Template 1: Manifesto Initiative Template

This template seeks a high-level summary of the Budget 2018 manifesto initiatives.

Your Vote Analyst will complete their assessment in the grey fields. Supporting information must be provided to your Vote Analyst. Please use the descriptions provided as a guide for what information is expected in each of the boxes below.

Contact your Vote Analyst in the first instance with any queries.

Section 1: Overview and Context

<table>
<thead>
<tr>
<th>Vote</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Minister</td>
<td>Hon Dr David Clark</td>
</tr>
<tr>
<td>Initiative title</td>
<td>Extending the Very Low Cost Access rate for General Practitioner visits to Community Services Card holders</td>
</tr>
<tr>
<td>Initiative description</td>
<td>This funding will reduce General Practitioner fees for 469,000 low income New Zealanders by:</td>
</tr>
<tr>
<td></td>
<td>• allowing all Community Services Card holders to access the same low General Practice rates that patients enrolled in Very Low Cost Access practices charge, regardless of whether they attend a Very Low Cost Access practice or not, and</td>
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<tr>
<td></td>
<td>• extending the Community Services Card to all Housing New Zealand tenants and New Zealanders that receive an accommodation supplement or income-related rent subsidy</td>
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<tr>
<td>Workstream</td>
<td>Manifesto</td>
</tr>
<tr>
<td>Responsible Vote Analyst</td>
<td>[Please provide your name and extension number]</td>
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</tbody>
</table>

1.1 EXECUTIVE SUMMARY

A. Short summary of the proposed initiative and expected outcomes.

This is one of a set of three Budget 2018 initiatives addressing financial barriers to accessing primary care. Specifically, this initiative more reliably provides co-payment relief to people who would benefit from it the most by linking subsidies to the person (CSC holders) rather than to practices.

This proposed initiative seeks $101 million p.a. to subsidise general practice visits for an additional 469,226 low income New Zealanders by:

1) allowing all Community Services Card holders to access the same low GP rates that patients enrolled in VLCA practices charge, regardless of whether they attend a VLCA practice or not
2) extending the CSC to all Housing New Zealand tenants and New Zealanders that receive an accommodation supplement or income related rent subsidy.

The maximum out-of-pocket cost for a GP consultation at a VLCA clinic is currently $18 for adults and $12 for 14 to 17 year olds.
In the short-term, we expect higher utilisation of primary care services for CSC holders. To manage an initial increase in demand, GP teams will likely need to extend opening hours, or conduct practice using new models of care. This provides an opportunity to increase the use of the wider primary care team, including nurses.

In the long-term we anticipate reduced demand on emergency and acute health services, improvement in overall health and wellbeing, and increased ability to participate in employment and education.

<table>
<thead>
<tr>
<th>Funding Sought ($m)</th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22 &amp; outyears</th>
<th>TOTAL</th>
</tr>
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<tbody>
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### IN-CONFIDENCE

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<td>Capital</td>
<td>-</td>
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<td>-</td>
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</tr>
</tbody>
</table>

### Vote Analyst Recommendation

Three components required: See Vote Analyst Assessment Guidance.
1. [Support in full/Partial support and Scale/Defer]
2. [Please provide a two sentence summary to explain your recommendation above].
   This will be entered into CFISnet and used in the supporting comment next to initiative assessments in advice to Ministers.
3. [Provide a succinct overall assessment which outlines the key judgements which support your two sentence summary (above)].
   This will be used in the Treasury moderation process and package development stages.

### 1.2 CONTEXT

| A. Has the initiative been stated in Labour's Fiscal Plan, Coalition agreement, or Confidence and Supply Agreement? | Y |
| B. Has the initiative been jointly developed with other agencies? | Y |
| C. Have you attached the supporting Better Business Case, Regulatory Impact Assessment, etc. (if applicable)? | N |
| G. If required, please provide additional information to support your answers above. | N/A |
Section 2: Problem / Opportunity & Strategic Alignment

2.1 PROBLEM DEFINITION OR OPPORTUNITY

A. Describe the problem or opportunity that this initiative seeks to address.

Some New Zealanders are avoiding or delaying visiting general practice due to cost.

People experience a number of different barriers to accessing primary care, the key barriers cited in international literature are affordability, approachability, acceptability, availability and appropriateness (the 5 A’s of access). Most New Zealanders have good access to general practice services, engaging with primary care when they need it. However, a significant number of those who struggle to access primary care in New Zealand cite affordability as a barrier. In 2016/17 approximately 28 percent of adults reported unmet need for primary health care, and 14 percent reported unmet need due to cost. These rates increase for Māori, Pacific Peoples, and those living in high deprivation. Many who experience barriers to accessing primary care choose to delay visits to primary care services, or not go at all.

Unmet need for primary care services is reported to be greatest in lower income populations, and evidence suggests that infrequent utilisation of general practice (i.e. as a result of unmet need) relative to the rest of the population is a contributing factor to inequality in health outcomes. Low income and unhealthy populations are thought to benefit the most from increased access to health care through decreased use of secondary health services, better management and lower incidence of long term conditions, and better productivity through lowered participation employment and education.

Avoiding or delaying visits to GPs is leading to adverse health outcomes and unnecessary attendance at emergency departments.

Decreased or delayed access to primary care can lead to unnecessary adverse health outcomes and cost to the sector, through preventable illness, prolonged illness, and unexpected admission to hospital.

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4. Schoen et al. 2004 "Primary Care and Health System Performance: Adults’ Experiences In Five Countries" Health Affairs, 23: w4-487-503


Internationally, health systems that place an emphasis on primary care have lower per capita costs, better health outcomes, and lower rates of premature mortality across a range of conditions.\(^9^{10}^{11}\).

Facilitating access to GPs for those who experience barriers to access to primary care will likely produce long term positive outcomes for individual health, the health system, and wider society through prevented or shortened illness, earlier diagnosis of conditions, better management of long term conditions, and less use of emergency and secondary health care services. Evidence suggests that improving access to primary care can also result in a reduction of unnecessary strain on hospital services through visiting people the emergency department instead of their GP, especially for low acuity conditions.\(^12\).

This initiative is one of a set of three Budget 2018 initiatives that seek to address financial barriers to accessing primary care. Specifically, this initiative more reliably provides co-payment relief to people who would benefit from it the most, by linking subsidies to the person by Community Services Card (CSC) rather than to geographic practices.

Existing schemes to reduce co-payments for certain groups (Free Under 13s and Very Low Cost Access schemes) still miss a significant number of vulnerable people.

Traditionally people with low incomes have higher health need and higher levels of unmet need for primary health care. This group has lower self-rated health, higher rates of long-term conditions and higher rates of unplanned hospital admissions. In the 2013 Census, 880,000 New Zealanders reported living in a household with a combined income under $25,000, which is less than a single fulltime job on the minimum wage. Of those 880,000 people, only 205,000 of those people were enrolled in a VLCA practice.\(^13\).

This initiative would to increase primary care access for a cohort who are likely to be experiencing financial barriers either due to low incomes or high housing costs relative to income. CSCs will be the mechanism to identify this cohort. The initiative provides CSC card holders with maximum co-payments at the same level as is available at VLCA practices, providing more affordable GP visits to an additional 469,226 people. This is a new approach to targeting in primary care which targets individuals rather than geographic location.


\(^13\) This statistic was produced using New Zealand Integrated Data Infrastructure, matching census data with National Health Index numbers in the National Enrolment Service database.
This will also provide additional choice for those on low incomes to receive care with a lower co-payment.

Many people currently enrolled in a VLCA practice have few affordable alternative services available to them. Some of these people travel far from their home or workplace to access care\(^\text{14}\), for some this will be a matter of preference, and for others this will be due to necessity. Anecdotal evidence suggests that some VLCA practices have long wait times. For a small number of VLCA enrollees, more appropriate care might be found elsewhere. Those eligible for CSC will be given an opportunity to seek regular care for an affordable price at a non-VLCA general practice, according to their preference.

CSC holders enrolled in VLCA practices that switch to non-VLCA practices will increase the cost of this initiative to the Government. This is due to them transferring from VLCA, which has a lower payment for capping co-payments than the proposed new initiative. The reasons for this are discussed below, and this represents an unfunded fiscal risk (see risks).

### B. What inputs will the preferred option buy and why?

**This should complement the information provided in the section xx of this template**

This initiative will buy a subsidy for all CSC holders equal to that currently provided to those enrolled at a VLCA practice.

This initiative is costed with a relatively simple formula:

\[
\text{Eligible Population} \times \text{Expected visits per year} \times \text{price per visit}
\]

This formula was used in advice to the previous government, it was used by the sector in their Primary Care Working Group 2015 proposal (the "Moody Report") and for the Free Under 13s initiative. This paper will discuss each variable below.

**Eligible Population: 469,226 people (2017 data)**

The Ministry understands the eligible population to be CSC holders enrolled in a non-VLCA practice. It also notes that the CSC will be expanded to 350,000 more people. The Government does not quote who those individuals are, but it does note "As with National’s policy, it extends eligibility for the Community Services Card to 350,000 more people". The National Party proposed expanding the CSC to Accommodation Supplement [AS] recipients and Housing NZ [HNZ] tenants. As a result, these criteria are used to define the population.

The Ministry does not agree with the 600,000 figure for eligible people, or the 350,000 figure for AS or HNZ. It’s likely this was based on incorrect figures from the Integrated Data Infrastructure. The Ministry has matched actual MSD clients (which is updated fortnightly) with NHI data. It yields a population of 469,226 people. Of these, 437,000 have a CSC, and just 32,000 are AS or HNZ but without a CSC.

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\(^{14}\) This statistic was produced by mapping the addresses for VLCA practices and the enrollees to Census 2013 meshblocks. The average distance between the place of residence and the VLCA practices was then calculated.

Census 2012 Meshblocks are the smallest geographic unit for which statistical data is collected and processed by Statistics New Zealand, varying in size from part of a city block to large areas of rural land.
### Section 9(2)(j)

<table>
<thead>
<tr>
<th>Date</th>
<th>Reference</th>
<th>Outcome</th>
</tr>
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<tbody>
<tr>
<td>1/1/21</td>
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</tr>
<tr>
<td>10/10/21</td>
<td>88888</td>
<td>✓</td>
</tr>
</tbody>
</table>

Outcome:

- ✓: Confirmed
- X: Unconfirmed
This is $6 million higher than the Government’s figure. The preferred option will reduce GP fees for the target population (CSC holders) by 1 July 2019. It will do this by increasing the proportion of the total cost of GP consultations purchased by Vote Health funds.

This option will offer new capitation rates to General Practices to compensate them for their enrolled population with CSCs and the predicted increase in demand. This will result in the provision of more consultations for the target group, allow low income families to spend less of their income on GP visits, and attend the GP more frequently, as needed.

The initiative also includes costs to improve current payment systems, and the processes concerned with the provision of CSC information to the National Enrolment system.

Currently the Ministry of Social Development (MSD) shares information with the Ministry of Health to enable a record of CSC status to be included on the National Enrolment System (NES). CSC status is then pushed through to Patient Management Systems (PMS) to allow practices to identify who has a CSC.

The [REDACTED] figure for the initiative includes estimated Practice & Ministry IT costs, and implementation costs.

The Ministry has estimated the following costs (one-off) for implementing the range of proposals. This includes both departmental and non-departmental expenditure.

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSC Matching Fidelity</td>
<td>$275,000</td>
</tr>
<tr>
<td>National Enrolment System eligibility enhancements</td>
<td>$450,000</td>
</tr>
<tr>
<td>Internal payment system enhancements</td>
<td>$250,000</td>
</tr>
<tr>
<td>Six PMS vendor changes</td>
<td>$900,000</td>
</tr>
<tr>
<td>Project management</td>
<td>$300,000</td>
</tr>
<tr>
<td>Super Gold Card changes</td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,675 million</strong></td>
</tr>
</tbody>
</table>

A review will identify to what extent existing processes are fit for purpose to support the ongoing implementation of this initiative. The Ministry of Health will undertake any work required to improve and maintain these processes. Current estimates for the costs of this work are based on current known, and assumed, issues with the system. These estimates will be refined following this review.

GP Patient Management Systems (PMS) will require new functionality to implement the initiative. PMS vendors will be contracted for the development of new PMS functions.

Providing more primary care consultations for this group is expected to result in reduced emergency department use, lower ambulatory sensitive hospitalisation rates, and higher rates of prevention,
early diagnosis and early treatment of conditions. It could also result in less low acuity emergency department use.

C. What options were considered to achieve the Government’s manifesto commitment and why did you choose your preferred option?

The manifesto commitment commits to providing a subsidy to 600,000 CSC holders, including around 350,000 extra New Zealanders newly eligible for CSC.

These numbers were the Ministry of Health’s best estimate of the target group in mid-2017. Since then, the Ministry of Health and the Ministry of Social Development have undergone a data match to refine their estimate, arriving at a figure closer to 460,226. There are estimated to be approximately 83,000 people newly eligible for a CSC, of which approximately 32,000 are not enrolled in a VLCA practice.

The options considered have included the desired coverage of the initiative, and phasing.

Coverage

Previous new initiatives in primary care have been implemented by setting a new service requirement and associated payment, which practices then opt-in to if the payment is attractive enough.

Achieving high coverage relies on practices opting in to the scheme. One price for this initiative (per enrolled CSC holder) is offered to all practices. Aiming for higher coverage will require that we offer a price for the initiative that is attractive to practices with higher consumer co-payments, meaning that more money is required to lower the CSC holder co-payment to VLCA rates.

The costings provided in this template have used a fee that is cost-neutral or better to approximately 77 percent of practices. This proportion means most communities will have access to a practice offering the service, and the service can be provided at a price that. Aiming for 100 percent is likely to result in a payment that is unaffordable (approximately double) to the Government longer term, and lower coverage could mean some communities miss out. This pricing in consistent with the negotiation of the Zero GP Fees for Under 13s initiative.

The table (right) illustrates the relationship between the coverage percentage and the price:

<table>
<thead>
<tr>
<th>% of practices</th>
<th>Co-pay</th>
<th>Derived price</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>$39</td>
<td>$21</td>
</tr>
<tr>
<td>50%</td>
<td>$43</td>
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</tr>
<tr>
<td>70%</td>
<td>$46</td>
<td>$28</td>
</tr>
<tr>
<td>80%</td>
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<td>90%</td>
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<td>$35</td>
</tr>
<tr>
<td>100%</td>
<td>$69</td>
<td>$51</td>
</tr>
</tbody>
</table>

Note, there is a difference between the price-influenced coverage and uptake. Even if exactly 77% of practices opt-in to the scheme, it is assumed that all CSC holders will receive the subsidy either by being in a practice that opts-in or moving to a practice that does should their current one refuse. This is supported by the fact that a diminishing proportion of CSC holders will be enrolled in the highest cost practices.

If some CSC holders choose to remain in practices that do not opt in (or simply do not visit their GP and therefore have no reason to change), then this would mean an underspend on the current
initiative. Note, however, in the risk section there are a number of factors that would cause an overspend that would eclipse any slight underspend here.

Phasing

Phasing the roll out (for example, regional roll out) of this initiative was considered as an option.

Phasing options considered were:

- Roll out by age,
- Phasing to first include current CSC holders, and to later include Accommodation Supplement recipients or Public Housing tenants.

Phasing would provide an opportunity to ensure that the learnings from the first phases inform better planning, capacity building (this issue covered in 4.1A) and would provide assurance to GPs of fair compensation though capitation rates, prior to more widespread adoption of the initiative. It would also allow for the Ministry and Health Sector to better focus troubleshooting efforts should implementation challenges arise. However phasing options will not meet the manifesto commitment of 1 July 2018, so were discounted.

Should the IT infrastructure required for CSC identification (see 2.1B, 4.1A) not be put in place in time, the initiative could be delayed by a period of weeks to months. CSC card holders are able to self-identify so practices could, if necessary, grant the subsidy at the point of service and be back paid for their enrolled CSC populations once IT systems are functional. GPs are unlikely to want to cover the costs of this, even for a short duration.

**VOTE ANALYST COMMENT**

Has the problem or opportunity been clarified and does it support the prioritisation of this manifesto initiative?

Has the agency clearly outlined what the initiative will be buying, for who (if applicable), and what it is intended to achieve?

What is the cost to deliver this proposal and is it comparable to other 'like' costs? Has the agency provided detail on the different components making up these costs?

Is clear information provided on the alternative options and counterfactual?

_If you do not have sufficient information, please follow up with your agency as these are key ingredients for the package development and bilateral advice._
### 3.4 FUNDING IMPLICATIONS

| **A. Provide option(s) for scaling, phasing and this initiative.**
<table>
<thead>
<tr>
<th>Builds on information provided in section 2.1.B of this template.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Government’s manifesto commitment sets out the target groups and states that the services will be available to New Zealanders from 1 July 2018. Scaling or phasing this initiative will not meet this commitment.</td>
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</tbody>
</table>
| **Phasing**
| Currently the Ministry of Health intends to have the initiative ready for national roll out by 1 July 2018. Phasing, through gradual roll out of the initiative was considered, but phasing would not enable the manifesto commitment to be met. |

<table>
<thead>
<tr>
<th><strong>B. Outline how the costs compare to those outlined in Labour’s Fiscal Plan (if applicable)?</strong></th>
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<tbody>
<tr>
<td>The Labour party estimated a cost of $95 million per year for this initiative which was included as part of the $259 million primary care package in the fiscal plan. However, this does not include funding for the risks discussed later, which will challenge negotiations.</td>
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<table>
<thead>
<tr>
<th><strong>C. Describe the implications on service delivery and risks/trade-offs for each of the scaled, phased or deferred scenarios section 3.4.A.</strong></th>
</tr>
</thead>
</table>
| **PSAAP Negotiations**
| The final cost of the initiative will depend on agreement between DHBs, and PHO representatives during PHO Service Agreement Amendment Protocol (PSAAP) negotiations, which will commence in February 2018. This negotiation will also include the Government’s other primary care commitments, which means insufficient funding for those initiatives could undermine this initiative. |
| This is a yearly process where PHOs and DHBs negotiate amendments to the PHO Services Agreement - the agreement that determines the scope of service and the remuneration of PHOs providing those services - is governed by the PHO Services Agreement Amendment Protocol (FSAAP). PHOs then have back-to-back agreements with practices*. It is up to practices whether they opt in to this initiative, which means the payment proposed must be competitive. |
| *General Practices are independent businesses and as such have the regular rights of independent business. Opt-in through contracts is the mechanism through which new initiatives are typically implemented. The Ministry’s legal advice is that compelling practices to providing certain services (beyond their health and safety requirements) would be met with legal challenge, and put a large strain on the relationships between practices and health authorities. |
Phasing provides an opportunity to ensure that the learnings from the first phases inform better planning, capacity building and would provide assurance to GPs of fair compensation though capitation rates, prior to more widespread adoption of the initiative. It would also allow for the Ministry and Health Sector to better focus troubleshooting efforts should implementation challenges arise.

Not phasing exposes this initiative to a larger scale of risks associated unknown factors e.g. greater than expected demand increase.

Phasing would not meet the manifesto commitment, and carries political risks associated with this.

**VOTE ANALYST COMMENT**

Have credible choices and implications been set out? Is it clear how costings differ from Labour’s Fiscal Plan? If this initiative is prioritised down or scaled to fit within the draft package, do you have sufficient information to make these judgements? At a minimum, can you provide to Ministers:

- What are the most valuable components?
- What is the do-minimum/point at which no worth doing?
- What are the risks or impacts of scaling?
- An understanding of why this needs to be funded for 2018/19?

The development of the Budget package will require trade-offs and prioritisation across initiatives. Advice to Ministers will need to set these choices (and the risks/consequences) out.
Section 3: Value for Money and Impacts

3.1 EXPECTED IMPACTS

A. What are the costs and benefits of this initiative compared to the counterfactual?

A discussion of the evidence informing the impacts of this initiative is provided in this section of the budget 2018 initiative “Cutting General Practitioner fees by $10 a visit”.

The logic underpinning the intervention is as follows (more detailed logic to be attached):

Lower co-payments → reduced number of people experiencing cost barriers to access, or unmet need for primary care due to cost → more access or timelier access to general practice → long term reduced demand on the system including avoidable hospitalisations and ED services → improved health for population → wider social benefits from more days in work and education.

* It should be noted that addressing financial barriers to access is only one way to increase the use of GP services. Others ways might include extending GP opening hours for those who have greater opportunity costs for taking time off work, improving public transport options to and from the GP or providing a wider range of services in the primary care space to better cater to the routines and other idiosyncrasies of a diverse population. In 2016/17 approximately 28 percent of adults reported unmet need for primary health care, and 14 percent reported specific unmet need due to cost.

Impacts

As outlined in the Cost Benefit Analysis Template, the NPV is $208m. The costs and benefits underlying this are:

Costs

- Cost to subsidise co-payments, and capitation adjustments for expected demand increase

Health benefits:

Population: CSC holders. It is predicted that the entire cohort will visit the GP more often as the cost of a visit will be less, e.g. as a precaution rather than a response to acute illness.

However, the benefits are conservatively estimated to be concentrated on the 25% of the estimated population with unmet need. Assumptions are discussed below (3.2A). This initiative does not claim to reduce financial barriers to primary care for all New Zealanders.
• Reduced ED attendances (NPV $90m) – Prior experience with introduction of low-cost care, as well as international literature, indicates greater GP utilisation should lead to a fall in ED visits,

• Reduced health costs for acute hospital admissions (NPV $79m) – More timely prevention of acute illness (e.g. flu vaccine) enabled by better access to GP care will also result in fewer acute admissions overall,

• Reduction in avoidable hospital admissions (NPV $27m) – Ambulatory Sensitive Hospitalisations (ASH) are a measure of the effectiveness of the health system, including primary care services. The ASH rate measures admissions to hospital for conditions that could have been treated in a community setting, including in primary care. With more GP visits, GPs will be better able to treat conditions before they develop and require hospital treatment,

• Decrease in the incidence and delay in the progression of long term conditions (NPV $522m) – GPs engage in prevention and early interventions with well-established effectiveness. Less consumption of GP services has been shown to result in a reduction of consumption of preventative services as a proportion of health services consumed.

Also, this initiative encourages consistency in the source of care over time, which is associated with better outcomes for people with long term conditions.

Wider societal benefits include

• Improved Quality Adjusted Life Years (QALYs) due to better care (NPV $174m) – improved access to primary care should lead to lower morbidity due to decreased incidence of avoidable, and better management of amenable long term conditions, and corresponding gains in QALYs,

• Private savings resulting from reduced private healthcare spending (NPV $954m)

The whole population will spend less in GP visits so will have additional money to spend elsewhere, and may experience less financial stress.

Expected impacts not modelled in CBAx spreadsheet

• Reduced mortality – numerous studies have indicated that all-cause mortality and mortality for specific conditions such as cancer and cardiovascular disease can be reduced through better primary care access, including through provision of lower-cost care. Mortality however hasn’t been modelled in the CBAx spreadsheet due to complications including vagueness concerning who in particular the mortality reductions affect (i.e. how many years saved), and unclear mechanisms around the nature and timing of the effect.
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- Increased ability to participate in employment and/or education. Increased productivity through better health, fewer days off work (the average hospital stay for an acute event is 3 days per acute event)
- Reduced welfare liability, through reduced and better managed chronic illness and long term conditions (e.g. reduced disability related benefits)
- Increased private income and tax revenue associated with increased time at work (as above)
- Improving inequities in access to health services and health outcomes.

Counterfactual

If the initiative does not go ahead, people will continue to face financial barriers to accessing primary care, resulting in negative outcomes in terms of hospitalization and poor health, with consequent knock-on effects on employment and education. People’s ability to afford primary care will be further eroded, as fees will continue to rise faster than inflation and wages. In addition, sustainability and quality challenges will continue for VLCA practices as they disproportionately serve a greater number of higher need New Zealanders and do so at a historically low price per enrolled person.

PHO Services Agreement Amendment Protocol (PSAAP) negotiations may also be affected, as deferment of this initiative would delay progressing the recommendations of the 2015 Primary Care Working Group report.

Should this initiative not go through, people with financial barriers to care may still receive some GP co-payment relief through the initiative to provide a $10 subsidy for GP consultations to all New Zealanders, but the impact will be limited in scope due to the limits of reach of current VLCA practices.

VOTE ANALYST COMMENT

[Please rate this initiative on a scale from 0-5 to reflect Value for money. Please explain your rating and provide a short comment on the quality of the cost-benefit analysis and the reliability of the inputs. See section 3.2.2 of the September guidance.]

Has a compelling counterfactual been provided? Or if not, have the risks and implications been made clear?
The prompts above should be completed at a minimum by the agency to ensure a consistent assessment across initiatives.

3.2 ASSUMPTIONS AND UNDERLYING EVIDENCE

A. Outline the assumptions underpinning the impacts described above.

Cohort size:
409,220 people have, or will be eligible for, a Community Services Card but are not enrolled in VLCA (calculated through matching data from the MSD database of Community Services Card holders and the National Enrolment service)
We assume negligible increase in further CSC adoption, as the Accommodation Supplement and Social Housing Tenancy have high adoption and similar income thresholds. We assume the cohort will grow at general population growth rates.

**Uptake**

77% uptake of initiative from general practices, but 100% of CSC holders. It is estimated that the price offered to compensate practices for lower patient co-payment and demand increase will be cost neutral or beneficial for 77% of all GPs.

**Demand**

Demand of GP visits is estimated to increase and has been approximated according to the price elasticity of demand estimates for primary care found in national and international literature\(^{15}\). The price elasticity of demand figure used in costings is -0.2.

This is similar to the experience of the recent implementation of the Zero GP Fees for Under 13s primary care initiative\(^{16}\). As of 2018/17 Q4, 6 – 12 year olds visited the GP 2.12 times a year on average, up from 1.82 times a year in 2014/15 Q4. This is a 16.2% increase, with a 100% price reduction, the price elasticity of demand is -0.162.

**Affected Population:**

Currently 20% of New Zealanders over 15 years of age in deprivation quintile 5 report that the price of a GP consultation is preventing them from visiting the GP more frequently\(^{17}\). The target cohort of this initiative represents a significant portion of the lowest income New Zealanders and consists of 18% of the non-VLCA, population. This group distinguishes itself from deprivation quintile 5 as there is assumed to be less variation in actual deprivation, as the deprivation index is location based (i.e. all high deprivation isn’t exclusive to areas within deprivation index quintile 5), and this group has been means tested.

As such, there is estimated to be unmet need for 25% of the population (added arbitrary 25% increase of unmet need in addition to deprivation quintile 5). The


\(^{17}\) O’Dea, D., Szeto, K., Dovey, S., & Tilyard, M., 1993 "The effects of changes in user charges on visits to New Zealand GPs" In Paper for the NZ Association of Economists conference. Christchurch: Lincoln University.
IN-CONFIDENCE

| B. What evidence supports the assumptions and impacts? | A discussion of the evidence informing the impacts of this initiative is provided in this section of the budget 2018 initiative “Cutting General Practitioner fees by $10 a visit”. This section has been reproduced verbatim below:

Reduced number of people experiencing cost barriers to access, or unmet need for primary care due to cost.

There is strong local and international evidence to support the assumption that cheaper co-payments increases primary care utilisation. Some key papers and data sources include:


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- Ministry of Health, 2017 “HR20171427 “ZERO FEES FOR UNDER 13S – 12 MONTHS UPDATE FOR 2018/17”

Evidence that increased GP visits will lead to reduced ED and hospital visits

Local evidence from introduction of free GP visits for under-13s demonstrated a 3.4% reduction in the number of lower-acuity ED visits as a result of the initiative, and this data has been used in the assumptions used for this bid.

International study has shown a statistically significant link between patients deferring GP care due to cost, and higher numbers of hospitalisations:


Reduced health costs for acute hospital admissions through more timely prevention of illness enabled by better access to GP care:

Gruber (2006, above) also illustrates that preventative services are especially sensitive to a decrease in general health consumption. That is, a decrease in GP use would be associated with a greater decrease in the use preventative services. Weakly implying that increased use of primary care may be associated with increased benefits of prevention.

Evidence linking stronger primary care provision and greater access with reduced ambulatory-sensitive admissions. Some key papers and data sources are:


Delay in the incidence and progression of long term conditions

There is moderate evidence that primary care use decreases complications associated heart disease (Gruber 2006, above), and diabetes:


The evidence presented by Leggetter et al. is strengthened when controlling for socioeconomic factors that influence primary care access:


There is also evidence that enabling regular access to a primary care clinician (e.g. through decreasing financial barriers to access), improves management of long term conditions including diabetes:
IN-CONFIDENCE


Gruber’s point that preventative services are especially sensitive to a decrease in general health consumption also apply in the case of prevention of Long Term Conditions.

Evidence that increased GP visits will lead to lower mortality

Some international evidence has shown a inverse relationship between GP utilisation and mortality rates:


The key data used to inform the assumptions in the model was drawn from Macinko et al. (2003). In a cross-sectional and longitudinal study of industrialised countries they found a weak relationship between physician visits and mortality, equating to a reduction of 0.3 in the mortality rate per 100,000 people for each extra visit per year; in the New Zealand context, this would mean a reduction of around 1% in the mortality rate. More generally, other international evidence indicates that stronger and more readily available primary care leads to improved mortality rates:

IN-CONFIDENCE


VOTE ANALYST COMMENT

Provide an assessment of the assumptions and judgements related to the expected returns. Are these clearly stated and reasonable and appropriate given the proposal’s intended outcomes? Does the evidence (qualitative and/or quantitative) provide reasonable certainty and confidence? Why/why not?

3.3 SENSITIVITY ANALYSIS

A. Provide examples or scenarios to show how impacts change with different assumptions or policy settings.

<table>
<thead>
<tr>
<th>Values</th>
<th>Discount rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6% real (default)</td>
</tr>
<tr>
<td>Net Present Value (NPV) $208m</td>
<td>$735m</td>
</tr>
<tr>
<td>Benefit Cost Ratio (BCR) 1.1</td>
<td>1.3</td>
</tr>
<tr>
<td>ROI - Societal total 1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>ROI - Government 0.4</td>
<td>0.5</td>
</tr>
</tbody>
</table>

VOTE ANALYST COMMENT

Has the agency completed sensitivity analysis which steps through the impact of different elements on the initiative?

This type of information will be critical when outlining choices and impacts/risks associated with trade-offs as the draft package is developed and advice is provided to Finance Ministers.
### 4.1 IMPLEMENTATION

**A. How will this initiative be delivered?**

<table>
<thead>
<tr>
<th>For any given gender, DHB region, age, and ethnicity (European/other, Asian, Pacific, or Māori) we will measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact on uptake of primary care services:</strong></td>
</tr>
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<td>• Utilisation of GP consultations – received quarterly from PHOs</td>
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<tr>
<td>• Utilisation of primary care nurse consultations – received quarterly from PHOs</td>
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<tr>
<td>• Reported GP fees – NZ Health Survey yearly, weekly from Primary Care Patient Experience survey</td>
</tr>
<tr>
<td><strong>Impact on Secondary Health Service use:</strong></td>
</tr>
<tr>
<td>• Admissions to the emergency department (as well as the lower acuity triage 4, and 5 admissions) – received weekly,</td>
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<tr>
<td>• Ambulatory Sensitive Hospitalisations (absolute, or as part a proportion of all acute hospitalisations) – received quarterly as a System Level Measure.</td>
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<td>• General Acute Admissions - received quarterly as a System Level Measure</td>
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<td><strong>Impact on Long Term Conditions</strong></td>
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<td>• Where Long Term Conditions are recorded and can be attributed to individuals and groups, the Ministry of Health will do so E.g. virtual Diabetes Register, CVD risk assessments, cancer registry, prevalence of the conditions tracked by the NZ Health Tracker</td>
</tr>
<tr>
<td><strong>Impact on patient experience (proxy for quality of care):</strong></td>
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<tr>
<td>• Perceived affordability of primary care services – received yearly from New Zealand Health Survey, weekly from Primary Care Patient Experience survey</td>
</tr>
<tr>
<td>• Inability to get a primary care appointment in 24 hours - Received yearly from New Zealand Health Survey, weekly from Primary Care Patient Experience survey</td>
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<tr>
<td>• Patient rated quality of visit, e.g. overall experience, GP good at explaining conditions and treatments, GP involves you in decisions about - Received yearly from New Zealand Health Survey, weekly from Primary Care Patient Experience survey</td>
</tr>
</tbody>
</table>

We will consider creating a measure, or small set of measures, regarding perceived value of primary care services. This could help explain cultural, age, and income related trends in primary care utilisation (e.g. Maori have relatively high ED and ASH rates, but low GP consultation rates even when accounting for income, could this be because of a cultural “under-valuation” of GP services?).

People’s health at all the time of GP visits can be an important factor in understanding the value of a marginal increase of GP utilisation at an individual level. Should individual utilisation and certain clinical data be made available, the Ministry of Health will investigate a practical measurement for general health.
**Workforce and consumer evaluation of implementation (conditional on departmental funding):**

Should funding allow, in-the-field interviews with staff and consumers could be used to assess success of implementation, identify pressures and barriers to optimal implementation, assess workforce experience of care provision, and to generally qualitatively test the theory of intervention against empirical findings. This will completed in two tranches – one tranche of qualitative analysis completed six months after implementation, and the other tranche completed after 18 months.

**B. Description of engagement with other agencies impacted by this initiative (if applicable).**

The Ministry has discussed the initiative with Inland Revenue, the Ministry of Social Development (MSD) (who administer the Community Services Card) and representatives from the primary care sector.

MSD have provided data on CSC holders that has assisted financial modelling (to get accurate population sizes). They have also provided advice around the operations of administering the CSC, and around the nuances of eligibility for Accommodation Supplement recipients and public housing tenants.

Engagement with the primary care sector to date has included consultation regarding the high level goals or vision for primary care, as well as operational issues in relation to this and other initiatives.

**C. How does this initiative relate to current activity undertaken by your agency and/or by others across the State Sector?**

This is one of a set of three budget 2018 initiatives addressing financial barriers to accessing primary care. The other two initiatives address universally lowering co-payments for GP consultations, and providing complete subsidies for Primary Care services for youth under the age of 14.

The Zero Fees for under 14 initiative aims provides assurance that cost is not a barrier for children between 13 and 14 years old, reflecting the value that the government puts on providing all New Zealanders with a healthy start in life. It will provide less restricted access to Primary Care for Year 9 students, assisting in the integration of the proposed Year 9 checks (and school based health services more generally), and Primary Care services in the community.

Related current activity

The VLCA scheme subsidises practices to cap patients co-payments to a maximum of $18 for an adult and $12 for youth (2017/18 rates). Practices can opt in to the scheme if their enrolled population made up of over 50 percent Maori or Pacific ethnicity, or people living in deprivation quintile 5 areas. Because VLCA is targeted to a geographic location, many people who would
benefit from cheaper co-payments do not receive them. This initiative seeks to address this by using CSC as the mechanism to identify people with low incomes, regardless of the practice they are enrolled at.

The options for how to manage the relationship between the new scheme and VLCA are still being worked through (for example, whether VLCA practices can leave the VLCA scheme for the CSC scheme). The review of primary care funding will address the longer term view of these two schemes.

There is support from the sector and wider on the need to address how subsidies for cheaper co-payments are delivered. A 2015 Primary Care Working Group report (driven by the sector independently of the Ministry and DHBs) and the 2017 Ian Axford fellowship paper on primary care both proposed subsidies targeted at the person rather than practice level.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Impact or Consequences</th>
<th>Likelihood</th>
<th>Severity</th>
<th>Overall Risk</th>
<th>Mitigation / Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting increased demand for GP services (change management, but there are kind of levers already such as winter rush stuff, could be an issue of training and availability)</td>
<td>This initiative will increase the demand of GP services. Overall strain on GP practices is predicted to be small (no more than 2.9%), as the size of the target group in comparison to the size of the</td>
<td></td>
<td></td>
<td></td>
<td>Meeting demand will require operational change (through slightly extended hours or shorter consultations), or change management lead by PHOs (more adoption of electronic patient portals,</td>
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</tbody>
</table>
The population enrolled in non-VLCA practices is small (16%). Unmet demand could result in slightly increased waiting times, limiting access for some.

Expanding the roles of existing staff, or improving patient triage. The Ministry of Health can assist in change management.

<table>
<thead>
<tr>
<th>Implementing subsidy through information systems (technological – probably within our scope, some contracting required, probably not much trouble)</th>
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<tbody>
<tr>
<td>Unforeseen technological issues might increase the time required to implement the initiative. This work may go over budget and/or may delay the date of this initiative’s implementation by weeks/months. The main uncertainty is person-hours required to complete the project. Timeframes should be able to be met through hiring FTE. Therefore, this is primarily a financial risk. Relative to the total cost of this initiative, the cost of IT work is small. So the severity of this risk is low.</td>
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</table>

An initial review of current processes will give a clear initial overview of predicted resource required. Frequent reporting on this work will adequately signal resourcing needs. Most resource will be FTE. Extra resources can be spent if required to make a July 1 deadline.
### VOTE ANALYST COMMENT

The implementation assessment will form a critical piece for the advice on the manifesto initiatives. In particular aspects such as the ability of the Government to ramp up for delivery, agency and market capacity and risks to the delivery need to be considered.

Please provide a brief comment on the agency’s capability to deliver the initiative and ensure that the expected outcomes are achieved.

Has your agency set out the potential barriers or roadblocks expected in implementing the initiative and whether a plan exists to mitigate these? (This could include, for example, limited supply in the market for resources required to deliver the initiative, access to the target population/self-selection issues, and/or ability of agency to contract with providers)

[Please rate this initiative red, amber or green according to your assessment of risks associated with the delivery of this initiative. Consider the size of the proposal relative to the agency’s activity, any cross agency impacts, and impacts to front-line service delivery.]

### 4.2 LEGISLATIVE AND REGULATORY IMPLICATIONS

#### A. Please detail any legislative implications and whether the Regulatory Impact Assessment (RIA) requirements apply.

<table>
<thead>
<tr>
<th>Changes to the Health Entitlement Cards Regulations 1993 will likely be required to redefine eligibility for the community services card.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Impact Assessment Requirements will apply.</td>
</tr>
</tbody>
</table>

### VOTE ANALYST COMMENT

[Provide an assessment of the regulatory impacts of this proposal in consultation with the Regulatory Quality team.]

### 4.3 PERFORMANCE MONITORING AND EVALUATION

#### A. Performance measures/indicators.

The overarching framework for evaluation for the primary care initiatives addressing financial barriers to care will apply to this bid and is described in this section of the initiative “Cutting General Practitioner fees by $10 a visit”. This is reproduced verbatim below:

For any given gender, DHB region, age, and ethnicity (European/other, Asian, Pacific, or Māori) we will measure:

Impact on uptake of primary care services:
- Utilisation of GP consultations – received quarterly from PHOs
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4.3 PERFORMANCE MONITORING AND EVALUATION

- Reported GP fees – NZ Health Survey yearly, weekly from Primary Care Patient Experience survey

Impact on Secondary Health Service use:
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Workforce and consumer evaluation of implementation (conditional on departmental funding):

Should funding allow, in-the-field interviews with staff and consumers could be used to assess success of implementation, identify pressures and barriers to optimal implementation, assess workforce experience of care provision, and to generally qualitatively test the theory of intervention against empirical findings. This will completed in two tranches – one tranche of qualitative analysis completed six months after implementation, and the other tranche completed after 18 months.
## 4.3 Performance Monitoring and Evaluation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>B. Outline how the implementation and performance of the initiative will be regularly monitored.</strong></td>
<td>The overarching framework for evaluation for the primary care initiatives addressing financial barriers to care will apply to this bid and is described in this section of the initiative “Cutting General Practitioner fees by $10 a visit”. This section has been reproduced verbatim below:</td>
</tr>
<tr>
<td></td>
<td>How would agencies ensure that there are effective feedback loops in place to inform continuous improvement?</td>
</tr>
<tr>
<td></td>
<td>This will be achieved through quarterly reporting. Reports will be shared with PHOs.</td>
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<tr>
<td></td>
<td><strong>Is funding being sought for evaluation?</strong></td>
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<tr>
<td></td>
<td>Funding will be provided within departmental expenditure, and will be allocated in accordance with the Ministry of Health prioritization processes.</td>
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<tr>
<td></td>
<td><strong>C. Describe the method proposed to evaluate the impact of the initiative [if appropriate].</strong></td>
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<tr>
<td></td>
<td><strong>Is any impact evaluation approach proposed for this initiative and why has the approach been selected as the most appropriate?</strong></td>
</tr>
<tr>
<td></td>
<td>A theory based evaluation is proposed to understand the key factors, monitor the outcomes, and measure the impact of the initiative. Theoretical assumptions based on previous national experiences and on international literature need to be tested.</td>
</tr>
<tr>
<td></td>
<td>Ideally, the evaluation will take the participatory approach involving stakeholders throughout the process from design to results, and include a post implementation and process review (leveraging the expertise of sector personnel), outcomes monitoring, and impact assessment. External consultation will be conditional on available departmental expenditure.</td>
</tr>
<tr>
<td></td>
<td>The evaluation will apply a range of mixed research methods, including administrative data analysis, pre and post implementation comparisons, cost benefit analysis, and (should funding allow) stakeholder interviews, to deliver evidence for decision making. An attempt will be made to establish counterfactual groups, including using propensity scoring matching.</td>
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<tr>
<td></td>
<td>This work would be greatly facilitated if the Ministry of Health comes to an arrangement with PHOs to allow the sharing of individual level utilisation data (we are currently in the preliminary stages of establishing a shared data solution with PHOs and DHBs), allowing the Ministry to take advantage of large samples with individual level variation. Inference about populations and their outcomes as a result of change of GP utilisation can be made at the population level (or as a cross section), but with individual utilisation linked to individual health outcomes such as those described in 4.3A would greatly improve the quality of evaluation.</td>
</tr>
</tbody>
</table>
4.3 PERFORMANCE MONITORING AND EVALUATION

Will the evaluation be able to estimate a counterfactual of what would have happened without the initiative? If so how will this be done?

A counterfactual may be able to be established through a comparison with practices who don’t opt in to the initiative (should this group be large enough, and in the absence of evidence of selection bias).

Potential risk in the evaluation includes: confidentiality associated with medical data, quality of data, lack of information on the health service provider capacity status, and insufficient internal evaluation capacity (resource) in leading/managing evaluation contracts and projects.

There are large potential benefits from having access to PHO data. Agreements on issues concerning data access and the exact nature of data being shared are yet to be made, and implementation of the proposed data sharing system are not trivial and will take months to implement. Although there is a chance that the PHO data sharing system won’t be made available until after the implantation of this budget initiative, it is expected that there will be access to historical data, thus allowing baseline measurements for this initiative to be made.

VOTE ANALYST COMMENT

Please provide a brief comment on the proposed performance monitoring and evaluation. A key aspect will be how success can be measured and the impact on the Government’s objectives.

Is there a clear and quality plan for how the success of the initiative will be measured and at which points or milestones?