordability and financial protection: Insights from Europe | Health for Everyone? : Social Inequalities in Health and Health Systems | OECD iLibrary (oecd-ilibrary.org)

[10] Jatrana and Crampton, Do financial barriers to access to primary health care increase the risk of poor health? Longitudinal evidence from New Zealand, Social Science & Medicine 288 (2021) 113255

relation to these consultations since the standard prescription co-payment was abolished for adults.[11]

41. Most pharmacies are small, independent businesses. Reintroducing the prescription co-payment with targeted exemptions is likely to lead to larger discounting pharmacies, often located in urban areas, choosing not to charge the consumer the prescription co-payments. Small businesses are unlikely to be able to compete with this approach. This could have negative impacts on the viability of the independent community pharmacy sector, with loss of community pharmacy health services that the larger discount pharmacies do not always provide. It could also affect people in more rural areas and lead to a decrease in filled prescriptions and a greater health burden.

42. Prior to the removal of the $5 co-payment, MSD estimated that approximately 158,000 MSD clients were receiving Disability Allowance (DA), at least in part, for prescription costs. Of that cohort, approximately 23,000 clients also received Temporary Additional Support (TAS). As most recipients of this assistance are CSC holders, they will remain eligible for free prescriptions under the current proposal. MSD estimates a small cohort of DA and/or TAS recipients that do not hold CSCs will need to return to claiming prescriptions as part of their disability costs. MSD considers that the approach to prescription co-payments would have minimal impact on its budgets.

Further opportunities to better target and simplify prescription co-payments

43. As part of the future primary and community healthcare policy work programme there are opportunities to consider changes to prescription co-payment settings to simplify the approach, prioritise and target assistance effectively at those in most need, and align with the aim of creating an efficient and equitable health system. Aspects of the prescription co-payment system you may want to consider for further work include the approach to prescriptions from unapproved prescribers, targeting additional groups for exemption, expanding pharmacist prescribing, settings for the prescription subsidy card and, more broadly, the approach to targeting mechanisms and entitlement cards, including the CSC.

We welcome your steer on opportunities to develop the approach to prescription co-payments and targeting assistance and can provide you with further advice.

Initial impact of removing the $5 prescription co-payment on the combined pharmaceutical budget

44. Following the previous Government's announcement removing the $5 prescription co-payment for New Zealanders 14 years and over it was agreed that the Ministry, Te Whatu Ora, Pharmac, and Treasury would report back to Ministers on the impact of removing the prescription co-payment on the CPB in November 2023 [HR2023025705 refers].

[11] Better Healthcare for all: Community Pharmacy staff on the effects of universal fees-free prescriptions, November 2023. PAI report NOV23 proof 2 (prescriptionaccessinitiative.org)

45. The initial data available for July and August 2023 shows that spending on prescription medicine might exceed the $21.8 million allocated to the CPB to cover the potential increased demand. However, the exact impact is unclear at this point. Further information on the initial impact is provided in **Appendix 1** and we will continue to monitor the impact over the remainder of the 2023-24 financial year.

Next steps

46. The next steps are to:

- provide you with updated estimates of the savings that would be realised from reinstating the $5 prescription co-payment, subject to your direction on scope and exemptions.
- provide you with a draft cabinet paper
- provide you with further advice on the opportunities to simplify and better target prescription co-payments as part of the primary and community healthcare policy work-programme.

ENDS.

Minister's Notes

Appendix 1: The initial impact of removing the $5 prescription co-payment on the Combined Pharmaceutical Budget

1. As part of Budget 2023, $706.746 million was allocated to Vote Health over four years to implement the removal of the standard $5 prescription co-payment for people 14 years of age and over. The funding covers the cost of removing the co-payment for the consumer, $661.4 million, and the dispensing fee for increases in the number of filled prescriptions, $45.4 million to Te Whatu Ora.

2. Because removing the co-payment was expected to lead to an increase in demand for prescription medicine, $21.8 million was transferred from Te Whatu Ora's dispensing fee budget to Pharmac's CPB to allow for additional demand [HR2023025705 refers]. The total CPB is approximately $1.5 billion.

3. The dispensing data available for analysis is for July and August 2023. This data enables comparison between the actual medicines expenditure and that forecast prior to implementing the co-payment policy,[12] and between the volume of filled prescriptions in July and August 2022 and that in July and August 2023. The changes observed in July and August 2023 have been used to project the expected financial impact on the CPB for the 2023/24 financial year.

Impact against the forecasted spending

4. The critical parameter in the analysis is the observed changes in medicine expenditure from that forecast and the additional budget of $21.8 million that Ministers made available to the CPB to cover any increase in medicine demand for the financial year 2023-24.

5. During July and August 2023, an additional $8.2 million was spent from the CPB, representing a 5.28% increase in net expenditure on community pharmacy medicines compared to that forecasted.

Impact against the data on filled prescriptions for July and August 2022

6. Table 4 shows and increase of around 626,000 in the total number of filled prescriptions for the period July and August 2023 compared to the same period in 2022.

Table 4: Filled prescription volumes in July-August 2022 compared to July-August 2023

	July and August 2022	July and August 2023	Difference
Total number of filled prescriptions (initial dispensings)	9,128,583	9,754,589	626,006 (6.86%)

7. A proportion of the increase in prescriptions filled is likely to be because of population growth and demographic changes. However, the increase is also consistent with some increase in demand due to the policy change. The exclusion of prescriptions dispensed under the Minor Ailments Scheme in the July and August 2023 period represents a

[12] Medicine expenditure represents expenditure net of any manufacturer rebates.

6.44% annual increase in filled prescriptions, indicating that the Minor Ailments Scheme is also expected to have had some impact on observed increase in filled prescriptions.

8. The available data shows that spending on prescription medicine might exceed the $21.8 million allocated to the CPB to cover the potential increased demand. However, the exact impact is unclear at this point.

How the removal of the $5 co-payment could impact the CPB over the year to July 2024...

9. We have used the increases in the first two months of the policy to project the potential impact on the CPB for the remainder of the 2023/24 financial year. Due to the limitations of making a full-year projection from initial implementation patterns, four budget impact scenarios are presented:

   a. Temporary effect. This scenario assumes the increased medicine use initially observed is temporary, and community pharmacy medicines expenditure will return to that previously projected over the remainder of the financial year. **The estimated impact on the CPB for the 2023/24 FY under this scenario is $8.2 million already seen.**

   b. Half-year effect. This scenario assumes the average relative increase in expenditure observed in July and August 2023 will be replicated each month until December 2023 (controlling for seasonal prescribing effects), then community pharmacy medicines expenditure returns to that projected due to exhaustion of increased demand within two prescription cycles. **The estimated impact on the CPB for the 2023/24 FY under this scenario is $23.9 million.**

   c. Full annual effect + adjustment for Prescription Subsidy Card (PSC) expiry and discount pharmacy effect. This assumes that there will be a sustained effect for the full financial year, with a monthly adjustment for the proportion of prescriptions that did not incur a co-payment prior to the policy implementation from 1 July 2023. **The estimated impact on the CPB for the 2023/24 FY under this scenario is $51.2 million.**

   d. Full annual effect at August maximum. This scenario assumes the total effect observed in August 2023 represents the full extent of increased demand and will continue for the remainder of the financial year. **The estimated impact on the CPB for the 2023/24 FY under this scenario is $60.3 million.**

10. We will continue to monitor the impact of the current policy settings to inform decisions on future CPB funding, and we will include the impact in any Budget 2024 considerations.

Limitations of the current data

11. Rates of prescribing, dispensing, and overall medicine usage and expenditure is affected by factors including individual, pharmacist and prescriber behaviours, seasonal and monthly trends, population distribution and change, patterns of disease, and procurement and pricing strategies. These factors mean there are limitations to attributing the changes seen in expenditure solely to the policy implemented from July 2023. Other limitations are:

- whether the increase in dispensing is temporary or sustained, and how the PSC and will impact on the policy.[13] The full impact on the CPB is unlikely to be clear until a full financial year of prescription data is available.
- the analysis projects the impact of the policy on the CPB based on only two months of data. Further analyses of changes in prescription demand by factors such as age, community services card, ethnicity, deprivation, and medicine types would provide a more comprehensive understanding of the policy impact.
- the data does not enable a robust assessment of changes in the nature of the pharmaceutical products dispensed. The larger increase in the volume of dispensing compared to the increase in costs may suggest that the initial change has been in the number of lower cost medicines dispensed.

[13] The PSC caps co-payment expenditure in the 12-month period from February at 20 items per person or family, meaning that historically many people were exempted from co-payments by January but would incur co-payments again in February with significant impacts on observed filled prescription rates between months.

MANATŪ HAUORA
MINISTRY OF HEALTH

Briefing

Advice on a bonding scheme for nurses and midwives

Date due to MO:	5 December 2023	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	H2023032970
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☒		

Contact for telephone discussion

Name	Position	Telephone
Dr Diana Sarfati	Director-General of Health	s 9(2)(a)
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a)

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Advice on a bonding scheme for nurses and midwives

Security level:	IN CONFIDENCE	**Date:**	5 December 2023
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This paper seeks your preferences for further advice on a bonding scheme for nurses and midwives.

Summary

2. Your manifesto commitments include a bonding scheme for nurses and midwives. This commitment is not referenced explicitly in either Coalition Agreement, but we understand you may wish to progress it as a New Zealand National Party policy priority.
3. We are ready to support you to deliver your manifesto commitment. We wish to understand your preferences for the scheme so that our future advice can provide options that support you to deliver your priorities and ensure the existing Voluntary Bonding Scheme complements your proposal.
4. The bonding scheme (the scheme) could be established by the end of 2024, provided there is little legal or administrative change required. This would require you to seek a Cabinet decision as part of Budget 2024 processes.
5. There are opportunities for the scheme to:
   a. reach more nurses and midwives
   b. simplify legal and administrative implementation
   c. address educational attrition.
6. Should these opportunities be a priority for you, some adjustments to the design of the scheme would be required. We have outlined possible adjustments in this advice.

Recommendations

We recommend you:

a) **Indicate** if you would like to receive further advice on a bonding scheme for nurses and midwives **Yes/No**

b) **Discuss** with officials your preferences for: **Yes/No**

   i. when to establish the bonding scheme

   ii. options to increase the reach of the bonding scheme

   iii. options to simplify legal and administrative implementation

   iv. options to address educational attrition

c) **Note** the existing Voluntary Bonding Scheme design is flexible and can be adjusted to complement your proposal

d) **Note** subject to your agreement to progress the bonding scheme, we will provide you with further advice in January 2024.

Dr Diana Sarfati

Director-General of Health

Te Tumu Whakarae mō te Hauora

Date: 6 December 2023

Hon Dr Shane Reti

Minister of Health

Date:

Advice on a bonding scheme for nurses and midwives

Background / context

7. We have also provided you with the Ministry of Health | Manatū Hauora's briefing *Health Workforce: Chapter 1* [H2023032584 refers], providing broader context on the health workforce in New Zealand.

8. One of your manifesto commitments is to deliver more nurses and midwives through a financial incentive paired with a bonding scheme (the scheme). Early career nurses and midwives would receive a financial incentive provided they remain working in New Zealand in that profession over 5 years. We understand that your objectives for the bonding scheme are to:

   a. improve the number of practising domestically trained nurses and midwives in New Zealand

   b. deliver the scheme within the costs indicated in your manifesto commitment.

9. This manifesto commitment is not mentioned explicitly in either Coalition Agreement. However, we understand it could be considered a policy to progress training more doctors, nurses, and midwives, referenced in the Coalition Agreement between the New Zealand National Party and New Zealand First Party.[1]

We are ready to support you to deliver your manifesto commitment

The scheme would provide a financial incentive to nurses and midwives

10. Your manifesto commitment outlined a bonding scheme that would:

    a. pay eligible nurses' and midwives' student loan repayments up to $4,500 per year for 5 years ($22,500 total) – providing an additional $4,500 per year of take-home pay

    b. require nurses and midwives to remain working in their profession in New Zealand for 5 years to be eligible

    c. add any payments made by the government back to the student loan if the nurse or midwife leaves the profession or New Zealand before 5 years' service has been completed

    d. be voluntary for nurses and midwives to apply

    e. be available to existing nurses and midwives who have been working for less than 5 years on a pro-rata basis

[1] **Paragraph 11(F)**

f. allow eligible nurses or midwives to pause their 5-year service period for specified reasons (such as parental leave or health reasons)

g. operate alongside the existing Voluntary Bonding Scheme run by Health New Zealand | Te Whatu Ora (refer **Appendix One** for more detail).

Progressing the commitment will require Cabinet decisions and legislative change

11. Cabinet agreement would be necessary to agree policy for the scheme and approve necessary funding. It may also be beneficial for you to proactively seek the support of affected Ministerial portfolios. This would identify implications for other portfolios early and reduce the risk of issues arising during the latter stages of the Cabinet decision-making process which could cause delays. For example, whether the proposed bonding scheme creates a precedent for other workforces facing shortages. We can provide you with advice and technical support for these discussions.

12. In addition to policy agreement and funding, legislative change would be required. Using the student loan scheme as proposed would require amendments to student loan legislation to enable payments to be added back to student loans if someone leaves the scheme early. Inland Revenue have also told us that administrative (IT system) change would also likely be needed.

13. An implementation period would be needed following Cabinet decisions and any legislative changes. This would be necessary to hire staff, develop processes and IT systems, and advertise the bonding scheme.

14. Depending on your priorities, you may wish to consider adjustments to the scheme that simplify its implementation by reducing the need for legislative and administrative changes. These are discussed below.

You have choices about how quickly to implement the scheme

A simple scheme has the highest likelihood of being implemented quickly

15. A simple scheme is one that requires minimal legislative or administrative changes (such as changes to IT systems). s 9(2)(f)(iv) [redacted] s 9(2)(f)(iv) [redacted]. A scheme of this nature could be established for the end of 2024, allowing the scheme to apply for the 2024 calendar year with applications for that year being processed retrospectively.

16. Should you be interested in establishing the scheme quickly, we will provide you with further advice as quickly as possible in January 2024 (subject to Budget processes). This advice will provide you with options on the scheme's design and its implementation.

17. A more complex scheme would be difficult to implement as quickly. There would be little time to deliver legislative and administrative changes following Budget decisions before the scheme was expected to be operational. It may be possible to implement a more complex scheme within the same timeframes, but progress would depend on its relative priority to other Government commitments and if Parliamentary Counsel Office (PCO) has available resource to draft legislation.

A 2025 or 2026 establishment may still need Budget decisions soon

18. A longer establishment timeframe (2025 or 2026) provides more time for any legislative or administrative changes to be made following Budget decisions. Budget 2024 decisions may still be necessary or preferable under longer establishment timeframes. This would ensure funding is available for the scheme once legislation is passed and provide any funds necessary for IT system changes to begin.

s 9(2)(f)(iv)

25. s 9(2)(f)(iv) [redacted]

Addressing educational attrition

26. Increasing the number of nursing and midwifery graduates would help achieve your objective of improving the supply of these professions. Approximately 70% of nursing students[3] and 60% of midwifery students complete their qualification, with rates being lower for Māori and Pacific students. These overall completion rates are lower than most other health professions, but higher or comparable to average completion rates for other non-health degree level qualifications. Financial hardship is commonly cited as one reason that these students do not complete their studies.

27. Our next advice could include options on how the bonding scheme could help address some of this educational attrition. For example, by the scheme starting its 5-year period and providing the financial incentive earlier at significant educational attrition points. This advice would consider how the bonding scheme could work alongside existing student support and other Coalition Agreement commitments, such as final year fees free study.

You will have choices for how the existing Voluntary Bonding Scheme can operate alongside your commitment

28. The Voluntary Bonding Scheme (VBS) is flexible within existing Cabinet set parameters. Health New Zealand | Te Whatu Ora (HNZ) decide which specialties and communities are eligible on the basis of being hard-to-staff and have the most pressing needs. The projected costs of the professions and communities HNZ choose must stay within allocated funding.

29. HNZ have recently expanded the VBS to include all New Zealand graduate midwives working in New Zealand from 2024.[4] This will support HNZ to deliver on its aims in its Health Workforce Plan 2023/24 to improve the retention of practising midwives. Previously, New Zealand graduate midwives were eligible for the VBS if they practised in a specified geographical region.

30. Future advice will provide you with options for how the VBS could operate alongside your manifesto commitment. s 9(2)(f)(iv) [redacted]

[2] Bäringhausen and Bloom, *Financial incentives for return of service in underserved areas: a systematic review* (2009), p.7.

[3] Rates differ depending on the qualification being sought.

[4] 2024 is the first year in which midwives practising anywhere in New Zealand can apply, however midwives that graduated from 2022 will also be eligible.

s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted] We will work with HNZ to ensure the two bonding schemes can complement each other.

There could be opportunities for complementary initiatives in your work programme

31. Research suggests that bonding schemes can improve retention for the length of the bond. We would expect to see some improvement in retention over the five-year bonded period, although the research is not clear on how much retention would improve.

32. Bonding schemes appear to be most effective when used as part of 'policy bundles' to address workforce challenges. Our review of literature indicates that people's choices on whether to stay or leave jobs are individual and context specific. Remuneration, workload and working conditions, educational and career development opportunities, ability to exercise skill, and the extent to which quality care can be delivered all play a role in how satisfying a job is for an individual. This is supported by surveys of New Zealand nurses and midwives who have left the workforce or are considering leaving.

33. Complementary initiatives that seek to address these other drivers could retain more of the workforce than a bonding scheme on its own. We have outlined other opportunities in our *Health Workforce: Chapter 1* briefing to you [HR2023032584] and can provide you with further advice should you wish.

Equity

34. A workforce that is representative of the communities and geographic areas it serves provides choice for different population groups. This enables the health system to respond to the needs of different population groups. Addressing educational attrition could support more Māori and Pacific nurses and midwives into the workforce to deliver on this aim. We will provide you with further advice on this, should you wish to explore this opportunity.

Next steps

35. We are available to meet with you to discuss your priorities for the bonding scheme. We will provide you with further advice on the design of the bonding scheme in January 2024.

ENDS.

Appendix One: Health New Zealand | Te Whatu Ora Voluntary Bonding Scheme Background

1. The Voluntary Bonding Scheme (VBS) was introduced in 2009 to encourage recently qualified health professionals to work in hard-to-staff communities and specialities. The VBS also aims to increase the representation of Māori and Pacific peoples within the health workforce.

2. The VBS was run by the Ministry of Health | Manatū Hauora until 2022 and is now run by Health New Zealand | Te Whatu Ora (HNZ).

3. New or recent graduates in eligible professions accepted to the VBS are eligible for payments in the first 3-5 years of their careers. These payments are used to repay student loan debt, or if there is no student loan, as extra income.

4. The VBS has some flexibility for HNZ to determine which professions are eligible based on existing delegations from the Minister of Health. HNZ consider the Government's priorities and workforce recruitment and retention data when making decisions. The professions and financial incentives for the next 2024 intake are shown below:

Profession	Number in most recent intake	First payment for years 1-3 (after tax)	Second payment for year 4 (after tax)	Third payment for year 5 (after tax)
General practice trainees	30	$30,000	-	-
Registered nurses and enrolled nurses	347	$8,499	$2,833	$2,833
Midwives	71	$10,500	$3,500	$3,500
Radiation therapists	11	$10,125	$3,375	$3,375
Medical physicists	0	$11,796	$3,932	$3,932
Sonographers	8	$11,796	$3,932	$3,932
Dentists	15	$30,000	$10,000	$10,000
Oral health therapists	6	$11,796	$3,932	$3,932
Pharmacists	New 2024 profession	$11,796	$3,932	$3,932
Anaesthetic technicians	New 2024 profession	$11,796	$3,932	$3,932

Minister's Notes

MANATŪ HAUORA
MINISTRY OF HEALTH

Briefing

Adjusting funding cap for Medicine programme

Date due to MO:	5 December 2023	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	H2023033205
To:	Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒	Māori Health Authority: ☒	

Contact for telephone discussion

Name	Position	Telephone
Dr Diana Sarfati	Director-General of Health	s 9(2)(a)
Maree Roberts	Deputy Director-General, Strategy Policy and Legislation	s 9(2)(a)

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Adjusting funding cap for Medicine programme

Security level:	IN CONFIDENCE	**Date:**	05 December 2023
To:	Dr Shane Reti, Minister of Health		

Purpose

1. This briefing provides you with advice on achieving your objective of training more doctors by increasing the funding cap applied to medical school enrolments and seeks your agreement to discuss this with officials.

Summary

2. You have signalled your immediate priorities to train more doctors through increasing the funding cap for Medicine programme.
3. The Government invests in tertiary education annually. The Education agencies (Tertiary Education Commission and Ministry of Education) administer the funding mechanism for degree-level and above courses which imposes equivalent full-time study (EFTS) funding cap for Medicine.
4. Government funding of Medicine programme is limited by a cap because of the high cost of training medical students, including student support costs and associated salaries for clinical placements.
5. Any changes to the funding cap for Medicine would require additional funding sought as part of the Budget process and appropriated to Vote Tertiary Education to cover the tuition subsidy and sixth-year trainee intern grant costs, and to Vote Social Development and Vote Revenue for student support costs.
6. The process to secure funding for an increase in the funding cap is usually led by the Minister of Health in consultation with the impacted portfolio Ministers, with final decisions made by Cabinet.
7. Working closely with relevant stakeholders such as the Treasury, Health New Zealand | Te Whatu Ora (HNZ) and Education agencies will allow officials to determine the extent and pace at which the funding cap for Medicine can be increased.

Recommendations

We recommend you:

a)	**Note** we understand that your immediate priorities are to train more doctors by increasing the funding cap for Medicine programme.	**Noted**
b)	**Note** that the total cost across different Votes to implement the 50 additional places for 2024 was estimated at a total cost of $235 million over ten years.	**Noted**
c)	**Note** that any change in the funding cap would require Cabinet approval and to be considered across Budget priorities.	**Noted**
d)	**Agree** to meet with officials to confirm your intent for training more doctors and progress this initiative as part of the Budget process.	**Yes / No**

Dr Diana Sarfati
Director-General of Health
Te Tumu Whakarae mō te Hauora
Date: 6 December 2023

Dr Shane Reti
Minister of Health
Date:

Adjusting funding cap for Medicine programme

Government funding for Medicine

1. The Government invests in tertiary education annually. The Education agencies (Tertiary Education Commission and Ministry of Education) administer the funding mechanism for degree-level and above courses.
2. The medicine programme (Medicine) is limited by an equivalent full-time study (EFTS) funding cap, which in turn restricts the number of places the medical schools offer to domestic students.
3. Government funding of Medicine is limited by a cap because of high costs associated with training medical students, which includes:
   a. managing tertiary education and student financial support systems costs
   b. ensuring availability of clinical placements as part of undergraduate training
   c. managing resource requirements to supervise and train at postgraduate years 1 and 2 (PGY1 and PGY2) and associated salaries.
4. The current cap on the number of first-year medical school intake is set at 539 equivalent full-time student places, though it will be 589 places from 2024.

Confirming your objectives to train more doctors

5. You have signalled your immediate priorities to increase the number of doctors trained in New Zealand by an additional 50 places from 2025 for the Auckland and Otago medical schools. It also includes a proposal to establish a new medical school with a training capacity of 120 places from 2027.
6. We believe your objective is to train 220 more doctors by 2030, including the additional 50 places from 2024.
7. Alongside this paper, you have also received advice on your priorities for the third medical school [*H2023033203 refers*].
8. We can adjust the funding cap for Medicine to achieve your objectives, which can be increased to provide additional places over a period of time through existing medical schools, or a combination of increasing the funding cap for existing medical schools and for a new medical school. Officials recommend having a discussion on your objectives to train more doctors and next steps.

Process to increase the funding cap for Medicine

9. To increase the funding cap for Medicine will require additional funding sought as part of the Budget process and appropriated to Vote Tertiary Education to cover the tuition subsidy and sixth-year trainee intern grant costs, and to Vote Social Development and Vote Revenue for student support costs.

10. The cost profile of any increase to the funding cap for Medicine will be different depending on how an increase is phased over time. The table below shows **indicative** total costings over ten years for increasing the funding cap for Medicine by 50.[1] We have also shown an increase of 120 and 170 places, to reflect longer-term increases aligned to the establishment of a third medical school.

Table 1: Indicative operating and capital costings to increase funding cap over 10 years

Additional places	Opex (~$m)	Capex (~$m)	Total (~$m)
50	202	33	235
120	510	85	595
170	710	120	830

11. The process to secure funding for an increase in the funding cap is usually led by the Minister of Health in consultation with the impacted portfolio Ministers, with final decisions made by Cabinet.

12. A discussion with the impacted portfolio Ministers will be vital to make any adjustments to the funding cap for Medicine.

13. Officials would continue to engage and work closely with:

    a) the Treasury and Education agencies to understand fiscal implications of increasing the funding cap

    b) the medical schools to understand their capacity to take on additional medical students

    c) HNZ to seek assurance on whether the health system has the capacity to train and supervise additional medical graduates each year.

14. Working closely with these stakeholders will allow officials to determine the extent and pace at which the funding cap for Medicine can be increased.

15. Changes to the funding cap for Medicine will also require consultation with the tertiary sector. The funding cap is specified in a funding mechanism issued annually by the Minister of Education to the TEC – in accordance with section 419 of the Education and Training Act 2020.

16. Subject to Cabinet's approval of funding, a further increase to the cap would be drafted into the proposed funding mechanism, which is put to the Minister of Education for approval to initiate consultation with the tertiary sector during August each year. The funding mechanisms are then confirmed or amended following the Minister of Education's consideration of consultation feedback.

17. The TEC will then determine the allocation of funding for the additional places across medical schools as part of business-as-usual funding processes.

[1] **10-year forecasting is vital as there are significant costs occurred across Votes in outyears.**

Factors to consider for the health and education systems

Wider fiscal considerations

18. We are working with Treasury and Education agencies to estimate the costs of additional placements, particularly student support cost implications. Officials will provide further advice on undergoing Budget processes should you agree to progress with increasing the funding cap for Medicine.

19. It is possible that further increasing the funding cap for Medicine may require higher tuition subsidy rates to support necessary investments in infrastructure and training capacity to deliver additional training places.

20. Increasing the funding cap for Medicine requires significant investment and may have trade-offs in other parts of health workforce development. There is a risk that significant investment in the medical workforce could be seen as coming at the expense of other health professionals.

21. Separate advice on the third medical school outlines the significant investment required in both the tertiary and health systems [*H2023033203 refers*].

Medical school capacity

22. s 9(2)(j) [redacted]

23. [redacted]

24. We will continue working with Education agencies and initiate engagement with the medical schools to further understand the impacts of increasing the funding cap on existing physical and support infrastructure, and academic staffing capacity requirements for appropriate medical training.

Support for medical graduates

25. Increasing the number of medical school graduates requires equivalent supervisory staff capacity in our health system. This requirement for the health system begins from the fourth-year of Medicine and first years of practice as a doctor.

26. HNZ considers that it will be able to accommodate more doctors in practice with sufficient supervisors by the time new cohorts are ready to practice.

27. HNZ has been committed to ensuring that all New Zealand-trained medical school graduates with a right to work in New Zealand receive an offer of employment. Evidence shows that of the nearly 2,600 domestic medical school graduates who applied for employment in New Zealand since 2019, all but two received an offer. However, international medical students have been given low expectations of employment in New Zealand by universities on recruitment. HNZ endeavours to increase retention and employment of international students.

28. Additionally, COVID-19 has resulted in a higher-than-usual number of deferrals – instances of students delaying completion of their medical training by a year. This has resulted in a relatively small intake of new medical graduates for 2024 (530), and a larger cohort (up to 585) anticipated for 2025. This will provide an opportunity for HNZ to demonstrate its capacity to support increased numbers of medical graduates.

29. We will continue to work with HNZ to grow and bolster our capacity to train and supervise more medical health professionals in the future.

Health workforce supply

30. A change in the funding cap for Medicine has a long lead time before we see additional workforce numbers and is unlikely to have meaningful impact on current workforce issues until the early 2030s. For example – a fully trained general practitioner (GP) will require about 11-12 years of training which means that a new student next year will grow our GP workforce numbers from 2036.

31. There are other opportunities to increase supply of the workforce through:

    a) exploring ways to adopt more efficient medical training approaches across the medical schools

    b) improving registration processes for internationally trained doctors

    c) strengthening representation of the workforce, and

    d) better utilising our workforce more broadly.

32. For example – there are opportunities to explore expanded, efficient pathways into practice – including by building on the New Zealand Registration Examination (NZREX) pilot already approved by the Medical Council for internationally qualified doctors in 2023.

33. We understand that similar workforce challenges are experienced globally, and many countries are working to address these issues by developing workforce strategies that recognise the need for a multi-faceted approach.

Equity

34. Any increase in medical school places requires a focus on how it impacts equity. We would expect to see an increase to the number of Māori, Pacific, and disabled students, as well as people living rurally and in high deprivation areas, being included in the new student intake.

35. The students should be reflective of the communities they will be providing health services for. Should a decision be made to increase medical school places, Health and Education agencies will work with the medical schools to identify how the additional places can help grow a medical workforce to ensure growing representation of Māori and Pacific peoples, and help grow a medical workforce which aspires to work in primary and community settings, particularly rural and provincial settings.

Next steps

36. Officials recommend having a discussion in relation to your objectives to train more doctors, and how you'd like to progress this work.

37. We will work with HNZ and Education agencies to provide further advice on next steps including Budget processes.

ENDS.

Minister's Notes

Te Whatu Ora
Health New Zealand

MANATŪ HAUORA
MINISTRY OF HEALTH

Briefing

Initial advice on establishing a Mental Health Innovation Fund

Date due to MO:	14 December 2023	**Action required by:**	18 December 2023
Security level:		**Health Report number:**	H2023033585
		Health New Zealand Report:	HNZ00033410
To:	Hon Matt Doocey, Minister for Mental Health		
Copy to:	Hon Dr Shane Reti, Minister of Health		

Contact for telephone discussion

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Jo Chiplin	Director Mentally Well National Commissioning Health New Zealand	s 9(2)(a)

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Initial advice on establishing a Mental Health Innovation Fund

Security level: **Date:** 11 December 2023

To: Hon Matt Doocey, Minister for Mental Health

Purpose of report

1. This briefing provides initial information and advice for implementing the Government coalition priority to establish a Mental Health Innovation Fund and signals further advice to follow regarding the commitment to provide funding for Gumboot Friday/I Am Hope Charitable Trust.

Summary

Mental Health coalition commitments

2. Government has made two coalition commitments within the Mental Health portfolio. Officials assume these are two separate commitments to:

   a. establish a Mental Health Innovation Fund of up to $20 million over 4 years

   b. fund the Gumboot Friday/I Am Hope charitable trust to $6 million per annum.

Establishing a Mental Health Innovation Fund

3. The Ministry of Health | Manatū Hauora (the Ministry) and Health New Zealand | Te Whatu Ora (Health New Zealand) welcome the establishment of the Mental Health Innovation Fund and the potential benefits it can deliver to help improve the mental health and wellbeing of New Zealanders.

4. Health New Zealand can establish and administer the Mental Health Innovation Fund as a competitive grant programme aligning with the 6 criteria already outlined in detailed Government policy documents, noting the additional requirement of matched funding and the restriction that grants not be used for overheads or administration costs. However, if demand exceeds the funding available, officials may need to develop additional prioritisation criteria.

5. Officials seek confirmation that the intention of the commitment as indicated in the fiscal plan is for new investment through Budget 2024 of $5 million per annum for 4 years, beginning financial year 2024/25, to establish the Mental Health Innovation Fund. Because of the time-limited nature of the funding to implement this commitment, Health New Zealand will seek proposals for time-limited innovations rather than ongoing service delivery proposals.

6. Officials advise that if the Fund is not established through new investment, further advice and processes will be required.

7. Health New Zealand can commence preparatory work on the Fund in early 2024, however full implementation cannot commence until funding for the commitment is confirmed.

Further advice will follow regarding funding for Gumboot Friday/I Am Hope Charitable Trust

8. Ministry officials are working through the best mechanism to implement the commitment to fund Gumboot Friday/I Am Hope Charitable Trust given some of the legal complexities involved. Further advice regarding implementation of this commitment will be provided as soon as possible.

9. While further advice is being developed, Ministry officials are seeking direction on the source of funding for the Gumboot Friday/I Am Hope Charitable Trust commitment. We recommend discussing the potential for additional funding, or otherwise implications of sourcing funding from within Vote Health, with the Minister of Health.

Recommendations

We recommend you:

a)	**Confirm** the intention of the commitment is to establish the Mental Health Innovation Fund through new funding investment as signalled in the fiscal plan	**Yes/No**
b)	**Confirm** the intention of the commitment is that the Mental Health Innovation Fund be established as a time-limited 4-year fund	**Yes/No**
c)	**Note** that Health New Zealand can commence preparatory work to establish the Mental Health Innovation Fund in early 2024 subject to confirmation of funding	
d)	**Agree** to discuss the source of additional funding for both the Mental Health Innovation Fund and Gumboot Friday/I Am Hope Charitable Trust, with the Minister of Health	**Yes/No**
e)	**Note** that if new funding is not available, additional procedural steps will be required to enable implementation of these commitments.	

Dr Diana Sarfati	Margie Apa	Hon Matt Doocey
Director-General of Health	**Chief Executive**	**Minister for Mental Health**
Ministry of Health	**Health New Zealand**	
Date: 13/12/2023	Date: 13/12/2023	Date:

Initial advice on establishing a Mental Health Innovation Fund

Context

1. As part of the Government coalition agreements, 2 priority commitments have been identified within the mental health and addiction portfolio:

   a. establishing and operating the Mental Health Innovation Fund of up to $20 million over 4 years

   b. funding the Gumboot Friday/I Am Hope Charitable Trust (the Trust) to $6 million per annum.

2. These commitments align with the critical role that non-governmental organisations (NGOs) play in supporting people's mental health and addiction needs in the community across the primary and specialist mental health continuum.

Establishing a Mental Health Innovation Fund

3. As indicated in the Government's fiscal plan and more detailed policy documents, there is a commitment to establish a Mental Health Innovation Fund (the Fund), of up to $20 million over four years for community and NGO mental health providers. This includes a requirement of matched funding from NGOs.

4. The Ministry and Health New Zealand welcome the establishment of this Fund and the recognition it gives to the critical and excellent work being done by NGOs out in communities to improve mental health outcomes. This Fund has the potential to deliver significant benefits in relation to the mental health and wellbeing of New Zealanders by driving and supporting innovation within the sector.

Administration of the fund

5. Health New Zealand can establish and administer the Fund as a competitive grant aligned with the Government Rules of Procurement and funding and procurement guidance from the Office of the Auditor-General.

6. Detailed eligibility and assessment criteria will be developed ensuring alignment with the 6 criteria outlined in the Government policy documents. This will also include any necessary clinical safety criteria. In the event demand exceeds the funding available, officials may also need to establish additional prioritisation criteria.

7. Officials seek confirmation that the intention of this commitment, as indicated in the Government fiscal plan, is that the $20 million for the Fund will be new funding through Budget '24 and the duration of the funding will be limited to 4 years. Due to the time-limited nature of the funding, the criteria developed will need to focus eligibility on proposals that are also time-limited, meaning funding proposals for ongoing service delivery would not be eligible.

8. Work to develop the detailed criteria can commence early in 2024, however full implementation cannot commence until the funding for the commitment described in the fiscal plan is made available.

9. Officials understand that funding for this commitment will not be progressed as part of the mini-Budget, therefore the funding will need to be secured through the routine Budget '24 process. The budget strategy expected to be released the week of 18 December is expected to provide greater clarity on pathways for progressing commitments with financial implications.

10. Officials advise that if the new funding indicated in the fiscal plan is not available, additional procedural steps will be required to enable implementation of this commitment. Officials can provide further advice on these steps if needed.

Further advice will follow regarding funding for Gumboot Friday/I Am Hope Charitable Trust

11. Ministry officials have identified some legal complexities related to implementing the commitment to fund Gumboot Friday/I Am Hope Charitable Trust (the Trust). Officials are developing advice on the best mechanism to implement this commitment in light of these complexities. This advice will be provided as soon as possible.

Source of funding to implement the Gumboot Friday/I Am Hope funding commitment

12. While advice on how to implement this commitment is in development, Ministry officials are seeking early clarification on the source of funding for this commitment. We note that the Government's fiscal plan does not include the commitment to fund the Trust. We are seeking clarification on whether the $6 million per annum for the Trust will be allocated as new funding or whether it is expected to be delivered through existing Vote Health funding as well as clarification on the duration of the funding.

13. Ministry officials understand that there has been no indication that funding for this commitment will be progressed as part of the mini-Budget, which means any new funding for the Trust will need to be sought through the Budget '24 process. We understand that Budget '24 will be under tight fiscal constraints, but the Budget strategy expected to be released the week of 18 December may provide greater clarity on pathways for progressing commitments with financial implications.

14. If new funding is not an option for this initiative, then further consideration of options and processes will be required.

15. Ministry officials recommend discussing the potential for new funding with the Minister of Health.

Next steps

16. Officials will develop and provide advice on implementation of the commitment to fund the Trust as soon as possible. In the meantime, we recommend you engage in discussions with the Minister of Health regarding new funding to implement the commitment to fund the Trust.

17. We will provide updates on processes and timeframes to implement the Mental Health Innovation Fund in early 2024.

18. We are available to discuss the information and advice provided in this briefing at an officials meeting.

Minister's Notes

Briefing

Manifesto commitment – Immunisation Incentive Payments Plan

Date due to MO:	19 December 2023	**Action required by:**	19 January 2024
Security level:	IN CONFIDENCE	**Health Report number:**	2023032822
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☒		

Contact for telephone discussion

Name	Position	Telephone
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Emma Prestidge	Group Manager Family and Community Health Policy, Te Pou Rautaki | Strategy, Policy & Legislation, Manatū Hauora	s 9(2)(a)

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Manifesto commitment – Immunisation Incentive Payments Plan

Security level:	IN CONFIDENCE	**Date:**	19 December 2023
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This report follows your immunisation deep dive discussion with health officials on Monday 11 December 2023 where you discussed how the system could be strengthened to improve childhood and other immunisations.

2. The purpose of this report is for you to:

   - **agree** to an approach for proceeding with your election commitment to provide general practice with a one-off payment of $10 for every enrolled patient if they achieve three improvement measures related to childhood immunisation (24 months), the Measles Mumps and Rubella vaccine and influenza vaccination (65 years and over).
   - **note** that there are a range of implementation options you may wish to consider to ensure general practice is well supported to achieve the target measures

Summary

3. We understand that the immunisation incentive payment plan is a key policy priority to address declining immunisation rates. This briefing seeks your direction on the policy design to inform the development of a bid for Budget 2024.

4. General practice is the main provider of childhood immunisations for most New Zealanders. However, persistent access barriers to general practice mean that efforts to increase immunisation rates need to make more effective use of the range of providers and outreach strategies available.

5. There are some options you may wish to consider as part of the implementation plan, such as the timeframes, where accountability sits, and how the funding should be directed, to mitigate some of the challenges to achieving the policy objectives.

6. Once you have given your direction on the policy design and implementation parameters via this briefing, the Ministry of Health, Health New Zealand | Te Whatu Ora (HNZ) and Māori Health Authority | Te Aka Whai Ora (in accordance with statutory roles) will work together to provide a more detailed implementation plan.

Recommendations

We recommend you:

a) **Note** that we understand the key objectives of the immunisation incentives plan are as follows:
   - Maximise overall immunisation population coverage
   - Address lack of immunisation uptake in target population groups
   - Increase support for general practice **Noted**

b) **Note** that policy design choices, particularly around the basis for funding, eligibility for incentive payments, and timing will influence the extent to which the incentive payment plan can successfully achieve the above objectives **Noted**

c) **Note** that the proposed design of the manifesto commitment will make it challenging for most practices to achieve all three target measures, and may result in a significant underspend of the proposed $52 million budget **Noted**

Decisions on implementation approach

d) **Agree** to the start date for the target measures as part of the incentive payment plan:
   - 1 July 2024 **Yes / No**
   - To be discussed **Yes / No**

e) **Agree** to the basis for directing funding when the target measures are successfully achieved:
   - Per patient in targeted age bands **Yes / No**
   - All enrolled patients **Yes / No**

f) **Agree** to the key point of accountability for the target measures and directing incentive payments:
   - Primary health organisations **Yes / No**
   - Individual general practices **Yes / No**

g) **Note** that if you target payments by relevant age bands as per recommendation (e), this would enable more funding to be used to put other supporting measures in place to meet the policy objectives, such as payments to other providers of key immunisations and enabling some upfront payments to cover outreach costs **Noted**

h) **Indicate** whether you wish to receive further advice on the potential supporting measures as per recommendation (g) **Yes / No**

i) **Note** that the estimated funding required for the incentive payments plan is up to $58 million, which would need to be sought through Budget 2024 **Noted**

i) **Note** that funding would be via a letter of agreement between Health New Zealand | Te Whatu Ora and primary health organisations, with the latter to support general practices/other providers with administration of the plan **Noted**

Dr Diana Sarfati
Director-General of Health
Te Tumu Whakarae mō te Hauora
Date: 20 December 2023

Hon Dr Shane Reti
Minister of Health
Date:

Manifesto commitment – Immunisation Incentive Payments Plan

Background

1. Your "Targeting better health outcomes" policy document outlines your pre-election commitment to introduce the Immunisation Incentive Payments plan (the incentive payment). The incentive payment is described as follows:

   GP clinics will be eligible for a one-off payment of $10 for every enrolled patient on their books provided they achieve each of the following three improvement measures by 30 June 2024:

   i. *Childhood immunisation (24 months) – improve immunisation rate by five percentage points or achieve a 95% immunisation rate among eligible patients.*

   ii. *MMR immunisation (1-17 years) – improve immunisation rate by five percentage points or achieve a 95% immunisation rate among eligible patients.*

   iii. *Influenza vaccination (65 years and over) – improve immunisation rate by five percentage points or achieve a 75% immunisation rate among eligible patients.*

   The baseline for each GP clinic is the immunisation rate for their enrolled patients in each of these target groups as of 31 October 2023.

2. There are 4.93 million New Zealanders currently enrolled within general practice as at September 2023. Table One below shows the current baseline immunisation numbers among this eligible population as at 31 October 2023. Appendix 1 provides additional context and information on the population groups within the improvement measures.

   Table 1: Baseline immunisation numbers for key measures of interest

Immunisation	Eligible age group	Total eligible	% complete for overall population
Childhood	Under 24 months	61,559	83%
MMR	1-17 years	1,053,225	85%
Influenza	65 years and over	860,950	64%

3. You have estimated the cost of the incentive payment plan as $52 million, which represents the maximum cost if every general practice achieves all three targets.

4. This would be in addition to existing initiatives to support greater immunisation. Over the past two years the fee for service payment for most immunisations has increased from $23.20 (in 2021) to $36.05 (from 1 July 2023). The Primary Health Organisation Services Agreement (PHOSA) also provides for additional performance payments based on achieving childhood immunisation targets for 8-month-olds.

5. We understand that this incentive payment could also support your proposed Health Target to improve childhood immunisations, for 95% of two-year-olds to receive their full age-appropriate immunisations. You have received a separate briefing on implementing Health Targets (H2023032864 refers).

Objectives of the manifesto commitment

6. We understand that this manifesto commitment is underpinned by a number of policy objectives, including:

   - the need to reduce the risk of outbreaks of vaccine preventable diseases, by maximising uptake of immunisations across the entire population
   - the need to address lack of immunisation uptake in the improvement measures' target population groups
   - increasing support for general practice to carry out one of their core roles.

We welcome your steer on which of these objectives (or alternatives) you wish to prioritise in the design of the immunisation incentive payment plan.

Key elements of the policy design

7. Based on the wording of the manifesto commitment and your public statements, we understand the key elements of the intended policy design as follows:

   a. **Basis for funding:** $10 is paid for each enrolled patient at individual general practices that achieve the three improvement measures.

   b. **Eligibility for payment:** Incentive payments are directed to general practices only, regardless of whether immunisations were delivered by other providers.

   c. **Timing of payment:** Payment is only made after the reporting timeframe has finished to confirm whether all three target measures were achieved.

8. The above policy design would most strongly support the objective of increasing immediate support for general practice, particularly for those that have already achieved the improvement measures and in some cases those that are close to the target. However, the plan may not adequately recognise the different challenges that some general practices face based on the demographics of their enrolled populations. You may wish to consider how the policy design and/or implementation could be adjusted to help overcome these challenges.

Implementation approach and estimated costs

9. The following implementation plan and estimated costs are based on the above policy design elements. Once you have confirmed these, HNZ will develop a detailed implementation plan.

Timeframes for measurement and payment

10. Baseline data will record the immunisation rate for each improvement measure in individual general practice as at the start date. They will need to meet all three improvement measures by the end date you determine, when immunisation rates for each general practice will again be calculated.

11. The incentive payment plan was proposed to run over an eight-month period – 31 October 2023 to 30 June 2024. Since the funding for this policy depends on Budget 2024 decisions, we recommend delaying the intended start date until 1 July 2024. This date allows sufficient time for Cabinet to confirm funding and the parameters of the incentive

payment plan. We seek your direction on the appropriate time period for the targets to be achieved in order to qualify for the incentive payments. Since progress towards the target measures will be reported on quarterly, we recommend that the end date for the incentive payment is aligned with this cycle (for example, either nine or twelve months).

12. General practice and primary health organisations (PHOs) do not currently have certainty about the scope, funding and expectations attached to the incentive payment plan. We recommend delaying the start date of the measurement period until the policy is confirmed so that key stakeholders know the target measures they need to focus on.

13. Shifting the start date out would also reduce difficulties associated with making general practices accountable for targets covering a retrospective period they did not have certainty of prior to the policy being confirmed. The Christmas period will not be an ideal time to begin planning with practice staff and patients likely to be on leave.

14. Once funding through Budget 2024 is confirmed, communications to the sector outlining the policy and expectations should be provided as soon as is practicably possible.

Estimated costs of the intended incentive payment plan

15. You have estimated the cost of implementing the incentive payment plan at $52 million, which represents the maximum cost if every general practice clinic in the country achieves all three targets.

16. The key elements of HNZ's estimated costs associated with the intended incentive payment plan, based on the policy design elements outlined above, include:

    a. The cost of the incentive payment of $10 per person for the entire enrolled population ($49.3 million in 2024/25)

    b. The cost of a 5% volume increase in vaccination coverage ($5.9 million in 2023/24)

    c. The cost of scaling up existing outreach efforts for the enrolled population ($2.6 million in 2023/24).

17. The total cost of the plan is estimated to be approximately $58 million. These costs are based on the key assumption that every individual general practice achieves the three performance measures and therefore is eligible to receive the incentive payment. These costs may need to be revised depending on your preferred start and end dates for the policy.

18. This costing includes one-off costs only and excludes any ongoing costs. Programme set up, implementation and communication costs in the National Public Health Service and primary and community healthcare providers would be absorbed within baselines using established processes to target the enrolled population.

19. The cost of the 5% volume increase in vaccinations has been included as achieving this increase is likely to contribute to the existing cost pressures that many general practices and other community providers are facing. If a 5% increase in volume above current vaccination coverage was maintained from 2024/25 onwards, this would likely cost an additional $1 million per annum at current fee-for-service rates. The cost of additional vaccines that PHARMAC would be required to purchase to meet demand have been excluded from costings at this stage.

Funding decisions should be confirmed prior to announcement of the policy

20. New funding for the cost of the incentive payment itself as well as anticipated volume increases in vaccinations to be delivered (up to $58 million overall) would need to be sought through Budget 2024. Officials will prepare a bid to be submitted at the end of January 2024 following your feedback on this briefing.

You could consider a funding approach that includes an allocation for supporting measures

21. You may wish to consider alternative funding approaches that could support other measures to assist with lifting immunisation rates including:

    a. repurpose any unused funding **after** the end date for the policy (i.e. funding not paid out to practices who did not achieve the target measures)

    b. scale down the funding for direct incentive payments based on age bands and pre-allocate some funding for supporting measures **during** the policy timeframe (described below).

22. There is a cohort of approximately three million enrolled people between the ages of 18 to 64 years that are not within the target population of the improvement measures, but for which general practice would receive $31 million of support to lift immunisation rates. You could instead limit incentive payments to those age groups in direct scope of the improvement measures. This could reduce the cost of the incentive payment plan by better targeting funding to the key age groups that are the focus of immunisation efforts, and would also free up remaining budgeted funding for other priorities.

23. Either of the above alternative funding approaches would give you the flexibility to fund supporting measures that would strengthen the likelihood of achieving the objectives of the incentive payment plan, even across a longer timeframe. For example, these supporting measures could include a portion of incentive funding available for other immunisation providers and/or making upfront payments to those providers that face greater challenges in immunising their populations. We can provide you with further advice if you would like to explore these options.

Mechanism for payment, monitoring and reporting of results

24. Funding for the incentive payment plan would be via a letter of agreement between HNZ and PHOs. PHOs would undertake the administration functions, such as monitoring and reporting, and would support general practice to implement the incentive payment plan.

You may wish to consider making PHOs the key point of accountability rather than general practices

25. One variation of the policy design could be to measure success at the PHO level (based on the overall enrolled population for each PHO) and providing payments directly to PHOs and/or within regional allocations for HNZ.

26. There are 30 PHOs of various sizes across the country, and 898 general practices. PHOs play a key role in facilitating and promoting service development, coordination and

integration.[1] They are ultimately responsible for the provision of immunisation services and achieving current immunisation measures, as well as promoting immunisation within their communities.

27. This option would allow greater flexibility in the use of funding, as well as other PHO resources and wider community connections. While we expect many PHOs will pass incentive payments directly to their contracted general practices, this would also give PHOs discretion to use the funding to reward a wider range of providers[2] that they have existing relationships with, based on the immunisation strategies for their communities.

28. For example, PHOs would be able to support general practices by directing funding to those practices that have contributed towards the PHO's overall success, including those that have made a substantial increase in their immunisation rates across the measures, or within one particular measure. As the potential payments will be larger at a PHO level than at an individual practice level, the incentive is more likely be a valuable motivation to shift immunisation rates upwards.

29. Another option to achieve this flexibility could be to include funding within HNZ's regional allocations. This would enable planning towards the improvement measures to be included into the Regional Integration Plans, that can create a collective call for action, including PHOs as well as other outreach services, other community providers/partners, public health, and integrated care teams.

We are seeking your direction on whether you would like more detailed information on options to achieve more flexibility.

Risks to consider in taking forward this commitment

Māori and other target populations are less likely to be enrolled with primary health organisations and the approach may not support obligations under Te Tiriti o Waitangi

30. One key reason for the decline in traditional delivery of immunisations is the increasing difficulty in accessing general practice, particularly for those with the most need. System barriers such as high co-payments, 'closed books' due to demand (as at June 2022, one third of practices were not accepting new enrolments) and location of services are just some factors that contribute to this. This is further influenced by the ease of access to vaccination services at community pharmacies where there is no need to enrol or expectation of ongoing continuity of care.

31. Populations that experience low immunisation coverage are less likely to be enrolled with a general practice, and those who are enrolled are more likely to experience barriers to accessing services. This means these populations are more difficult to reach through general practice. Achieving the targeted immunisation rates for these populations is likely to require a tailored approach from providers, for example using a combination of targeted communications, different workforces such as kaiāwhina, different providers

[1] PHO Services Agreement 2023.

[2] Depending on the PHO in question, these providers may include community pharmacies as well as other community-based health services such as Māori and Pacific providers.

such as community pharmacies and community health services (including Māori and Pacific providers), and local outreach initiatives to make immunisation more accessible.

32. Using the enrolled population misses 96,917 unenrolled health service users within the improvement measures' target populations.[3] This would therefore overestimate the true population vaccination coverage, leaving New Zealand more susceptible to an outbreak of a vaccine preventable disease.

33. Māori babies were consistently 20% less likely to be enrolled with a PHO at six weeks of age compared to European/Other babies between 2019–2022. This gap has increased for older babies, as Māori three-month-olds were over 30% less likely to be enrolled with a PHO in 2019 compared to European/Other babies, increasing to 45% in 2022.

34. In 2022, Māori (82.9%) were 16% less likely to be enrolled in a PHO compared to European/Other people (99% of European/Other people). The difference in PHO enrolment was particularly high for the immunisation target groups, with Māori in the 0-4, 5-19 and 65 years and above age groups all around twice as likely to be unenrolled compared to European/Other people in 2022.

35. However, there is evidence from the COVID-19 response that the community outreach approach, used alongside online channels and digital technology, helped Māori and Pacific providers immunise those who had not previously engaged with the health system. Data indicates that this approach not only enabled Māori organisations to deliver 35% more COVID-19 vaccine doses to Māori than non-Māori organisations, but it also led to significant increases in uptake of the influenza vaccine for Māori over 65. To ensure equitable health outcomes for Māori and other targeted populations, a more targeted approach to vaccination is required.

The workforce is under pressure and not all general practices have available resources

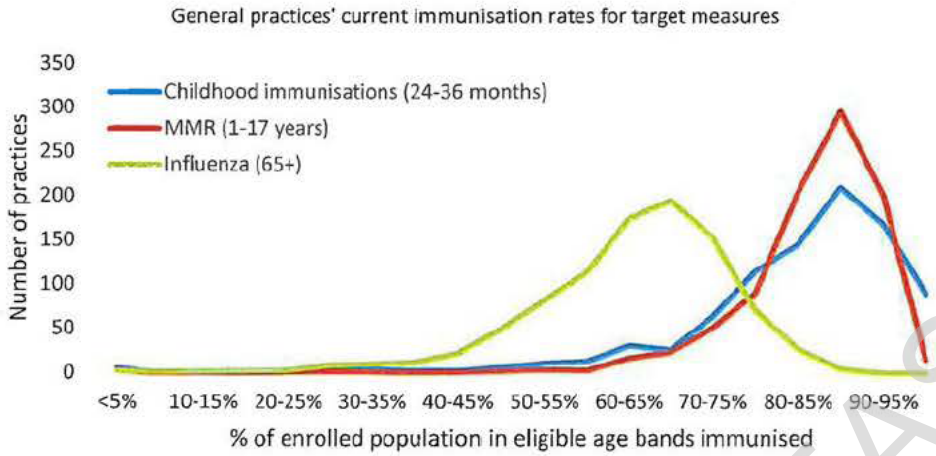
36. The overstretched general practice workforce and other resourcing pressures are a significant barrier to increasing immunisation rates. For example, a Very Low-Cost Access (VLCA) general practice working with low socio-economic communities may not have available resources, such as workforce and cashflow, to follow up enrolled patients. Other practices that are close to reaching the target measures may have already exhausted attempts to contact enrolled patients.

37. The general practices struggling with resourcing pressures will have to assess the level of risk involved in investing funding upfront with no guarantee of meeting the improvement measures, and would therefore not receive the incentive payment despite putting time and resources into trying to meet the targets.

38. This contrasts with other general practices that may have already met or exceeded the measures. Figure 1 shows the distribution of general practices by their immunisation rates for in their eligible populations for the target measures.

[3] Te Whatu Ora. National Enrolment Service September 2023 (2023). Te Whatu Ora. Health Service Users 2022 (2023).

Figure 1: General practices' current immunisation rates for eligible populations[4]



39. Preliminary analysis of 898 general practices shows that only two practices have sufficient immunisation coverage among their enrolled populations to be meeting all three of the target measures as at 31 October 2023, with a further 70 practices within 5% of all three target measures, and a further 184 within 10%.[5]

40. We note that there is a risk of a significant underspend given the difficulty of all general practices achieving all three target measures and/or a 5% increase in their baseline rates in the specified timeframe. This could be mitigated in part through an implementation approach that enables more flexible use of funding, including allowance for upfront payments where practices are more likely to face resource constraints in delivering outreach approaches.

41. Even if general practice were to be the only provider eligible for the incentive payment, implementation guidance could encourage greater collaboration, for example general practice sharing their enrolment data and coordinating other providers to deliver vaccinations and outreach services. This would align accountability with incentives. No matter how many other providers are involved in immunisation efforts, general practice would retain accountability through being eligible to receive the incentive funding. This encourages general practice to act as the coordinator and work with Pharmacies, Māori and Pacific providers, and others in order to provide greater access and outreach.

42. The evidence and recommendations from the Immunisation Taskforce Report show that there are many systemic reasons[6] for low immunisation uptake in some population groups, and over decades there has been very little in the way of an effective

[4] This data includes immunisations delivered outside of general practice. It is provided by general practice in this context because the data is linked to enrolments.

[5] Note that this data only covers immunisations recorded in the National Immunisation Register. This means that the 'fully immunised' percentage may not be an accurate reflection of population immunity, and is most likely an underestimate. This effect is seen more in the older age groups of children and adolescents.

[6] These include a lack of effective governance, lack of consistency and quality of practice, lack of oversight and measurement of outcomes, and lack of co-design or input from community groups, especially Māori.

government response. This means that shifting current immunisation trends will be a difficult task, as these trends are also linked to the broader weaknesses with how the primary and community healthcare system is set up in New Zealand. Some of the key recommendations from the Taskforce report include expanding the vaccinator workforce (particularly for childhood immunisations), reducing the complexity of the authorisation process, working on a comprehensive antenatal immunisation system, reviewing enrolment into health services from birth, and further work on proactive outreach and catch-up immunisations.

43. Officials will be available to discuss the potential for a longer-term work programme on these issues if you would like to consider this opportunity.

Next steps

44. Subject to your feedback and decisions on the implementation approach, we will prepare material to support a bid for funding through Budget 2024. We will also start developing an implementation plan, communications collateral, and options for monitoring and evaluation of the success of the policy in lifting immunisation rates.

45. Officials will be available should you wish to have a discussion on your objectives and preferred approach to taking this commitment forward.

ENDS.

Minister's Notes

Appendix A: Context and information on the target population groups in the immunisation measures

Childhood immunisation (24 months)

1. Lifting childhood immunisation rates has been identified as a priority by the World Health Organisation. This is in response to an international decline in rates in recent years, which were exacerbated by the COVID-19 pandemic. HNZ and MHA are addressing the decline of childhood immunisation rates as a priority to reduce preventable illness and avoid further inequities.

2. Between 1 January - 31 March 2023 83.2% of children turning two years of age had all their age-appropriate scheduled vaccinations. However, for Māori this was 68.9% and Pacific 81.2%. Further analysis shows a significant ethnic disparity measured at ages closest to scheduled vaccination events, for example the six month completed immunisation rates for tamariki Māori in South Auckland are 34%.[7]

Measles, mumps and rubella (MMR) immunisations

3. The MMR vaccine is scheduled for children at ages 12 and 15 months. High MMR coverage for the whole population is important, particularly for young adults who are known to have low rates (MMR coverage information is only held for people born since 2005). Regular reporting does not capture children who missed on-time MMR vaccinations and have subsequently caught up on the vaccination.

Influenza for people over 65 years old

4. The natural decline in immunity associated with ageing can increase an older person's vulnerability to both the risk of getting flu and of serious complications. Mortality is also significantly higher in older people with flu. Recognising this, the influenza vaccine is publicly funded for all New Zealanders over 65-year-olds along with other high-risk groups.[8]

5. While influenza immunisation rates have increased in recent years, in 2021/22 only 65% of all New Zealanders over 65 years had the influenza vaccination, despite being eligible for free vaccination. Māori and Pacific people's influenza vaccination rates were lower than the overall population (57% and 56% respectively), and for 55–64 years 31% Māori, 36% Pacific, 30% European/Other.

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[7] Immunisation Taskforce Report, 2022.

[8] For 2023, PHARMAC approved publicly funded flu vaccines for Māori and Pacific peoples between 55 – 64 years, recognising the younger age structure of these populations and the impact of the pandemic on hospitalisation.

Briefing

Budget 24: Shifting to a sustainable strategy for managing COVID-19 and preparing for future outbreaks and pandemics

Date due to MO:	25 January 2024	**Action required by:**	29 January 2024
Security level:		**Health Report number:**	H2024034757
To:	Hon Dr Shane Reti, Minister of Health		
Refer to:	Hon Nicola Willis, Minister of Finance (*Subject to recommendations below)*		
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☐		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a)
Dr Andrew Old	Deputy Director-General, Public Health Agency	s 9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Budget 24: Shifting to a sustainable strategy for managing COVID-19 and preparing for future outbreaks and pandemics

Security level:		**Date:**	25 January 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This briefing:
   a. notes the need to shift investment in COVID-19 prevention and response into a sustainable post-pandemic public health service:
   b. notes the opportunity to minimise the ongoing impact of COVID-19, to maintain preparedness for future health emergencies, and to maintain improved day-to-day public health capability to anticipate, prevent and respond to a range of threats from communicable diseases; and
   c. seeks your decision on whether you wish to:
      i. proceed with the invited Pharmac COVID-19 vaccinations and therapeutics initiative unchanged; or
      ii. seek an invitation from the Minister of Finance to expand the invited Pharmac COVID-19 therapeutics and vaccines bid; or
      iii. seek a new bid to sustain these activities through Budget 24.

Summary

2. You have been invited by the Minister of Finance to submit budget initiatives in respect to Pharmac for the general Combined Pharmaceutical Budget and specifically for COVID-19 therapeutics and vaccines where current time-limited funding is due to end on 30 June 2024.
3. Other items with time-limited funding tagged to support COVID-19 management were not included in the budget bid invitation letter that you received.
4. As a result, the full costs of practically delivering COVID-19 therapeutics and vaccine will need to be addressed separately as part of Budget 24.
5. The Treasury has confirmed that advice can be tendered to confirm that you would like to seek an invitation to submit bid/s for funding through Budget 24 for these areas not originally included in the bid invitation letter, and to support the longer-term strategy for managing COVID-19 and preparing for future pandemics.
6. Throughout the pandemic, the funding allocated for COVID-19 management has been agreed on an as required basis, reflecting the need to constantly re-evaluate and refine our response as the pandemic evolved. Funding in the 2023/24 financial year was

significantly lower than previous years, reflecting the ongoing scaling back of our response and transitioning of activities where possible into a new business-as-usual.

7. However, COVID-19 does, and will likely continue to present unique challenges and pressures on the health system. To minimise its ongoing impact on New Zealanders and the health system, the Ministry of Health is informed by the draft Government Policy Statement (GPS) priorities, including ensuring preparedness for future waves and new variants, timely and equitable access to COVID-19 services such as vaccines, and integrating past investment in successful response infrastructure into the wider health system.

8. As we continue to transition from an emergency COVID-19 response to a new, sustainable footing, it is important to strike the right balance between fiscal prudence, and retaining service delivery capacity and capability that aligns with government health priorities.

Recommendations

We recommend you:

a) **Note** that you have been invited by the Minister of Finance to submit Budget 24 initiatives for Pharmac for the Combined Pharmaceutical Budget (CPB) and specifically for COVID-19 therapeutics and vaccines.

b) **Note** that the Pharmac initiatives only seek funding for purchase costs and will not include delivery costs for these services.

c) **Note** that if this is not addressed, time-limited funding for the delivery of vaccines and therapeutics will expire on 30 June 2024, leaving no funding for the delivery and administration of vaccines and therapeutics purchased under the Pharmac CBP.

d) **Note** that other time-limited funding, including for costs of testing and surveillance, would also end with resulting reductions in current services.

e) **Note** that this briefing therefore seeks your decision on whether you would like to seek a further invitation from the Minister of Finance to submit Budget 24 bid/s on funding to administer and deliver purchased vaccines and therapeutics, as well additional areas where time-limited funding will expire to support the shift to a sustainable strategy for managing COVID-19 and preparing for future pandemics.

f) **Note** that costed options are provided for your consideration, along with associated fiscal, and health system and outcome implications.

g) **Indicate** if option 1 is your preference: **Y/N**

Option	Total cost over a 4 year period $m	Activity
Option 1 – Proceed with the Pharmac COVID-19 vaccine and therapeutics invited initiative and allow current time-limited funding not already invited into Budget 24 to expire (*not recommended*). No further funding will be sought in Budget 24 (beyond that already invited via the Pharmac bids). This option will allow the Pharmac CPB to proceed with the purchase of vaccines and therapeutics, but with no funding for the administration and delivery of the vaccines and therapeutics to the public	660.000	Purchase of vaccines and therapeutics only. This would result in unavoidable costs for Health New Zealand | Te Whatu Ora to ensure vaccines and therapeutics reach the eligible public. Under this option, funding for delivery of vaccines and therapeutics would have to be found through a reprioritisation of baseline which in turn will result in: • Not being able to administer vaccines and therapeutics despite having purchased them • Limited and inconsistent delivery of vaccines and therapeutics, including significant delays while reprioritisation exercise takes place to absorb costs into baseline • Increased broader system pressures arising from clinically vulnerable people unable to receive vaccines and therapeutics in a timely manner • Unclear public communications arising from inconsistent or delayed delivery across the country • Compromising other, non-COVID-19 vaccines in the overall national immunisation programme. • It would also not sustain funding for ongoing system resilience and pandemic preparedness, including enhanced disease surveillance (such as wastewater testing and whole genome sequencing).

OR

h) **Indicate** if option 2a is your preference: **Y/N**

Option	Total cost over a 4 year period $m	Activity
Option 2a - Invest to mitigate the worst COVID-19 impacts *(secondary recommended option - excluding option 3 to minimise cost).* This is the most comprehensive option to ensure the delivery of Pharmac-purchased vaccines and therapeutics, and for an effective level of testing and aligns with Treasury guidance that requires agencies to show that their initiative can be practically delivered.	685.600	This option aligns to the $165m/year funding for Pharmac and ensures delivery of vaccines and antivirals to a more targeted eligible population. In addition to the Pharmac COVID-19 invited initiative: • Add funding to support a comprehensive delivery vaccine and therapeutics, and include testing • Add funding for testing (RATs and PCRs).

AND/OR

i) **Indicate** if option 2b is your preference: **Y/N**

Option	Total cost over a 4 year period $m	Activity
Option 2b – Invest to mitigate the worst COVID-19 impacts *(secondary recommended option)* This is a reduced option to 2a.	493.080	This option would require further reductions in eligibility for COVID-19 vaccines and antivirals and may result in lower purchasing costs for Pharmac. In addition to the Pharmac COVID-19 invited initiative: • Add funding to support a less comprehensive delivery

		vaccines and therapeutics testing. • Add funding for reduced levels of testing (RATs and PCRs). Risks associated with this option include: • Increased burden on health care settings such as increased hospital admissions and potentially increased mortality associated with a decreasing immunity. • Direct impact on broader childhood and flu immunisation which may result in a loss of a trained vaccinator workforce.

AND/OR

j) **Indicate** if option 3 is your preference: **Y/N**

Option	Total cost over a 4 year period $m	Activity
Option 3 – In addition to either 2a or 2b, invest in ongoing system resilience and pandemic preparedness *(primary recommended option – in addition to option 2a or 2b)*	88.240	In addition to the Pharmac COVID-19 invited initiative, this option would include: • the activities of either 2a or 2b; and • investment in ongoing system resilience and pandemic preparedness including public health surveillance and national reserve supplies.

k) **Note** that there are further choices on the activities funded within each of these options, which can be considered further if options 2 or 3 are progressed.

l) **Note** that options 2a, 2b and 3 will all require approval from the Minister of Finance to either:

- Expand the scope of the Pharmac COVID-19 vaccine and therapeutic invited initiative to include the activities outlined in recommendations h, i, and j; or

- Seek a new invited initiative to include the activities in recommendations h, i, and j.

m) **Note** that officials will provide further advice on the options in recommendation l once you have indicated your preference for options 1, 2a, 2b and 3.

n) **Agree** to refer this paper with your preferred options to the Minister of Finance seeking approval for the inclusion of an additional initiative in the Budget 2024 process. **Y/N**

o) **Note** that with agreement from the Minister of Finance, the Ministry of Health, with support from Health New Zealand | Te Whatu Ora, will prepare relevant Budget initiative documents accordingly.

p) **Indicate** whether you would like to meet with Ministry of Health and Health New Zealand | Te Whatu Ora officials to discuss the advice in this paper further. **Y/N**

Subject to recommendation (o) proceeding, this recommendation is for the Minister of Finance and the Minister of Health to jointly: q) **Agree** to invite an additional initiative for ongoing COVID-19 management and pandemic preparedness activities into the Budget 2024 process.	
Hon Nicola Willis **Minister of Finance** Date:	Hon Dr Shane Reti **Minister of Health** Date

Dr Diana Sarfati
Director-General of Health
Te Tumu Whakarae mō te Hauora
Date: 31 January 2024

Hon Dr Shane Reti
Minister of Health
Date:

Budget 24: Shifting to a sustainable strategy for managing COVID-19 and preparing for future outbreaks and pandemics

With COVID-19 now endemic, management has been significantly scaled back

1. COVID-19 is now an endemic disease in New Zealand. This necessitates a transition from a pandemic, health crisis management response, to managing the virus as part of our core public health services.

2. Significant progress has been made over the past year to support this transition. Most COVID-19 specific services have been discontinued or scaled back including:

    a. the national case investigation and contact tracing centre has been integrated into the National Public Health Service and is being funded through baseline

    b. the purchase of personal protective equipment (PPE) has returned to being funded and managed within Health New Zealand |Te Whatu Ora as well as non-Health New Zealand | Te Whatu Ora health service providers returning to self-sourcing and purchasing

    c. the cessation of the COVID-19 health system specific telehealth service

    d. community testing sites for COVID-19 have closed, with ongoing testing requirements integrated into the health system

    e. funding to Pacific and Māori providers for manaaki wrap around services for COVID-19 cases has ceased

    f. Care in the Community hubs have been integrated into models of regionally led and locally designed services

    g. eligibility to receive publicly funded COVID-19 boosters has been targeted at specific populations since 1 April 2023

    h. access to free rapid-antigen tests (RATs) through a central supply and distribution model has been managed through existing inventory, with only minimal additional purchases planned for the remainder of the financial year.

But COVID-19 continues to present unique challenges and place additional demands on the health system

3. Despite the transition to managing COVID-19 as an endemic disease, it still represents a significant and additional ongoing disease burden that the system did not need to manage pre-2020.

4. It is anticipated that New Zealand will experience further waves of COVID-19 infections, hospitalisations and deaths in 2024 and beyond, as immunity from previous infections and vaccinations wanes in the community, and with the continued emergence of new variants.

5. COVID-19 is likely to continue placing significant pressure on an already stretched health system, particularly on the frontlines of our primary care practices and hospitals, for the foreseeable future. In 2023 alone there were close to 1,000 deaths where COVID-19 was the underlying or a contributing cause and around 13,000 people hospitalised for COVID-19. This is double the rates for influenza with an estimated 500 people a year dying of influenza and around 5,000 people hospitalised in 2022.

6. The ongoing management of COVID-19 presents a unique challenge due to its specific characteristics including:

   a. the prevalence and potential impact of post-infection conditions, such as long COVID, on New Zealand's societal wellbeing and productivity over the long term

   b. ongoing greater disease burden in terms of hospitalisation risk and death compared to other respiratory diseases such as influenza

   c. the frequent mutations in the SARS-CoV-2 virus resulting in regular new variants with immune evasion properties

   d. the waves of COVID-19 that do not yet have a regular pattern, but seem to not (yet) follow the seasonal winter peak that other respiratory viruses, such as influenza, tend to follow (at least in part due to the increased frequency of mutation as per 6(c) above)

   e. the impacts of COVID-19 remain uneven, particularly in relation to hospitalisations, with Māori and Pacific peoples, older New Zealanders and people with comorbidities amongst those disproportionately impacted.

7. COVID-19 will be with us for the foreseeable future, and we need to ensure that we are well placed to manage COVID-19 over the long term, and build on our progress to date, so that our systems and communities are better prepared to respond to both future waves of COVID-19, and to other communicable diseases with outbreak potential.

8. However, we are now shifting our approach to COVID-19 to see it as one of a number of communicable diseases that need to be managed within the public health system, rather than a separate public health risk requiring a separate response.

9. Pharmac is also operating on this premise, recently confirming to the Ministry of Health that in access to vaccinations and treatments, it will be essentially treating COVID-19 the same way as influenza vaccine and treatments. s 9(2)(f)(iv) [redacted]

10. Currently, the key objectives for managing COVID-19 are underpinned by the COVID-19 Strategic Framework which was designed to help us manage short-medium term goals whilst also simultaneously preparing and integrating longer-term priorities that will strengthen our pandemic preparedness more broadly across the health system. Specifically, the three objectives within this Strategic Framework are:

    a. **Prepare**: We are prepared for future waves and new variants. Our experience with COVID-19 has highlighted the importance of being prepared for future threats to public health.

    b. **Manage**: We minimise the direct and wider impacts of COVID-19 on Aotearoa New Zealand and our people.

    c. **Integrate**: We strengthen and integrate resilience across our systems. A primary focus for this is to shift away from a state of emergency response, maintaining the

gains, drawing on the lessons learned and integrating the management of COVID-19 into a stronger and more resilient health system.

Transitioning to a sustainable funding model that retains capacity, capability and preparedness

11. We need to transition COVID-19 management away from targeted time-limited funding to a sustainable funding model consistent with one of the Government's three priorities for Budget 24: *to deliver effective and fiscally sustainable public services.*

12. There are options to maintain some activity in the short-medium term, to minimise pressure on the system and risk for vulnerable populations, while also integrating other innovations and infrastructure into a new BAU so that we can respond effectively to future outbreaks or emergencies.

13. In assessing the options presented in this paper, we have ensured that they give effect to government priorities pertaining to delivering better public services by supporting the longer-term strategy for managing COVID-19 and preparing for future pandemics.

14. Furthermore, this will help to deliver on timely access to quality health care for all New Zealanders as outlined in the draft GPS priority areas such as:

    a. Access: ensuring every person, regardless of where they live in New Zealand, has access to the health care and services they need.

    b. Timeliness: ensuring New Zealanders can access the health care and services they need in a timely and efficient way.

    c. Quality: ensuring the health care and services delivered in New Zealand are safe, transparent, easy to navigate and continuously improving.

    d. Workforce: ensuring we have the right people with the right capabilities in the right place at the right time

    e. Infrastructure: ensuring the health system has the digital and physical infrastructure it needs to meet New Zealanders' needs now and into the future.

Options

15. You have been invited by the Minister of Finance to submit budget initiatives in respect to Pharmac for the general Combined Pharmaceutical Budget and specifically for COVID-19 therapeutics and vaccines where current time-limited funding is due to end on 30 June 2024.

16. Other items with time-limited funding tagged to support COVID-19 management were not included in the budget bid invitation letter that you received, include:

    a. The COVID-19 Response via Health New Zealand | Te Whatu Ora

    b. The COVID-19 Immunisation Programme via Heath New Zealand | Te Whatu Ora

    c. The COVID-19 activities via the Institute of Environmental Science and Research, such as surveillance through wastewater testing and whole genome sequencing.

17. The Treasury has since confirmed that advice can be tendered to confirm whether you would like to seek an invitation to submit bid/s for funding through Budget 24 for the areas not originally included in the bid invitation letter, and to support the longer-term strategy for managing COVID-19 and preparing for future pandemics.

18. This paper provides three high-level options for shifting to a sustainable funding strategy for ongoing activities to manage COVID-19 and maintain preparedness for pandemic or communicable disease health emergencies.

19. The 3 options are:

    a. **Option 1: No new investment in COVID-19 response activities and only pursue the invited Pharmac component of COVID-19 costs.** This option would create unavoidable costs for Health New Zealand | Te Whatu Ora as it would still need to deliver and administer the vaccines and treatments purchased under the Pharmac invited component of COVID-19 costs, if that bid is successful in Budget 24. This cost would need to be absorbed by Health New Zealand | Te Whatu Ora within its baseline through reprioritisation resulting in significant risks outlined in paragraph 24 below.

    OR

    b. **Option 2: Seek additional investment through Budget 24 to include the costs of delivering the vaccines and treatments that would be purchased under the Pharmac invited component of COVID-19 costs.** This option better supports the Pharmac invited initiative as it will ensure this initiative aligns with Treasury guidance that requires agencies to show that their initiative can be practically delivered.

    AND/OR

    c. **Option 3: Seek additional investment through Budget 24 for ongoing system resilience and preparedness.** This option ensures the health system retains key infrastructure and capability to maintain preparedness for future health emergencies, and to maintain improved day-to-day public health capability to anticipate, prevent and respond promptly to a range of threats from communicable diseases.

20. The Ministry of Health **recommends a combination of Options 2 and 3**. While this option has the highest cost, we consider that it still offers good value against the government's objectives and priorities, supporting the sustainability of the current health system and the health of those most at risk, and ensures we are prepared for any future COVID-19 variants or waves and other communicable disease outbreaks.

21. Should you wish to proceed with a budget initiative based on one of these options (or combination therein), officials will continue to work with Health New Zealand | Te Whatu Ora on a line-by-line analysis of all activities and outputs associated with your chosen option. This will include further consideration on where activities within these options could be absorbed by baseline and the impact/s of doing so to better gauge the trade-offs and flow-on effect of reprioritisation.

Option 1 ($660m - $165 per year for four years) – Allow current time-limited funding not already invited into Budget 24 to expire *(not recommended)*

22. You can choose to not seek a further invitation to submit bids in Budget 24 outside of the scope of what has been invited by the Minister of Finance for Vote Health. This will result in current time-limited funding expiring on 30 June 2024 (paragraph 16 refers).

23. As a result, the Pharmac COVID-19 therapeutics and vaccine initiative would contain only the cost of vaccine and antiviral purchasing and will not include the full costs of practically delivering both services, including staffing, testing, suppliers, and other dependencies to ensure services reach targeted communities. This approach will not

align the Pharmac-invited initiative with Treasury guidance that requires agencies to show that their initiative can be practically delivered.

24. This option also creates significant risks including:

    a. *Loss of capability and capacity:* including in key health surveillance infrastructure including whole genome sequencing and wastewater testing, limiting ability to respond to both the ongoing COVID-19 outbreak, as well as future communicable disease outbreaks, pandemics and other health emergencies; and

    b. *Cost pressure:* Health New Zealand | Te Whatu Ora would face significant unavoidable cost pressures to deliver vaccines and antivirals to eligible cohorts which would compromise wider health initiatives and programmes to drive better health outcomes. Specifically risks associated within the vaccine programme could include:

        i. Not being able to administer vaccines and therapeutics despite having purchased them

        ii. Limited and inconsistent delivery of vaccines and therapeutics, including significant delays while a reprioritisation exercise takes place to absorb costs into baseline

        iii. increased broader system pressures arising from clinically vulnerable people unable to receive vaccines and therapeutics in a timely manner

        iv. Unclear public communications arising from inconsistent or delayed delivery across the country

        v. Compromising other, non-COVID-19 vaccines in the overall national immunisation programme.

    c. There would also be increasing cost pressures within the health system due to increased disease burden from COVID-19, including increased pressure within primary care and pharmacy, and likely increased mortality and loss of broader social and economic outcomes for education and productivity.

    d. *Poor health outcomes and inequities:* If costs for some aspects of COVID-19 management (eg, vaccinations, tests and/or treatments) were shifted to consumers, this would likely lead to higher disease burden overall and disproportionately worse access to healthcare and health and wellbeing outcomes for groups unable to afford these services.

    e. *Reduced emergency preparedness:* one key lesson learned both domestically and internationally is that entering a pandemic, or indeed any health emergency including at the local level, with a health system already under pressure will increase death rates, further stretch already backlogged services, impacts the health workforce, and disproportionality impact those already vulnerable within the population.

Option 2 (includes Option 2a ($685.600m) – *OR* Option 2b ($493.080m) - Invest to mitigate the worst COVID-19 impacts in the short-medium term *(secondary recommended option - excluding option 3 to minimise cost)*

25. To avoid the risks and health system costs outlined in option 1, option 2 proposes seeking additional investment to include the costs of delivering the vaccines and

treatments that are purchased by Pharmac, s 9(2)(f)(iv) [redacted]. This initiative aligns with Treasury guidance that requires agencies to show that their initiative can be practically delivered.

26. This option strikes a balance between maintaining services to support the successful delivery of vaccines and therapeutics, while giving space to integrate COVID-19 response management into the broader health system and avoiding the most significant COVID-19 health impacts and flow on costs as would occur in option 1.

27. Improved immunisation rates is a government priority and a key mechanism for managing communicable disease including COVID-19, particularly among vulnerable populations, and reducing demand on the wider system. New delivery models, infrastructure (e.g., local distributions and service facilities), and workforce (e.g., trained vaccinators, pharmacy and community providers) that were successfully developed during the COVID-19 response are now also being used for the delivery of a wider range of immunisations (including annual flu and childhood immunisations).

28. COVID-19 testing and treatment in the community (access to RATs, PCRs and antiviral therapies) helps to minimise transmission and severity of illness, particularly amongst those most vulnerable. This is in turn helps to reduce GP visits, hospital admissions, deaths, and pressure on the wider system and maintain broader health system capacity. RATs are effective in quickly identifying when a person is most infectious and enable timely access to anti-viral therapies (AVTs) making it an effective tool to prevent hospitalisations.

29. There are about 2.8m RATs currently distributed per month across 6,000 customer groups including primary care and pharmacy. On average 1750 courses of AVT are dispensed per week as a result of an average of 2200 funded clinical consultations per week.

30. Separate advice has been provided to you on options for COVID-19 testing up until 30 June 2024 (refer to HNZ00035731). It notes that that Health New Zealand | Te Whatu Ora will be purchasing, within current funding, to ensure that those most at risk of poor health outcomes and those who meet the Pharmac AVT criteria are able to access testing up until 30 June 2024.

31. Further investment is required to maintain access to RATs and antiviral therapies via primary care and community pharmacy for those eligible and most at risk.

32. We have provided two scenarios under option 2, which scale the delivery of vaccines, and provision of antivirals and testing.

Breakdown of Option 2a costs

33. Health New Zealand | Te Whatu Ora has provided costs associated with option 2a in Appendix 1. A summary of option 2a, and associated risks, is provided below.

Immunisation programme under option 2a	**Total cost $m over 4 years**	**Risks**
Maintain the current immunisation approach aligned to $165m/year funding for Pharmac and provide delivery of vaccines and antivirals based on reduced access eligibility.	347.116	Risks associated with this option if no funding is secured include: • No targeted population access to vaccine boosters for those who are not clinically vulnerable will still result in an increase in the numbers of those who become seriously ill and require hospitalisation. • Difficulty in surging services in the event of a significant wave or variant of concern and ability to respond to demand. An impact on funding for other services to ensure the system can maintain vaccinator workforce, which may also result in loss of workforce.
Testing, laboratory services and antivirals under option 2a	**Total cost $m over 4 years**	**Risks**
RATs: Fund primary care and pharmacy services to secure approximately 17 million RATs as a "test first with RAT approach" for rapid access to AVTs. Enable access to a distributed supply of 16.3 million RATs to support testing of those at greatest risk of severe illness, as well as for patient and outbreak management within high-risk facilities/settings.	338.484	Risks associated with this option include: • Access to community RATs would remain an issue particularly for use by people in remote areas such as the Far North, East Coast and lower South Island. • There is the potential for increased transmission as seen in Northern Hemisphere currently if there is limited access to testing within community settings. • There would be no PCR laboratory processing surge capacity for a new variant or allowance to alter surveillance and testing requirements. This is the capacity level minimum.

PCRs: Maintain baseline testing capacity of 1,000 PCR per day by primary care. This approach ensures testing and laboratory capacity reflects current surveillance requirements associated with severe acute respiratory monitoring alongside COVID-19 and ensures undifferentiated respiratory illness and access to antiviral therapeutics can be managed appropriately. **Antivirals**: Retain current eligibility, access and funding model through primary care and community pharmacy to publicly funded clinical assessment for AVTs at 2,200 consults per week on average.		• Does not include any consultations or tests for those that would not meet the current Pharmac AVT access criteria. Does not allow for any increase in access criteria or reflect the management of a new COVID-19 variant.

Breakdown of option 2b costs

34. Health New Zealand | Te Whatu Ora has provided costs associated with option 2b in Appendix 2. A summary of option 2b, and associated risks, is provided below.

Immunisation programme under option 2b	**Total cost $m over 4 years**	**Risks**
Deliver a smaller immunisation approach by further reducing eligibility for COVID-19 vaccines and antivirals (which may result in lower purchasing costs for Pharmac).	239.384	Risks associated with this option include: • Decreased population immunity resulting in: o Increased burden on health care settings broadly during remaining seasons due to burden of care and treatment for those who cannot access

		a vaccine outside of winter. o Increased hospital admission rates, increased testing and primary care and potentially increased mortality across the year. • Direct impact on broader childhood and flu immunisation coverage as a single campaign is less sustainable and enduring, which may result in a loss of a trained vaccinator workforce. • One booster only is inconsistent with current public heath advice.
Testing, laboratory services and antivirals under option 2b	**Total cost $m over 4 years**	**Risks**
RATs: Fund primary care and pharmacy services to secure approximately 9.3 million RATs as a "test first with RAT approach" for rapid access to AVTs and scaled across seasonal demand. Enable access to a distributed supply of 13 million RATs to support Healthcare settings only: • Public Hospital • Pharmacies and collection sites • Aged Residential Care **PCRs**: Maintain baseline testing of 850 -1,000 PCR per day for processing under pay per test. This approach ensures testing and laboratory capacity scales to requirements	253.696	Risks associated with option include: • Pharmacy and primary care services will have to ensure they have the infrastructure in place for the private purchasing and delivery of RATs to meet seasonal demand particularly in winter and spring. • Reduction of access to healthcare providers to support cheaper diagnostic testing (e.g. RAT vs PCR), healthcare worker testing and testing for outbreaks. This therefore reduces the ability to manage onward transmission and outbreaks in community settings. • Many of those at risk of severe disease are infected by whanau members. Limiting free RATS to those within health care settings may prevent opportunities to prevent those at risk from getting COVID-19. • Early diagnosis of COVID-19 in whanau of those at risk of severe disease would aid in protecting those at risk from infection and

of approximately 4 waves. Allows for severe acute respiratory monitoring alongside COVID-19 and ensures undifferentiated respiratory illness can be managed appropriately. **Antivirals**: Primary Care and Pharmacy Assessment costs for consultations aligned with AVT access at an average of 1750 consultations per week based on AVT dispensing rates and eligibility.		would likely facilitate earlier diagnosis and access to AVT for those most at risk. Early AVT has the biggest impact on preventing severe illness requiring hospitalisation. • There will be less self-management which could result in greater number of infections, which in turn will have a flow-on impact on the health system, i.e., more ED admissions and hospitalisations. • This option could create a barrier to testing and treatment as a result of increased costs associated with purchasing of RATs by public who do not meet criteria.

Option 3 ($88.24m) – Add investment in ongoing system resilience and pandemic preparedness *(primary recommended option – in addition to option 2a or 2b)*

35. Option 3 proposes seeking additional investment in ongoing system resilience and preparedness, specifically public health surveillance and critical pandemic supplies, to ensure the health system can respond to future health emergencies and communicable disease outbreaks (refer Appendix 3 for more detail).

Public health surveillance

36. To be able to respond efficiently to future disease outbreaks New Zealand needs to retain a level of surveillance and laboratory intelligence to inform policy decisions and the actions of front-line workers. Effective public health surveillance is key to informing science and evidence-led public health services and ensuring early detection and case investigation and that subsequent responses are proportional to the risk presented by a pathogen during an outbreak.

37. The COVID-19 outbreak demonstrated a need for more modern tools for New Zealand's disease surveillance network including whole genome sequencing and wastewater testing. In response, the Institute of Environmental Science and Research (ESR) was funded to rapidly develop the required testing capability and capacity. While this surveillance infrastructure was developed initially for COVID, it can be used efficiently and effectively to support monitoring of a broad range of diseases and pathogens.

38. Retaining these specialised laboratory service capabilities (expertise and testing infrastructure) and improved disease surveillance to monitor a wide range of pathogens will support ongoing early intervention and prevention of future outbreaks. These services are most cost effective, and are more sustainable and scalable for future events, if regular minimum testing volumes are retained, along with key specialised staff. These

tools provide infrastructure for testing for a range of communicable diseases, including COVID-19.

39. ESRs shareholding Ministers have recently approved a significant investment into rebuilding the Kenepuru facility where this work is undertaken. When complete, the new build will significantly improve the physical efficiency of the site and ensure maximum value from any ongoing Health investment.

Activity	Total cost $m over 4 years	Risks
Public heath surveillance	38.240	If funding is not secured these programmes will return to pre-pandemic levels which include decommissioning wastewater testing and significantly winding back whole genome sequencing. This will impact public health surveillance and our ability to identify and respond to future outbreaks. The loss of service would take time and money (particularly to recruit appropriately qualified and trained staff) to reinstitute these technologies if required again in the future.

Critical pandemic supplies

40. Ensuring a well-resourced and maintained supply of critical pandemic equipment (personal protective equipment (PPE), ventilators, etc) was a key lesson from COVID-19. Health New Zealand | Te Whatu Ora has advised that ongoing funding is required to maintain minimum PPE and critical medical supply management through warehousing and maintenance of infusion pumps, syringe drivers and ICU equipment such as ventilators and consumables, and a small replenishment fund.

Activity	Total cost $m over 4 years	Risks
Critical pandemic supplies	50.000	Managing the increased 12-week high pandemic use stock hold of PPE far exceeds historic (pre COVID-19) investment in a national reserve supply.

Population implications

41. As noted earlier, the impacts of COVID-19 remain uneven, particularly in relation to hospitalisations and deaths, with Māori and Pacific peoples, older New Zealanders and people with comorbidities amongst those disproportionately impacted.

42. The preferred options presented in this paper will best support equity through mitigating the most severe impacts of COVID-19, as well as potential future pandemics and outbreaks, on these and other vulnerable populations.

Next steps

43. We recommend that you seek agreement from the Minister of Finance to invite additional bids into the Budget 24 process, should you wish to proceed with any of the options presented.

44. Based on your direction and agreement from the Minister of Finance, officials will prepare budget initiative documents. These are required to be submitted to the Treasury by 16 February 2024.

45. Officials are available to meet with you discuss the advice and options in this paper further.

ENDS.

Minister's Notes

Appendix 1: COVID-19 vaccines

Option 2a costings: Delivery of vaccines and treatments at reduced access eligibility

	Cost 2024/25 ($m)	Cost 2025/26 ($m)	Cost 2026/27 ($m)	Cost 2027/28 and outyears ($m)	Total over 4 years ($m)
Vaccine administration	54.02	35.01	20.81	20.81	**130.65**
Vaccine pay per dose	39.73	39.73	29.3	29.3	**138.06**
National immunisation programme team	6.05	4.16	3.83	3.83	**17.87**
Immunisation scheduling	3.6	1.8	1.8	1.8	**9**
Supporting Services (storage infrastructure, consumables, pharmacovigilance)	10.01	10.01	6	6	**32.02**
Telehealth baseline Vaccine Capacity	4.03	1.842	1.842	1.842	**9.556**
Transitional communication costs	2.14	1.07	0	0	**3.21**
Transition technology support	6.75	0	0	0	**6.75**
TOTAL	**126.33**	**93.622**	**63.582**	**63.582**	**347.116**

Option 2b costings: Delivery of vaccines and treatments at further reduced access eligibility

	Cost 2024/25 ($m)	Cost 2025/26 ($m)	Cost 2026/27 ($m)	Cost 2027/28 and outyears ($m)	Total over 4 years ($m)
Vaccine administration	20.81	20.81	20.81	20.81	**83.24**
Vaccine pay per dose	29.3	29.3	29.3	29.3	**117.2**

	Cost 2024/25 ($m)	Cost 2025/26 ($m)	Cost 2026/27 ($m)	Cost 2027/28 and outyears ($m)	Total over 4 years ($m)
National immunisation programme team	3.83	3.83	0	0	**7.66**
Immunisation scheduling	1.8	1.8	0	0	**3.6**
Supporting Services (storage infrastructure, consumables, pharmacovigilance)	6	6	6	6	**24**
Telehealth baseline Vaccine Capacity	1.842	1.842	0	0	**3.684**
Transitional communication costs	0	0	0	0	**0**
Transition technology support	0	0	0	0	**0**
TOTAL	**63.582**	**63.582**	**56.11**	**56.11**	**239.384**

Appendix 2: COVID-19 testing and treatment

	Cost 2024/25 ($m)	Cost 2025/26 ($m)	Cost 2026/27 ($m)	Cost 2027/28 and outyears ($m)	Total over 4 years ($m)
Under Option 2a					
Purchase RATs	25.312	13.650	13.650	13.650	**66.262**
Lab services	27.372	27.372	25.800	25.800	**106.344**
RATs funding for primary care and pharmacy	17.850	17.850	9.720	9.720	**55.140**
Outreach access to RATs	0.132	0.066	0.000	0.000	**0.198**
RAT warehousing and logistics	3.008	1.504	1.504	1.504	**7.520**
Data and digital support	3.360	3.360	0.000	0.000	**6.720**
Primary care and pharmacy assessments	26.400	22.140	22.140	22.140	**92.820**
Licensing costs	1.680	0.000	0.000	0.000	**1.680**
Winter communications campaign	1.800	0.000	0.000	0.000	**1.800**
TOTAL	*106.914*	*85.942*	*72.814*	*72.814*	***338.484***
Under option 2b					
Purchase RATs	13.650	13.650	13.650	13.650	**54.600**
Lab services	25.800	25.800	25.800	25.800	**103.200**

	Cost 2024/25 ($m)	Cost 2025/26 ($m)	Cost 2026/27 ($m)	Cost 2027/28 and outyears ($m)	Total over 4 years ($m)
RATs funding for primary care and pharmacy	9.720	9.720	9.720	9.720	**38.880**
RAT warehousing and logistics	1.504	1.504	1.504	1.504	**6.016**
Data and digital	3.360	3.360	0.000	0.000	**6.720**
Primary care and pharmacy assessments	22.140	22.140	0.000	0.000	**44.280**
TOTAL	*76.174*	*5 76.174*	*50.674*	*50.674*	***253.696***

Appendix 3: longer-term system resilience and pandemic preparedness

Public health surveillance	Cost 2024/25 ($m)	Cost 2025/26 ($m)	Cost 2026/27 ($m)	Cost 2027/28 and outyears ($m)	Total over 4 years ($m)
Whole genome sequencing	5.77	5.77	5.77	5.77	**23.08**
Wastewater testing	2.50	2.50	2.50	2.50	**10.00**
Enhanced influenza like illness surveillance	1.29	1.29	1.29	1.29	**5.16**
TOTAL	*9.56*	*9.56*	*9.56*	*9.56*	***38.24***

Critical pandemic supplies	Cost 2024/25 ($m)	Cost 2025/26 ($m)	Cost 2026/27 ($m)	Cost 2027/28 and outyears ($m)	Total over 4 years ($m)
Maintain 12-week high pandemic PPE reserve supply	10.000	10.000	10.000	10.000	**40.000**
Replenishment	2.5000	2.5000	2.5000	2.5000	**10.000**
TOTAL	*12.500*	*12.500*	*12.500*	*12.500*	***50.000***

Briefing

Reinstating the prescription co-payment – advice on additional prescription co-payment settings

Date due to MO:	31 January 2024	**Action required by:**	4 February 2024
Security level:	IN CONFIDENCE	**Health Report number:**	H2023033404
To:	Hon Dr Shane Reti, Minister of Health		
Copy to:			
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☐		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, Strategy Policy & Legislation, Manatū Hauora	s 9(2)(a)
Emma Prestidge	Group Manager, Family and Community Health Policy, Strategy Policy and Legislation, Manatū Hauora	s 9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Reinstating the prescription co-payment – advice on additional prescription co-payment settings

Security level:	IN CONFIDENCE	**Date:**	31 January 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This paper provides the further advice and financial estimates you have requested in relation to reinstating the $5 prescription co-payment for those aged 14 and over, with exemptions for people with a Community Services Card (CSC) and those aged 65 and over.

Summary

2. You have confirmed that you wish to reinstate the $5 prescription co-payment for those aged 14 years and over, with exemptions for people with a CSC and all those 65 years of age and over. The policy would retain the current settings for the Prescription Subsidy Card (PSC). This policy would be implemented from 1 July 2024 [H2023033029 refers].
3. The total estimated revenue from prescription co-payments for the settings that you have confirmed is $269.622 million over four years, assuming an annual 2.5% increase in filled prescriptions. This estimate removes the impact from reduced medicine use included previously.
4. You have requested further advice on additional targeting mechanisms, potential exemptions, and ways of reducing the administrative burden on pharmacists.
5. You have several options in terms of how to target exemptions, at which groups, and in terms of the scope of exemptions provided (i.e., in relation to approved and unapproved prescriber settings), which could inform the final policy design. The impact on revenue is shown in **Table 1**. **Appendix 1** summarises the impacts of the different decisions related to targeting and scope of exemptions.
6. Te Whatu Ora has begun preparations to implement the reinstatement of the $5 prescription co-payment so that the policy changes can commence on 1 July 2024, with the aim of minimising the administrative burden on pharmacists.
7. Available data shows that the current prescription co-payment settings continue to have an impact on the Combined Pharmaceutical Budget (CPB). If the pattern of use continues, the cost to the CPB during 2023/24 is likely to be around $45.6 million. The final co-payment settings from 1 July 2024 are expected to have an on-going impact on the CPB and this impact has not yet been included in Pharmac forecasting for 2024/25 and outyears.

Recommendations

We recommend you:

a) **Note** that

i) the estimated revenue from exempting only CSC holders from co-payments (including those 65 and over with a combination SuperGold card and CSC (CSC/SGC) is $384.0 million over four years.

ii) there is minimal cost savings from using the SuperGold Card instead of age identification in pharmacy management systems to target exemptions at those aged 65 and over.

iii) exempting people with a CSC and those aged 65 and over from co-payments for prescriptions written by unapproved prescribers is estimated to reduce co-payment revenue by $7 million over four years.

iv) reducing the cost of prescription co-payments from current unapproved prescribers to $5 for all New Zealanders without a CSC or under 65 years of age is estimated to reduce co-payment revenue by $13 million over four years.

v) extending the existing age exemption for prescription co-payments from people under 14 years to all those 14-17 years is estimated to reduce co-payment revenue by $9.61 million over four years.

b) **Note** that it is not possible to provide a cost for applying a $100 annual cap across all prescription types while maintaining the approved/unapproved prescriber classification for determining co-payments. Removing the differentiation between prescription co-payments for approved and unapproved prescribers would achieve the $100 annual cap.

Targeting the prescription co-payment exemptions

c) **Agree** to

i) use the age identified in pharmacy management systems to exempt all those aged 65 and over from paying the prescription co-payment **Yes/No**

or

ii) use the CSC/SGC to target exemptions from prescription co-payments to those 65 and over who meet the CSC income threshold **Yes/No**

d) **Agree** to extend the zero prescription co-payments from the current 0-14 to the 0-17 years age group **Yes/No**

Scope of exemptions to the prescription co-payment

e) **Agree** to

i) expand the scope of the exemption for the eligible groups to include prescriptions from unapproved prescribers **Yes/No**

ii) remove the categorisation of **approved and unapproved** prescriber co-payments for all New Zealanders. Those who are not exempt would pay a $5 co-payment. This achieves the $100 annual cap. **Yes/No**

f) **Note** that the current prescription co-payment settings are continuing to have an impact on the Combined Pharmaceutical Budget and that this is currently estimated to be $45.6 million by the end of the 2023/24 financial year.

Emma Prestidge
Group Manager, Family and Community Health Policy

Date: 31 January 2024

Hon Dr Shane Reti
Minister of Health

Date:

Reinstating the prescription co-payment – advice on additional prescription co-payment settings

Background and context

8. In December 2023 the Ministry of Health – Manatū Hauora provided you with advice and revenue estimates for reinstating the prescription co-payment with targeted exemptions [H2023033029 and weekly report 14 December 2023 refers].

9. You have requested further advice on:

   i. using the SuperGold Card as a mechanism to identify eligibility for co-payment exemption instead of age;

   ii. targeting co-payment exemptions using the CSC and the combination SuperGold card and CSC (CSC/SGC) for those 65 and over;

   iii. removing the prescription co-payment for prescriptions written by unapproved prescribers, such as private specialist and dentists, for people with a CSC and those aged 65 years and over;

   iv. applying a $100 annual cap across all prescription co-payment types; and

   v. minimising administration for pharmacists, including improving the PSC system to enable easier and more effective tracking of co-payments.

10. This briefing also provides you with an update on the impact of the current prescription co-payment settings on the CPB in 2023/24, and its impact on the savings expected from prescription co-payments in the period through to 2027/28.

Determining eligibility for prescription co-payment exemptions

11. You have confirmed that children aged under 14, CSC holders and those 65 and over will be exempt from the prescription co-payment. This section includes options to make further changes to the targeted exemptions. Making these changes will also impact the overall estimated annual revenue to be gained from reinstating the prescription co-payment.

Options for targeting assistance at those 65 years and over

12. There are three options for determining who in the 65 and over age group should be eligible. These options are:

   - targeting those most in need within the group using the CSC/SGC combination card, or
   - using the age identifier in pharmacy systems
   - using the SuperGold card (this is not recommended)

Using the combination SuperGold card and CSC…

13. This is a potential variation on your manifesto commitment and would target assistance at those for whom cost is a significant barrier to accessing care. This option aligns well with the rationale of assisting those in most need as stated in the manifesto commitment.

14. The CSC/SGC enables effective targeting to those 65 years and over who are on low income i.e., people meeting the income requirements for the CSC. There are around 337,000 CSC/SGC holders compared to the 65 and over population of 864,800.

15. The estimated revenue from exempting CSC holders including those with a CSC/SGC is $384.0 million over four years. This is compared to the $269.622 million in estimated revenue from the exemptions you have confirmed.

Using the age identifier in pharmacy systems…

16. Using the age identifier is the simplest and most effective means of exempting all those 65 and over from paying the prescription co-payment. Pharmacists can easily identify someone's age, and whether they would be exempt from the co-payment, through pharmacy management systems.

Using the SuperGold Card…

17. The SuperGold Card is issued automatically when a person's NZ Superannuation is approved. There are currently around 859,000 SuperGold Card holders, compared to 864,800 people aged 65 and older (Statistics NZ 2023), and therefore 99.5% of people in this cohort have the card. While data is not available on the number of filled prescriptions for SuperGold Card holders, the numbers mean that exempting all those with a card from the prescription co-payment would have minimal impact on the revenue generated compared to exempting the 65 and over age group as a whole.

18. Using the SuperGold Card would add to administrative pressure on pharmacists. For example if data held on a SuperGold Card cannot be automatically matched to an NHI number at the beginning of the dispensing process the pharmacist will need to do this when the person collects their medicine. If you wish to use the card to target exemptions, Te Whatu Ora would need to work with the Ministry of Social Development to access the data and amend the IT systems and pharmacy management systems.

Option for targeting assistance to those aged 14 to 17 years

19. You have confirmed you wish to exempt those under 14 years from the prescription co-payment. Those aged 14-17 years who are dependants of CSC holders will not be exempt from the prescription co-payment. There remain some challenges in linking dependants of CSC holders with CSC holders in pharmacy management systems regardless of the implementation work that Health New Zealand is progressing.

20. Extending the existing age exemption from people under 14 years to all those under 18 years is an option that would help improve access to healthcare and considerably simplify co-payment settings by resolving the issue of pharmacists needing to identify CSC dependents within pharmacy systems.

21. The volume of filled prescriptions in the 14 to 17 age cohort is approximately 1.7% of the total annual volume. The co-payment revenue that would be expected to be

foregone if targeted exemptions are extended to the 14-17 year old age group is estimated as $9.61 million over the four-year period.

Scope of exemptions to prescription co-payments

22. Under current settings the scope of the exemption for the eligible group relates only to the prescription co-payment for items from approved prescribers. This section provides advice on options to simplify settings as they relate to unapproved prescribers, where items currently attract a $10 or $15 co-payment. Unapproved prescribers include private specialists and dentists who are not funded through Vote Health.

23. We have identified two broad options to consider:

- expanding the scope of the targeted exemption for the eligible group to cover prescriptions from unapproved prescribers, with no change for other New Zealanders, and
- simplifying the system by removing the distinction between approved and unapproved prescribers.

Removing co-payments for prescriptions from unapproved prescribers for exempt groups…

24. Prescriptions from unapproved prescribers represent approximately 4% of all filled prescriptions and these were not included in the Budget 2023 changes to co-payment settings implemented on 1 July 2023. These prescriptions incur a $15 co-payment for adults ($5 with a CSC or High Use Health Card (HUHC), Care Plus, and $10 for those aged 14-17 years).

25. Removing unapproved prescriber co-payments for the two exempt groups would reduce co-payment revenue by $7.01 million over four years. The total revenue from reinstating the prescription co-payment would therefore reduce from $300.378 to $293.377 over four years. Those with a HUHC or eligible for Care Plus would not be exempt unless they had a CSC or were aged 65 and over.

Make unapproved prescriber co-payments $5 for all New Zealanders that are not exempt from prescription co-payments…

26. The differentiation between approved and unapproved prescriber co-payments makes healthcare more costly for people and adds administrative complexity for pharmacists, other health professionals, and consumers. To improve access to quality and timely healthcare, simplify policy settings, and reduce administration for the pharmacy sector, it may be worth considering removing the different rates of prescription co-payments for unapproved and approved prescribers for all New Zealanders.

27. This approach would apply a $5 prescription co-payment to all prescriptions collected, including from currently unapproved prescribers. People with co-payment exemptions would not pay the co-payment. The PSC would still apply after 20 prescription co-payments are paid within the year and this option would achieve the $100 annual cap across all prescription types.

28. The costs of reducing unapproved prescriber prescription co-payments to $5 for all New Zealanders except the exempt groups reduces the revenue by $13 million in total over

four years. This is between $1.44 million and $1.55 million more per year compared to removing the co-payment for the exempt groups. However, removing the differentiation would simplify the system and reduce the cost of care.

Implementing a $100 annual cap rather than the Prescription Subsidy Card...

29. In your 2023 election manifesto you committed to applying a $100 cap on the total co-payment amount a person or family pays for prescriptions during a year.

30. The current PSC is triggered when an individual or family has paid 20 prescription co-payments. For the $5 prescription co-payment the PSC equates to an annual cap of $100. The card also covers prescriptions that attract co-payments of $10 or $15 written by unapproved prescribers and means a person or family can spend up to $200 or $300 before the card is triggered.

31. From the data available it is not possible to estimate the cost of applying a $100 cap for prescription subsidy card eligibility under a mechanism where community pharmacies measure the amount spent by a person or family instead of items collected. This is because there is currently limited visibility of the total amount that individuals or families spend on co-payments to reach the 20 items.

32. If you decide to remove the differentiation between approved and non-approved prescriber co-payments the PSC would become a $100 cap as all prescription co-payments for those who pay would be $5.

Revenue effects of targeting and exemption options

33. The prescription co-payment settings can be adjusted using different targeting mechanisms such as the CSC, CSC/SGC, and age, and with exemptions provided for co-payments to approved and/or unapproved prescribers.

34. Making further exemptions such as to unapproved prescriber co-payments or removing co-payments for dependents in the 14-17 age category, could improve access and targeting to need but will decrease the revenue estimated from the settings you confirmed in December 2023. Using the CSC, including the CSC/SGC for those 65 and over, increases the revenue estimated over 4 years and is more targeted to need than exempting all those aged 65 and over.

Table 1: Estimated revenue from reinstating the prescription co-payment and the cost of additional exemptions

	Settings	Cost over 4 years	Estimated Revenue over 4 years
i	Reinstate the co-payment for prescriptions from **approved prescribers** for people 14 years and over with exemptions for people with a CSC and all those aged 65 and over **(confirmed settings)**		$269.622 million
a.	expanding the exemption for eligible groups to include zero co-payments for prescriptions from **unapproved prescribers**	$7.01million	$262.612 million

b.	removing the **different rates of prescription co-payment for approved and unapproved prescribers** for all New Zealanders. Those who are not exempt would pay $5. This achieves the $100 annual cap.	$13.0 million	$256.622 million
	Exempt those 14 to 17 years old in addition to the current confirmed settings		
c.	Reinstate the co-payment for prescriptions from **approved prescribers** for people **18 and over** with exemptions for CSC and all those aged 65 and over	$9.61million	$260.012 million
d.	Reinstate the prescription co-payment for people **18 and over** with exemptions for those with a CSC and all those 65 and over and **remove the different rates of prescription co-payments for approved and unapproved prescribers** for all New Zealanders. Those who are not exempt would pay $5.	$22.61million	$247.012 million
	Using the CSC and CSC/SGC combo card		
ii.	Reinstate the prescription co-payment for prescriptions from **approved prescribers** for people **14 years and over** with exemptions for people with a CSC including those 65 and over with a combination CSC/SGC.		$384 million
a.	expanding the exemption for eligible groups to include zero co-payments for prescriptions from **unapproved prescribers**	*$7.01million*[1]	*$376.99 million*
b.	Reinstate the prescription co-payment prescriptions for people **18 and over** with exemptions for those with a CSC including those 65 and over with a CSC/SGC and **remove the different rates of prescription co-payments for approved and unapproved prescribers** for all New Zealanders. Those who are not exempt would pay $5. This achieves the $100 annual cap.	*$22.61million*[2]	*$361.39 million*

Preparations for implementation

35. Preparations for implementing the reinstatement of the prescription co-payment are focussed on minimising the administration burden that the policy could place on pharmacists.

Prescription Subsidy Card...

36. Health New Zealand has started to scope the options for improving and simplifying the PSC system. The new system will enable pharmacists to look-up the item count towards getting a PSC and link the number of prescriptions written for family members towards a PSC. It will mean that a person or family's eligibility is captured in pharmacy systems at the beginning of the dispensing process.

[1] **This figure was initially calculated under a scenario where both CSC holders and all those 65 years and over are exempt from co-payment. If only CSC holders are exempted from co-payments, we expect the impact of removing 65 year olds who do not have a CSC from the unapproved prescriber exemption would reduce the $7.01m cost estimate by approximately 50-70% (as CSC holders currently pay $5 for prescriptions from unapproved prescribers), however further analysis would need to be conducted to confirm this estimate.**

[2] **As above**

37. A new system is likely to be available by 1 February 2025 (aligning with the beginning of the PSC year) with an interim system to track items by 1 July 2024. Health New Zealand will provide you with updates on progress through the weekly report.

Enrolment services database

38. Developing the database to enable pharmacists to link a CSC to a NHI and link dependents to a CSC, is likely to take around three months with further time required for pharmacy management system vendors to integrate the change into their systems. This system will be available for the 1 July 2024 implementation of the policy. Health New Zealand will provide you with updates on progress through the weekly report.

Impact of the current prescription co-payment settings on the Combined Pharmaceutical Budget in 2023/24

39. The current prescription co-payment settings are continuing to have an impact on the CPB during this financial year. Current data indicates that the impact on the budget for the whole year is likely to be around $45.6 million. Year-end data may change this estimate depending on medicine uptake over the remainder of 2023/24. Only $21.8 million has been made available to the CPB to cover increases in medicine demand and therefore there is likely to be a shortfall of $23.8 million for the year.

40. There is no additional money allocated to the CPB for expenditure related to the current or proposed prescription co-payment settings for the years to 2027/28. Therefore, the expected CPB expenditure associated with the various co-payment setting recommendations in this briefing will offset a proportion of the co-payment revenue shown in Table 1. We will continue to provide you with updates on the impact on the CPB through the weekly report.

Next steps

41. Subject to your decisions in this paper, the Ministry will finalise the bid for re-instating the prescription co-payment for Budget 2024.

ENDS.

Minister's Notes

MANATŪ HAUORA
MINISTRY OF HEALTH

Briefing

Budget 24: COVID-19 initiative: draft letter to the Minister of Finance

Date due to MO:	5 February 2024	**Action required by:**	5 February 2024
Security level:		**Health Report number:**	H2024035664
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☐		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a)
Dr Andrew Old	Deputy Director-General, Public Health Agency	s 9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Budget 24: COVID-19 initiative: draft letter to the Minister of Finance

Security level:		**Date:**	5 February 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1 This briefing provides you with:

a. a draft letter to the Minister of Finance formally requesting an invitation to submit a Budget 24 bid for the delivery of COVID-19 vaccines, antivirals and testing, and maintenance of surveillance capability to support the longer-term strategy for managing COVID-19 and preparing for future pandemics, and

b. advice on initial feedback received from Treasury on the contents of the bid.

Background

2 You recently received a briefing (HR2024034757) seeking your agreement to request a further invitation from the Minister of Finance to submit Budget 24 bid/s for funding to administer and deliver Pharmac-purchased vaccines and therapeutics (e.g. antivirals), as well additional areas where time-limited funding will expire in June 2024 to support the shift to a sustainable strategy for managing COVID-19 and preparing for future pandemic.

3 Funding for the purchase of COVID-19 vaccines and antivirals has been invited to the Budget 2024 process. A separate initiative is required to fund the delivery costs for these vaccines and antivirals. As the two are linked, the quantum for each initiative will need to align with the overall policy direction for the response to COVID-19.

Formal letter seeking an invitation

4 We understand that verbal approval was given from the Minister of Finance to proceed with a budget initiative based on the options recommended in HR2024034757.

5 Subsequently The Treasury has confirmed that you will need to write to the Minister of Finance formally requesting an invitation for the additional Budget 24 bid. Please find a copy of a draft letter attached as Appendix 1.

Advice on initial feedback

6 We have also received advice from Treasury that the Minister of Finance has indicated that she was unwilling to provide new funding for rapid antigen tests (RATs) or wastewater testing. It is unclear whether the Minister was referring to the cessation of free RATs to the general public (current policy setting), or whether she was meaning a cessation to public funding of RATs for those eligible for antivirals, and the provision of RATs to in aged residential care, primary and hospitals, etc.

7 Further advice on what is sought with this funding and the potential risk with this direction is provided below to inform your discussions with the Minister of Finance. We have also outlined these issues in the draft letter to the Minister of Finance.

The role of RATs

8 You recently agreed to maintain supply of free RATs to the general public until 30 June 2024. The funding proposed in the Budget 24 initiative moves away from publicly funding RATs for the general population. In the preferred option, ongoing funding of RATs will be targeted at those eligible for antiviral therapy and to manage outbreaks in aged residential care, hospitals and other healthcare settings.

9 Access to antiviral COVID-19 treatments can be provided to eligible people following either a positive PCR test or Rapid Antigen Test (RAT). RATs have served as a way to offset the increased capacity burden within laboratory settings alongside compliance of COVID-19 pandemic response settings to support our ability to reopen as a country and remove mandates progressively in 2022 and 2023.

10 The introduction of community access to antiviral therapeutics required evidence of a positive COVID-19 result and administration of the antiviral within 5 days of symptom onset. Given the high case numbers at the time and the capacity of our primary and community care settings, public health advice supported broad community access to RATs for the purpose of testing, and as evidence to support the criteria assessment for access to antiviral therapeutics.

11 We understand you will be seeking Budget 24 funding for the purchase of COVID-19 vaccines and antiviral therapeutic medicines. Without ongoing funding for RATs, people eligible for antivirals antivirals will not have access to rapid testing modalities to confirm a diagnosis and/or seek clinical assessment if other health conditions are prevalent. Those at risk of serious illness and hospitalisation will therefore not be able to access the antiviral therapies publicly funded through Pharmac in a timely and effective way.

12 This was noted in recent advice to you from Health New Zealand (HNZ00035731):

a. *RATs are used for our most clinically vulnerable population groups to meet the Pharmac eligibility criteria for AVTs. If RATs were unavailable for this group, it would likely create a barrier to AVTs access, resulting in treatment not being sought (due to not being able to test) and increased emergency department presentations and hospitalisation of cases.*

13 The targeted provision of RATs is directly linked to the ongoing provision of antivirals due to the need to test to confirm diagnosis. Without new funding, Health New Zealand will have to fund the clinical use of RATs through reprioritisation of baseline budgets, potentially restricting access to at-risk groups, causing delays and impacting on other services and programmes.

14 Reduced access to RATs is likely to result in increased use of PCR testing for diagnostic purposes, leading to increased costs and reduced patient experience (and access to treatment) whilst awaiting laboratory results. The negotiated per unit PCR for laboratory processing is $75.00 (excl GST) alongside the $90.00 (excl. GST) for a standard business hours clinical assessment fee. RATs currently purchased in bulk (over 1 million units) have a purchasing value of $1.05 each.

15 Alternatively, Te Whatu Ora could choose to no longer support funded access to RATs pushing costs to consumers, further compromising timely access to antiviral therapeutics

resulting in increased emergency department walkins and hospital admissions. A consumer-pays approach is highly likely to have a negative equity impact on communities most vulnerable.

16 RATs are a vital tool in protecting the health system from the impact COVID-19 through;

a. Supporting pharmacy or primary care to test people who meet the Pharmac AVT criteria for antivirals. Ensuring funded access to RATs for those eligible for antivirals will reduce GP visits, hospital admissions, deaths, and pressure on the wider system and maintain broader health system capacity.

b. Supporting the testing of those at greatest risk of severe illness within high-risk facilities/settings (such as hospitals, aged care facilities, etc)

c. supporting healthcare facilities to quickly identify any risk of a COVID-19 infection and thereby ensure early and effective outbreak management.

Wastewater testing

17 Retaining and integrating investments made in innovations and infrastructure developed during the COVID-19 response, such as whole genome sequencing and wastewater testing, will ensure we can respond promptly and effectively to future COVID-19 and other outbreaks and health emergencies.

18 Wastewater testing (WWT) is a cost-effective method of testing a whole community. It is an efficient and unique method of gaining information on infection trends for a population across a range of communicable diseases beyond just COVID-19. Currently, WWT is the only tool we have for establishing accurate trends of infections in the community.

19 The next best indicator of the circulating levels of COVID-19, or other infectious diseases, is hospital admissions. While critically important to track hospitalisations, as a surveillance tool, hospitalisations are a lag indicator, giving little to no early warning or time to prepare. In addition, hospital admissions only give a picture of severe disease across the country.

20 WWT is also an important tool in managing the disproportionate impact on populations at risk of serious illness from infectious diseases, including COVID-19. Māori, Pacific, disabled, and other at-risk communities tend to have higher disease prevalence and burden, but are less represented in the case data due to lower testing rates. WWT provides a safety net of surveillance that is not reliant on these communities accessing testing supplies and GP visits.

21 WWT is a flexible technology that is also being used internationally to evaluate trends across a host of diseases, from polio, Mpox, and norovirus, to influenza, RSV, the recent cryptosporidiosis outbreaks in Queenstown, and others. Currently, New Zealand uses WWT to monitor polio, as part of our international agreements with the World Health Organization (WHO) and providing evidence of New Zealand's polio-free status.

22 Most surveillance tools work by providing routine intelligence, for example testing week-to-week, providing a baseline level of testing regardless of the level of cases. Without a level of baseline, surveillance tools can't provide intelligence on outbreaks or increases in infection levels. Although any active testing regimen can be stopped and started, starting up a surveillance tool 'as needed' is of little value, unless there is time for a 'run in' period to establish the baseline levels. This run-in time is not possible in the context of disease outbreaks and pandemics.

23 The loss of WWT would create a significant gap in our overall approach to infectious disease surveillance.

Population implications

24 The impacts of COVID-19 and other infectious diseases remain uneven, particularly in relation to hospitalisations and deaths, with Māori and Pacific peoples, older New Zealanders and people with comorbidities amongst those disproportionately impacted.

25 For COVID-19, access to RATs as a means to access antivirals for this vulnerable population group will improve clinical outcomes, by significantly reducing serious illness requiring hospitalisation.

26 For other diseases, including COVID-19, ongoing access to WWT will ensure our public health system has the ability to monitor trends overtime, and get early warning of new outbreaks, allowing the system to prepare and respond effectively.

Next steps

27 You are asked to review and sign the draft letter attached as Appendix 1 to the Minister of Finance.

28 Officials are available to meet with you to discuss the advice in this paper.

29 Officials will continue to prepare the necessary budget initiative documents, while awaiting further direction from yourself and the Minister of Finance.

Recommendations

We recommend you:

a) **Note** that a letter formally requesting an invitation to submit a Budget 24 bid for the delivery of COVID-19 vaccines, antivirals and testing, and maintenance of surveillance capability is required.

b) **Note** that the draft letter seeks inclusion of funding for RATs and wastewater testing within the budget initiative

d) **Sign** the draft letter at Appendix 1 **Yes/No**

Dr Diana Sarfati
Director-General of Health
Te Tumu Whakarae mō te Hauora
Date:

Hon Dr Shane Reti
Minister of Health
Date:

ENDS.

s 9(2)(g)(i)

[redacted]

Minister's Notes

Briefing

Budget 2024: Options to support the primary care sector and scaling COVID-19 time-limited funding

Date due to MO:	26 March 2024	**Action required by:**	N/A
Security level:		**Health Report number:**	H2024038078
To:	Hon Dr Shane Reti, Minister of Health Hon Matt Doocey, Minister for Mental Health		
Refer to:	*Subject to recommendations below* Hon David Seymour, Associate Minister of Health (Pharmac) Hon Casey Costello, Associate Minister of Health		
Consulted:	Health New Zealand: ☐ Māori Health Authority: ☐		

Contact for telephone discussion

Name	Position	Telephone
Steve Waldegrave	Acting Deputy Director-General, Te Pou Rautaki | Strategy, Policy and Legislation, Manatū Hauora	s 9(2)(a)
Steve Barnes	Group Manager Strategy, Te Pou Rautaki | Strategy, Policy and Legislation, Manatū Hauora	s 9(2)(a)

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Budget 2024: Options to support the primary care sector and scaling COVID-19 time-limited funding

Security level:		**Date:**	26 March 2023
To:	Hon Dr Shane Reti, Minister of Health		
	Hon Matt Doocey, Minister for Mental Health		

Purpose

1. This briefing provides advice on alternative options to support the following two Vote Health initiatives following decisions at the bilateral meeting with the Minister of Finance on 11 March 2024:
   a. supporting the primary care sector as a result of the *Primary care funding – support for immunisations and health targets* initiative not progressing, and
   b. scaling options for a reduced level of funding to address time-limited funding for COVID-19.
2. Note that, due to the sensitivity of this information, we have not engaged with Health New Zealand | Te Whatu Ora (HNZ) in the development of this advice.

Summary

Primary care

3. s 9(2)(f)(iv) [redacted]
4.

Option	Assessment	Minister's comments
s 9(2)(f)(iv) [redacted]	s 9(2)(f)(iv) [redacted] s 9(2)(f)(iv) [redacted]	
s 9(2)(f)(iv) [redacted]	s 9(2)(f)(iv) [redacted] s 9(2)(f)(iv) [redacted]	
Option 3: Repurpose any further potential savings (vacancies and efficiencies) from the disestablishment of the Māori Health Authority (MHA) funding.	This option is contingent on updated forecast financial information following the transfer of functions to HNZ and the Ministry of Health, including on uncommitted commissioning spend, and any potential additional savings that may become available. ***Implementation readiness:*** Possible implementation in the 2024/25 financial year, contingent on financial information.	
Option 4: Repurposing uncommitted funding in contingencies / Budget 2022 initiatives.	Most uncommitted funding currently in baselines is for mental health, which the Minister for Mental Health is taking advice on. Further advice on the implications of stopping other services is required before proceeding with this option. You may also wish to reiterate to HNZ the need to continue to reassess its 2023/24 year end forecast spend for primary care activities to see if there are any potential areas which could be freed up for one-off savings. ***Implementation readiness:*** Possible implementation in the 2024/25 financial year.	

5. Note that each option presented is likely to require further analysis to ensure implications are identified and mitigated to avoid unintended consequences for the primary care sector. As a result, the options may not be able to be implemented by the end of the current financial year.

COVID-19

6. The *Timely access to COVID-19 vaccine and therapeutics and ongoing cost-effective management of COVID-19* initiative sought $773.84 million at Budget 2024. The in-principle decision at the bilateral meeting on 11 March 2024 reduced the funding for this initiative to $232 million.

7. Scaling below the original quantum sought requires even more significant narrowing of policy settings to reduce costs, impacting on access, timeliness and equity.

8. A visual representation of how this revised quantum could be applied is set out at **Appendix 1 – Option 2**, illustrating the potential trade-offs and risks associated. This option may require further testing as some components are based on approximations that have not been tested with HNZ due to budget sensitivity. Option 1 provides a comparison of what a 45% funding scenario could include.

9. All options prioritise funding for public health surveillance infrastructure (whole genome sequencing, wastewater testing and enhanced influenza-like-illness) as these are central to our ability to detect and respond to future disease outbreaks.

10. There are two key dependencies to note with the level of funding for COVID-19 management activities:

    a. the concurrent cost pressure funding discussion occurring through the Budget 2024 process, whereby key implications of scaling the *Timely access to COVID-19 vaccine and therapeutics and ongoing cost-effective management of COVID-19* initiative will have an impact on HNZ baselines, and

    b. the quantum of funding pre-approved by Cabinet for Budget 2024 to address Pharmac time-limited funding for COVID-19 vaccines and antivirals.

Recommendations

We recommend you:

Primary care

a) s 9(2)(f)(iv) [redacted]

b) **Note** that Ministry of Health officials have developed four alternative options to the initiative, however each has some limitations or trade-offs to consider, and further analysis is required for each option to identify all implications and mitigations pending your direction. **Noted**

c) **Note** that it is unlikely than any of the options presented will be ready for implementation in the current financial year, with possible implementation of options 3 and 4 in the 2024/25 financial year. **Noted**

d) **Note** that you have agreed to a strategic policy work programme that will reconsider the foundations of the primary and community healthcare system s 9(2)(f)(iv) [redacted] **Noted**

e) **Indicate** your preferred option and any additional directions via the table in paragraph 4. **Yes/No**

COVID-19

f) **Note** that following the in-principle decision to scale funding for the *Timely access to COVID-19 vaccine and therapeutics and ongoing cost-effective management of COVID-19* initiative at Budget 2024 to $232 million, there are significant trade-offs and risks to consider for the delivery of viable activities to manage COVID-19. **Noted**

g) **Note** that options to achieve the revised quantum are set out in Appendix 1, illustrating the trade-offs and risks, which include further limiting eligibility, stopping other services to enable absorption into HNZ baselines, or stopping COVID-19 activities. **Noted**

h) **Note** that the options are based on some assumptions that would need to undergo further testing before proceeding. **Noted**

i) **Note** that scaled funding for delivery of vaccines and antivirals may have implications for decisions taken by Cabinet regarding funding the cost of vaccines and antivirals. **Noted**

j) **Indicate** your preferences and views regarding options to scale the COVID-19 initiative in the space provided at Appendix 1. **Yes/No**

k) **Indicate** whether you would like to refer this advice to:

Hon David Seymour, Associate Minister of Health (Pharmac)	**Yes/No**
Hon Casey Costello, Associate Minister of Health.	**Yes/No**

Hon Dr Shane Reti
Minister of Health
Date:

Hon Matt Doocey
Minister for Mental Health
Date:

Steve Barnes
Group Manager, Strategy
Te Pou Rautaki | Strategy, Policy and Legislation, Manatū Hauora
Date:

Budget 2024: Options to support the primary care sector and scaling COVID-19 time-limited funding

Primary care

Context

11. The *Primary care funding – support for immunisations and health targets* initiative sought $52 million in Budget 2024 to support general practice to improve immunisation and contribute towards health priorities and targets.

12. Funding sought was to be made as an up-front payment to support broader capability in general practices. It would have been accompanied by a letter of expectations asking practices to focus on improving immunisations, wait times for appointments, and opening books to new enrolments. This payment was designed as a boost to practices for the 2024/25 financial year while ongoing solutions to the funding and accountability model for primary and community healthcare are being worked through.

13. You (the Minister of Health) have agreed to a strategic policy work programme that will reconsider the foundations of the primary and community healthcare system (H2024036142 refers). s 9(2)(f)(iv) [redacted]

14. You (the Minister of Health) met with the Minister of Finance for the Vote Health Budget 2024 bilateral meeting on Monday 11 March. At this meeting, you and the Minister of Finance made a number of in-principle decisions, including that the *Primary care funding – support for immunisations and health targets* initiative would not progress in Budget 2024 (H2024037497 refers).

15. Given this decision, Ministry officials have considered alternative options around how this sector support might be funded. This briefing provides officials' advice and assessment of each of these options for your consideration and direction.

Challenges in the primary care sector

16. The primary and community healthcare sector is facing challenges such as increasing demand and complexity of care.

17. The sector considers that investment in primary care in previous Budgets has not been sufficient to address the pressure that general practices are facing in the current environment, including the upwards pressure on nursing salaries as a result of recent pay equity settlements.

18. The intention of providing interim support until ongoing solutions to the primary and community healthcare funding and accountability model are developed is to give general practices the flexibility to use funding to address the key pressures affecting them.

Options to support the primary care sector

s 9(2)(f)(iv)

19. s 9(2)(f)(iv)

20. s 9(2)(f)(iv)

s 9(2)(f)(iv)

21. s 9(2)(f)(iv)

s 9(2)(f)(iv)

22. s 9(2)(f)(iv)

23. s 9(2)(f)(iv)

[1] Health and Disability System Review. 2019. Health and Disability System Review - Interim Report, p.150

24. s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted]

25. s 9(2)(f)(iv) [redacted]

26. s 9(2)(f)(iv) [redacted]

27. s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted]

28. s 9(2)(f)(iv) [redacted]

Option 3: Repurpose any further potential savings (vacancies and efficiencies) from the disestablishment of the Māori Health Authority funding

29. You have previously received advice (MHA35530 refers) from the MHA on estimated savings from disestablishing the MHA. As at February 2024, the MHA is forecasting cash of $107 million. It is known that most of the residual MHA funding will transfer to HNZ as the primary recipient of MHA staffing and contracts.

30. The concurrent Budget initiative *Disestablishment of the Māori Health Authority – return of funding* identified that there are potential further savings not yet accounted for, that will not be able to be determined with high confidence until the transfer is complete.

31. At this stage, the extent of MHA's funding in 2023/24 that may not be required in either the Ministry or HNZ is estimated as follows:

    a. $20 million, likely made up of unfilled vacancies/less resources required to deliver the function and possibly some additional interest income, and

    b. $10 million in surplus cash that the MHA was intending to retain as an earnings/equity buffer for future periods.

32. In addition, the MHA has underspent by $30m in commissioning expenditure in the year to date to 29 February 2024. The MHA is currently forecasting for commissioning to be fully spent by the end of the 2023/24 year (i.e., a catch-up on the underspend from 2022/23 plus additional contracts transferred during the current year from HNZ), but this seems unlikely based on the current spend rate.

Assessment of viability

33. To support an assessment of viability, Ministry officials recommend that you request the MHA provide you an update of its forecast financial information as at disestablishment, including on uncommitted commissioning spend, and any potential additional savings that may become available.

34. Ministry officials can then provide further advice on options to use any 2023/24 savings towards primary care, though this would require an expense transfer to 2024/25 that may need to be approved by Cabinet. In addition, if the funding is to be reprioritised, this would require a transfer between appropriations (unless this would be for Māori-related Primary Care services funded through the *Delivering Hauora Māori Services* appropriation). Transferring funding currently appropriated for hauora Māori services to fund general primary care services may risk maintaining or worsening health inequities for Māori.

Option 4: Repurposing uncommitted funding in contingencies / Budget 2022 initiatives

35. There are few opportunities to repurpose uncommitted funding or Budget 2022 initiatives. Most uncommitted funding currently in baselines is for mental health, which the Minister for Mental Health is taking advice on.

36. Alternatively, there is an option to terminate contracts for lower priority services (with a lead time advising of an intention not to renew of around 6 months) and for the activities to cease. This could free up funding for reprioritisation to other areas.

Assessment of viability

37. Proceeding with terminating contracts for lower priority services may result in significant consequences for the people accessing those services. Further analysis of specific consequences and who is impacted would be required for identified low priority services.

Other options considered

38. We have also considered a *transfer from the Delivering Hospital and Specialist Services appropriation*. This could have the effect of crowding out other services

and would require engagement with HNZ, along with explicit recognition of the impacts on these other services. This option has not been progressed as HNZ is already reporting pressures in costs associated with its hospital and specialist services, and therefore signalling the challenges of reprioritising funding from this area.

39. s 9(2)(f)(iv) [redacted]

Equity

40. The primary care sector faces several ongoing challenges that have a direct impact on people trying to access primary care services. These challenges span workforce, wait times, immunisation rates, and enrolment rates – all of which impact on peoples' ability to get well and stay well.

41. A lack of access to primary and community health care, including preventative care, means that people's conditions worsen and this places greater strain on the health system and drives poorer health outcomes.

42. With priority population groups including Māori, Pacific peoples and elderly people experiencing greater co-morbidities, addressing primary care challenges is critical to ensure equity of access and equity of outcomes.

43. However, the options presented in this paper also have the potential to exacerbate or introduce new inequities. The next steps set out below will be important to weigh up the potential equity impacts of possible options, especially where reprioritisation of funds would impact other services.

Next steps

44. Subject to your direction on the options presented in this paper, Ministry officials will progress further analysis on your preferred option(s) as specified within the assessment of viability section for each.

COVID-19

Context

45. The *Timely access to COVID-19 vaccine and therapeutics and ongoing cost-effective management of COVID-19* initiative sought $773.84 million over four years, to prioritise targeted access to vaccines and antivirals to those at greatest risk of serious illness (reducing eligibility from current settings), and to maintain critical surveillance activities for ongoing pandemic preparedness.

46. The submitted initiative reflects that some COVID-19 activities were already scaled back by narrowing eligibility based on highest need and risk, including:

    a. reducing eligibility for further COVID-19 vaccine doses to people aged 65+, Māori or Pacific peoples aged 50+, and for those with complex health needs from 1 July (currently, anyone 30+ is eligible for further boosters), and

    b. reducing eligibility for therapeutics to people aged 70+ (currently 65+), Māori or Pacific peoples aged 50+, people aged 50+ who have not completed a primary course, and people with complex health needs.

47. The in-principle decision at the Vote Health bilateral meeting to limit the quantum for this initiative progressing through remaining Budget 2024 stages to $232 million (30% of the funding sought) will result in significant trade-offs, impacting on the viability/availability of these services.

48. Options include:

    a. s 9(2)(f)(iv) [redacted]

    b. **Option 2 – scaled to 30% of original cost ($230.833m over 4 years):** this will fund ongoing surveillance at full cost and scaled delivery of key components of COVID-19 vaccine delivery, and limited processing of PCRs (focused on hospitals only). There will be no support to access antivirals outside of hospital settings. Compared to the original cost, this option will require HNZ to reprioritise and baseline from approximately $160m to $543.07m over four years to cover the shortfall.

Options to scale COVID-19 funding

49. Scaling below the original quantum sought to fit within the in-principle decision requires even more significant narrowing of policy settings, which will result in:

    a. removing all provision of RATs free to the public,

b. reducing outreach delivery of COVID-19 vaccine boosters (i.e., relying on general practice and pharmacies to deliver),

c. enforcing a requirement and associated costs for a prescription to access antiviral medication, and

d. limiting funding for PCRs for diagnostic testing in hospitals.

50. To illustrate how different levels of quantum could be applied to COVID-19 management, options are set out in Appendix One showing how activities could be prioritised for a 45% and 30% of the quantum sought in the budget bid. The options set out in Appendix One reflect an order of prioritisation for COVID-19 measures to illustrate what activities would need to be discontinued or absorbed into HNZ baselines (by reprioritising and stopping other services), in order to manage the revised quantum of funding.

51. In determining what activities could be absorbed or stopped, consideration has been given to ensure that those most at risk can still find an alternative option to access health care and services when they need it.

Public health advice supports prioritising infrastructure

52. Public health advice strongly recommends prioritising public health infrastructure over other activities in the bid. This approach would support longer-term pandemic preparedness to identify and respond to future disease outbreaks, as well as build on the significant investment made in these technologies during the COVID-19 response.

53. Both options presented at Appendix 1 prioritise funding for public health surveillance infrastructure including whole genome sequencing and wastewater testing, as these are central to our ability to detect and respond to future disease outbreaks.

54. Unlike other COVID-related activities, surveillance infrastructure cannot be scaled up or down to respond to a future outbreak. Without ongoing funding, these programmes will return to pre-pandemic levels, which include decommissioning wastewater testing and significantly winding back whole genome sequencing. Significant time and money (particularly to recruit appropriately qualified and trained staff) would be required to reinstitute these technologies again in the future when required.

55. Within the proposed 30% scaled funding, surveillance activities would continue to be supported as submitted.

Indicative implications for HNZ

56. For other COVID-19 management activities, work has been underway to transition these into core public health services with costs absorbed into baselines. Many COVID-19 activities have already been transitioned into business-as-usual approaches in 2023/24, including most of the care for people with COVID-19 in primary care and over telehealth, some contracting with community providers, and the outbreak response staffing in HNZ.

57. With the shift in funding indicated by the in-principle decision, the transition of remaining activities into baselines will occur at a faster rate, and may result in activities being stopped to reprioritise funding. Some activities, such as provision of RATs, vaccination outreach services and free dispensing of antivirals in the community, will stop under the scaled options. Other activities, such as the national immunisation programme team and maintenance of PPE supplies, will require HNZ to reprioritise and absorb into their baselines, which may compromise wider health initiatives. This is likely to see an increase in the burden of disease and associated impact on health services.

Indicative implications for the health system user

58. The table below sets out what the impact on users of the health system could look like for the scaled quantum, in comparison to the current status and the approach proposed in the submitted budget bid.

Activity	Current status	Submitted budget bid	Scaled option
Vaccination – eligibility for funded vaccination	All people aged 30+can get boosters. People who are immunocompromised or have significant or complex health needs or multiple comorbidities would continue to be eligible for further boosters aged 16+.	s 9(2)(f)(iv)	
Vaccination – delivery	People who are eligible can get vaccinated at GP or pharmacy. Currently around 30% of boosters are delivered through outreach and this is a key action to boost vaccination rates among Māori, Pacific peoples, and disabled communities.	Maintain current vaccination delivery mechanisms (i.e., via GPs and pharmacy (approx. 70% of vaccines delivered) as well as novel channels and outreach (approx. 30%).	Mostly, eligible people would only be able to access COVID-19 boosters at their pharmacy or GP. Outreach activities to deliver boosters in the community closer to eligible people would be removed.

Activity	Current status	Submitted budget bid	Scaled option
Vaccination – communications	Booster campaign as part of Winter 2023 communications.	Deliver 2 campaigns for new vaccine in Winter 2024 and preload of Winter 2025. Refreshed and renewed collateral for two campaigns in remaining Winter 2025 and ahead of Winter 2026. Transition costs for COVID-19 vaccine specific information into a centralised and managed public health communication channel post the launch of the new COVID-19 vaccine throughout the Winter 2025.	There would be no COVID-19 specific communications to promote further boosters or to remind eligible people when they are "due" for a booster. Transitional communication costs would have to be absorbed by HNZ.
Vaccination – expected outcomes	Expect around 1.25m doses administered in 2023/24.	Anticipated 1.25m booster uptake.	Anticipate 0.9m booster uptake.
Antivirals – eligibility	People aged 65+ can access antivirals (including Māori and Pacific peoples from 50+). People who are immunocompromised or have significant or complex health needs or multiple comorbidities would continue to be eligible.	Only people aged 70+ would be able to access COVID-19 antivirals (including Māori and Pacific peoples aged 55+). People who are immunocompromised or have significant or complex health needs or multiple comorbidities would continue to be eligible.	
Antivirals - delivery	Those eligible for free antivirals are able to receive these from a pharmacy without a prescription. Pharmacies are funded to assess patients and dispense antivirals.	Those eligible for free antivirals are able to receive these from a pharmacy without a prescription. Pharmacies are funded to assess patients and dispense antivirals.	Eligible people would only be able to access antivirals by prescription through their GP.

Activity	Current status	Submitted budget bid	Scaled option
Testing - RATs	Currently anyone can access RATs for free – noting this was a decision that Minister made in January (to maintain that access until 30 June).	Free RATs available in primary care and pharmacy to those eligible for antivirals to support assessment and access to those antivirals.	No RATs are funded. Consumers, including those eligible for antivirals, would likely be charged for RATs as part of GP consultation.
Testing – PCRs	Currently funded for services provided by 9 laboratories (3 private, 6 public) that are contracted on a fee for service basis to process COVID-19 PCR tests. Specifically, this output covers the costs of contracts with Laboratory service providers based on of $75 per test at a max of 1000/day and 98% within 24 hours.	Continue to fund services provided by 9 laboratories (3 private 6 public) that are contracted on a fee for service basis to process COVID-19 PCR tests. Specifically, this output covers the costs of contracts with Laboratory service providers based on of $75 per test at a max of 850-1000/day and 98% within 24 hours.	There would be much more limited use of PCRs, primarily/only in hospitals. This would significantly reduce the volume of PCRs being processed in public laboratories, and likely end any processing in private laboratories.
PPE	The cost of maintaining a 12-week supply of PPE is covered This includes the temperature regulated warehousing facilities cost and a small replenishment of stock ($2.5 million) per annum.	The cost of maintaining a 12-week supply of PPE is covered. This includes the temperature regulated warehousing facilities cost and a small replenishment of stock ($2.5 million) per annum. The monthly spend to maintain 12 weeks high pandemic use supply of PPE is $0.829 million across warehousing sites nationwide.	There would be a lower volume of PPE held as part of our pandemic preparedness. This increases risk. We assume it would be possible to buy in more PPE, if needed, in a new pandemic or a significant COVID-19 outbreak.

59. Reducing the quantum of funding for COVID-19 activities presents a significant shift from current COVID-19 settings, placing even more reliance on individuals to self-test and self-manage when they are unwell. More importantly, this will have a significant impact on:

    a. *Access:* greater barriers to access to vaccines and antiviral medication will impact on achieving health outcomes in accessing health care and services.

    b. *Timeliness:* barriers to access will impact on timely and efficient access to health care and support..

60. Additional cost and access barriers will impact disproportionately on those at greatest risk and already disadvantaged.

Next steps

61. We seek your direction on your preferred option and any additional directions on primary care, as well as your preferences and views regarding options to scale the COVID-19 initiative.

62. We can provide further information on the COVID-19 management approach if requested.

ENDS.

Minister's Notes

Appendix 1: Options to scale COVID-19 time-limited funding

Original preferred option ($773.84m)

Provided for ongoing pandemic preparedness activities (including surveillance and PPE) and activities to manage the ongoing impact of COVID-19 (including access to vaccines and therapeutics targeted to those at greatest risk of serious illness)

Component	Proposed costings ($ millions) at B24
Vaccine administration	130.65
Vaccine pay per dose	138.06
National immunisation programme team	17.87
Immunisation scheduling	9
Supporting services (storage, consumables, pharmacovigilance, cold chain)	32.02
Telehealth baseline vaccine capacity	9.556
Transitional communication costs	3.21
Transitional technology support	6.75

s 9(2)(f)(iv)

1: Scaled to 30% of original cost ($230.833m)

This option prioritises:

- Full funding for ongoing surveillance infrastructure and activities
- Scaled funding for key components to delivery COVID-19 vaccines (reduces promotion and recall, assuming a lower uptake as a result). Also focusses delivery of vaccines in traditional primary care channels (GPs and pharmacy)
- Scaled funding for laboratory processing of PCRs in hospitals at a minimum. PCRs are required in hospitals for undifferentiated illness to inform treatment. This is an estimated contribution, may require some costs to be absorbed by Te Whatu Ora

It does not include any funding for:

- Vaccine administration which supports delivery of vaccines through novel channels and outreach. Likely to negatively impact equity of vaccine uptake.
- End free assessment and provision of antivirals in pharmacy. Returns to standard model via GP (with associated costs for users).
- Access to RATs, which is likely to negatively impact ability in the community to access eligibility for antiviral therapies.

Component	Proposed costings ($ millions) at B24	Impact
Whole genome sequencing	23.08	As submitted
Wastewater testing	10.00	As submitted
Enhanced influenza like illness surveillance	5.16	As submitted
Vaccine pay per dose	129.70	Scaled but still viable We are assuming lower uptake of boosters - at around 900,000 over 2024/25 (down from 1.25m in original bid)
Supporting services (storage, consumables, pharmacovigilance, cold chain)	29.518	Scaled but still viable (reflects delivery of 900,000 boosters)
Transitional technology support	3.375	Scaled but still viable (reflects delivery of 900,000 boosters)
Laboratory processing services	30	Scaled with risks. This will significantly reduce the volume of PCRs able to be processed by laboratories and consequently will mean much more limited use of PCRs, primarily/only in hospitals.
RATs/MF Rapid Test funding for primary care and pharmacy	0	**There will be no free distribution of RATs to the public to enable testing for COVID-19, in particular to access antivirals. Consumers, including those eligible for antivirals, will have to pay privately**

Primary care and pharmacy assessments for antiviral dispensing	92.82	s 9(2)(f)(iv)	RAT warehousing and logistics (primary site)	0	**Not required as no free distribution of RATs to the public**
Laboratory processing services	106.344		Vaccine administration	0	**Outreach activities (outside of GPs and pharmacy) to deliver boosters in the community closer to eligible people will be stop.**
RATs to support health care settings	66.262		National immunisation programme team	0	**HNZ will have to absorb the cost of this function**
RATs/MF Rapid Test funding for primary care and pharmacy	55.14		Immunisation scheduling	0	**Reminders to eligible people that they are due for a booster will stop.**
Outreach access and distribution of RATs (secondary site)	0.198		Telehealth baseline vaccine capacity	0	**HNZ will have to absorb the cost of this function and/or negotiate it into existing telehealth services**
RAT warehousing and logistics (primary site)	7.52		Transitional communication costs	0	**HNZ will have to absorb**
Data and digital support testing reporting (PCR and WGS)	6.72		Primary care and pharmacy assessments for antiviral dispensing	0	**This will stop funding for assessment and dispensing of AVTs by primary care and pharmacy. Eligible people will only be able to access antivirals by prescription through their GP with associated costs.**
Licensing cost (CCM Patient management AVT)	1.68		RATs to support health care settings	0	**HNZ will have to absorb this cost.**
Winter communications campaign SARI	1.8		Outreach access and distribution of RATs (secondary site)	0	**Distribution of RATs to areas where access to traditional testing services is compromised (eg East Coast, West Coast) will stop.**
Whole genome sequencing	23.08		Data and digital support testing reporting (PCR and WGS)	0	**HNZ to absorb (was one year transition cost)**
Wastewater testing	10		Licensing cost (CCM Patient management AVT)	0	**HNZ to absorb (was one year transition cost)**
Enhanced influenza like illness surveillance	5.16		Winter communications campaign SARI	0	**There will be no COVID-19 specific communications to promote further boosters.**
Maintain 12-week high PPE reserve supply warehousing	40		Maintain 12-week high PPE reserve supply warehousing	0	**There will be a lower volume of PPE held as part of our pandemic preparedness**
PPE replenishment	10		PPE replenishment	0	**There will be a lower rate of PPE replenishment as part of our pandemic preparedness**
Total package	**$773.84m**		**Total package**	**$230.833**	

Key for navigating scenarios:

	Component is presented as it was submitted (or revised figure, if applicable) and is viable
	Component is scaled and still viable
	Component is scaled with significant risks
	Component would be absorbed as it cannot be deferred (TWO will have to reprioritise and absorb into baseline)

Minister's comments