

MEMORANDUM TO CABINET

PRIMARY HEALTH CARE STRATEGY – ACHIEVING LOW COST ACCESS

PROPOSAL

1. This paper seeks Cabinet's approval to the next stages of the implementation of the Primary Health Care Strategy. Cabinet is asked to agree to the further roll-out of low cost access to primary health care, including low cost pharmaceuticals (maximum \$3 per item) through Primary Health Organisations (PHOs) as follows:
 - 1 July 2005: 18-24 year olds
 - 1 July 2006: 45-64 year olds
 - 1 July 2007: 25-44 year olds.

This means that the roll-out will be completed within a 5 year timeframe.

2. Cabinet is asked to agree that the 1 July 2005 and the 1 July 2006 stages be funded from the Health Funding Package. Cabinet is also asked to agree that the final stage of the roll-out (1 July 2007) be funded from the 2007/08 Baseline.

EXECUTIVE SUMMARY

3. A key aspect of the Government's Primary Health Care Strategy is to achieve affordable access to care and remove the need for the Community Services Card (CSC) in primary healthcare services. Implementation of low cost access began in July 2002 with some of the highest need parts of the country being targeted first. PHOs in these areas are funded under the 'Access' formula to provide low cost access for all enrollees. More recently I have increased funding to other PHOs, through the 'Interim' formula, to achieve low cost access for children up to age 17 and people aged 65 and over through Interim PHOs. This has been achieved within the Health Funding Package.
4. My aim is to complete the transition to low cost access by 1 July 2007, that is within 5 years from the beginning of implementation, instead of the 8-10 years initially signalled. This will involve increasing government funding for the 18-64 age group enrolled with Interim PHOs, and will create a high degree of confidence that all New Zealanders will benefit from the establishment of PHOs and lower cost access to care.
5. To make the cost of the further roll-out more manageable, I propose to do this in three stages: people aged 18-24 first; followed by people 45-64; and finally those aged 25-44.

6. Recent survey information has shown that patient fees for children under six are indeed low and that Access PHOs are generally charging low fees to all patients. On the other hand, the average fees being charged by Interim-funded PHOs for the 6-17 age group could be seen to not adequately reflect the increase in funding for that group in October 2003. They do, however, generally fall within the maximums agreed by DHBs.
7. As a result of the information from the fee survey, the Ministry of Health worked closely with DHBs and Interim PHOs to ensure that fees for enrollees aged 65+ were set at the low levels required before the roll out of additional funding on 1 July 2004. The Independent Practitioner Association Council, representing significant numbers of GPs, accepted the need for such an approach.
8. [Withheld under the Official Information Act 1982 sub sections 9(2)(f)(iv) and (g)(i) as these issues are under active consideration]
9. Finally I am planning two further initiatives to improve access to primary health care:
 - I intend to increase government funding to enable Care Plus patients to receive low cost prescriptions (\$3 per item) from 1 April 2005 at the latest. This will provide the same low cost access to pharmaceuticals for Care Plus patients as is currently available to High Use Health Card holders.
 - I intend to increase government funding for influenza immunisations. This will improve rates of immunisation and help keep older people out of hospital. It will also have the added benefit of supporting other key immunisation initiatives for meningitis and the development of a national immunisation register.
10. I am proposing to fund the roll-out of low cost access from within the Health Funding Package, and I intend to complete it by 1 July 2007. At the moment the Health Funding Package is only allocated through to the end of 2006/07. However there is sufficient funding in the existing 2007/08 Baseline to complete the roll-out of low cost access in the 2007/08 year.
11. While the proposed package is affordable within Vote Health, it will leave limited flexibility to manage other pressures in the sector in the 2004/05 and 2005/06 years. I have previously provided Ministers with detail as to how these pressures will be managed.

BACKGROUND AND PROGRESS WITH PHO ESTABLISHMENT

12. The Primary Health Care Strategy aims to improve the health of New Zealanders through a strong primary health care system that is easy to access. The PHOs that are being established around New Zealand are the vehicle for achieving the Strategy's aims. Establishment of, and enrolment in, PHOs is well ahead of projections. As of 1 July 2004, there were 73 PHOs with a total of nearly 3.57 million New Zealanders enrolled. More than two thirds of all Maori; nearly all Pacific peoples; and about 80 percent of those living in the most deprived areas (i.e. deprivation deciles 9 and 10) are now enrolled in a

PHO.¹ This higher than expected growth is being managed from within existing baselines.

13. PHOs have a population health focus, and are intended to involve a whole team of health professionals offering a variety of services and providing continuity of care for their enrolled populations. Population based health promotion programmes are now being delivered by some PHOs, involving a wider range of professionals and supported by health promotion advisors. PHOs bring public health initiatives alongside traditional general practice to strengthen health promotion and illness prevention efforts. Community participation in the governing process of PHOs is also important to give local people a voice in the planning and delivery of services in their communities. [Withheld under the Official Information Act 1982 sub sections 9(2)(f)(iv) and (g)(i) as these issues are under active consideration] PHOs are charged with getting in front of ill-health, reducing inequalities in health, and improving the prevention and management of chronic disease for their enrolled populations. Funding is provided by District Health Boards for PHOs on a capitation basis to allow for a more proactive and inter-disciplinary approach to service delivery.
14. PHOs are required to implement services to improve access for high needs populations that have traditionally had poor access to primary health care and are over-represented in admissions to hospital. More timely primary health care is critical to keeping people out of hospital and improving health outcomes. Examples of initiatives to improve access in various parts of the country include:
 - free home visits to educate parents about immunisation, followed by free transport for children to get immunised
 - monthly meetings for people with diabetes and asthma, where issues ranging from diet to annual checks are discussed
 - longer opening hours for general practices/health centres
 - nursing outreach services providing care in the home for: people who have not attended a scheduled appointment at a primary or secondary health clinic; people requiring care after discharge from hospital; and people unable to attend a primary health service.
15. While getting PHOs established is a critical part of achieving the Primary Health Care Strategy's vision, it is by no means the end of implementation. The Ministry has established a 'PHO Future Development Taskforce' and is consulting with the sector on initiatives to ensure that PHOs are able to achieve the aims of the Strategy. The proposals currently being discussed cover the following areas for the future development of PHOs:
 - encouraging teamwork in PHOs
 - broadening the scope of PHO services
 - ensuring participation by providers serving high need populations
 - developing PHO management and governance capability
 - developing PHO infrastructure

¹ These populations have been shown to have high healthcare needs.

- building on other initiatives (e.g. integrated care or chronic disease management initiatives piloted in the past, or already in place in different parts of the country).

ROLL-OUT OF LOW COST ACCESS

16. In implementing the Strategy, funding has been targeted to the highest need parts of the country first through the Access formula. This was important to improve access quickly for those with the poorest health status and with the biggest potential for health gain. When implementation of the Strategy is complete, all New Zealanders enrolled in PHOs will have low cost access to primary health care consultations and prescriptions, without needing to use a CSC. The current timetable for moving to low cost consultations and prescriptions is as follows:

Table 1 Implementation timetable agreed to date

1997	Children under 6 entitled to free or very low cost visits and free pharmaceuticals
<i>Primary Health Care Strategy implementation:</i>	
1 July 2002	People enrolled with Access PHOs entitled to low or reduced cost visits
1 October 2003	6-17 year olds enrolled with Interim PHOs entitled to low or reduced cost visits
1 April 2004	People enrolled with Access PHOs entitled to low cost pharmaceuticals (maximum of \$3 per item) 6-17 year olds enrolled with Interim PHOs entitled to low cost pharmaceuticals (maximum of \$3 per item)
1 July 2004	People aged 65 and over enrolled with Interim PHOs entitled to low or reduced cost visits and low cost pharmaceuticals (maximum of \$3 per item) Care Plus patients entitled to low or reduced cost visits. (Care Plus patients are the 5% of PHO enrolees with the greatest need for intensive management in primary health care e.g. people with 2 or more chronic illnesses*)

**Some Care Plus patients will get low cost access sooner by virtue of their age group. Care Plus provides more services as well as low cost access to people needing intensive management in primary health care.*

17. My aim is to complete the transition to low cost access and low cost pharmaceuticals (maximum \$3 per item) for all enrolees by 1 July 2007, that is within 5 years from the beginning of implementation, instead of the 8-10 years initially signalled. This will give confidence that all New Zealanders will benefit from lower cost access, as well as the integrated care required of PHOs. It also allows for measured planning for implementation.
18. In summary, the arguments for moving to low cost access for all New Zealanders are as follows:
- compared to other countries, New Zealand has been unusual in having a high reliance on private funding for primary health care services. Though

patient subsidies largely funded the cost of GP visits when introduced in the 1940s, the real value had declined to the point where individual patients bore the greatest burden of costs and around half of the adult population paid the full cost of GP visits

- high user charges for general practice services are associated with people not getting services when they need them, and high rates of avoidable hospitalisations (that is, hospitalisation for conditions that can be well managed in a primary health care setting)
 - by significantly increasing the share of public funding, the Government is in a much better position to require that primary health care services: focus on providing services to those who have been missing out (as well as those already accessing care); address health priority areas such as diabetes and cardiovascular disease; co-ordinate care across the system; and collect health information
 - the predicted burden of chronic disease (growing levels of depression, of obesity and consequent diabetes and cardiovascular disease etc) will be manageable only if we strengthen prevention and early management
 - the expert group charged with reviewing the CSC system, was unable to find ways to effectively address problems such as low take-up by high need populations. In other words, it did not prove possible to find a way to target that could be relied upon to reach all those in need of low cost care.
19. Additionally, it is important to recognise the pressure from both the public and GP groups to close the gap in funding between Access and Interim PHOs as quickly as possible. This gap is being closed as each age group enrolled in Interim PHOs moves to low/reduced cost access.²

Adults aged 18-64 enrolled in Interim PHOs

20. The main task remaining is to reduce costs of consultations and prescriptions for people aged 18-64 enrolled in Interim PHOs. To make the cost of this more manageable, I am proposing moving this group to low cost access in three stages: people aged 18-24 first; then people aged 45-64; followed by people aged 25-44.
21. There are good arguments for moving first with the 18 – 24 year old group or the 45 – 64 group. The argument for putting 18-24s first is that improving access to primary health care for people in this age group can have a life-long impact on health through for example, better detection of early symptoms of mental illness, early signs of alcohol or drug abuse, or sexually-transmitted infections. On the other hand, the 45 – 64 group suffer more from chronic diseases; are more frequent users of the health care system; and, have higher rates of avoidable hospital admissions. In comparison to the 18 – 24 and 45 –

² One exception to this is 6-17 year olds where Access PHOs receive funding for more visits (but the same per visit subsidy) than Interim PHOs. This was put in place as it was thought that the utilisation rates for this age group would be higher in Access PHOs. The Ministry has indicated that over time it will move to align this funding at an estimated cost of between \$11.8 and \$12.5 million (GST incl). This would be funded from the Primary Strategy funding path.

64 year old groups, the 25 – 44s are healthier and make less use of the health care system overall.

22. Recognising that one could make a compelling case for going first with either the 18 – 24 or 45 – 64 year old groups, the decision is to put the 18 – 24s first.
23. Table 2 below sets out the proposed timetable for completing the implementation of low cost access and removing reliance on the CSC. The associated costs are shown in Table 4.

Table 2 Roll-out of low/reduced cost visits and \$3 prescriptions to Interim-funded PHOs (CSC no longer needed)

<i>Funded from current Health Funding Package</i>	
Adults aged 18-24 incl.	1 July 2005
Adults aged 45-64 incl.	1 July 2006
<i>Funded from Baselines</i>	
Adults aged 25-44 incl (final step)	1 July 2007 (5 years after start)

ACHIEVING LOW PATIENT FEES

24. Gaining the commitment of PHOs to maximum patient fees has continued to be a highly contentious issue with GP representative groups. From the Government's viewpoint, ensuring patient fees are affordable is a crucial component of increasing access to primary health care. The level of fees needs to be affordable, and patients need a clear understanding of what the fees are, in order to significantly improve access.
25. The Government is committed to ensuring that patient fees remain low. To avoid gradual increases in user charges the PHOs will receive automatic annual adjustments to their funding.
26. Changes in access to primary health care will be tracked in the following ways:

- the number of consultations, broken down by demographic group, will be monitored through the information PHOs are required to submit every quarter
 - the formal evaluation of the Strategy will provide more qualitative measures of improvements in access to primary health care, e.g. through 23 case studies that form part of the evaluation, and by surveying patients within and outside PHOs about their experiences in accessing care
 - over time, results from the regular NZ Health Survey will track changes in numbers of people who accessed care when they felt they needed primary health care, and numbers picking-up prescriptions.
27. As results from the evaluation will not be available for some time, the Ministry commissioned a survey (in February 2004) of primary health care providers to establish the level of their standard consultation fees. The survey included all general practices and had an excellent response rate of 91% (a total of 1,265 providers were contacted and of those 108 did not respond to the survey). The survey has produced useful results as shown below.

Table 3 Patient fees currently being charged by PHO practices

Standard fee for enrolled patient	Access PHOs		Interim PHOs	
	Average fee	90% of practices charge this amount or less	Average fee	90% of practices charge this amount or less
<i>Children under 6</i>	\$0.37	\$0	\$2.09	\$10.00
<i>Children 6-17 with CSC</i>	\$7.03	\$15.00	\$18.49	\$27.00
<i>Children 6-17 without CSC</i>	\$7.93	\$15.00	\$21.05	\$30.00
Adults with CSC	\$13.84	\$20.00	\$28.88	\$36.00
Adults without CSC	\$17.19	\$30.00	\$42.97	\$52.00

28. The table shows the following key results:
- average patient fees for children under six are very low in both Access and Interim PHOs
 - average fees for Access PHOs are very low across all age groups (Access PHOs are funded to provide low cost access for all enrolees)
 - the average fees being charged by Interim PHOs are higher than expected for some patient categories. In particular, the average fees being charged for 6-17 year olds following the roll-out of new funding for this age group are not as low as I would have hoped. This may be partly explained by

the very low fees being charged for under sixes: in other words, Interim PHOs may be cross-subsidising to deliver on the Government policy of free visits for under sixes. However, for those practices with fees in the upper 10% of the range, charges for 6-17 year olds are disappointing

- the difference in patient fees for 6-17 year olds between Access and Interim PHOs raises questions about the underlying cause (e.g. differences in utilisation levels, remuneration of health professionals, or service delivery models). The Ministry will start to analyse these differences using information from interviews being conducted with PHOs as part of Strategy evaluation. Results from these interviews will be available later this year
 - some PHOs are still differentiating fees based on the CSC even after funding has been provided to move groups of enrollees to low cost access (e.g. for 6-17 year olds in Interim PHOs, and for 6-17s and adults in Access PHOs).
29. While I am disappointed with the patient fees for 6-17 year olds, it is the Ministry's understanding that with one or two exceptions all the PHOs fees are within the levels agreed between the PHOs and DHBs. This indicates that the DHBs have agreed fee levels that are on the high side. I have asked that the Ministry work more closely with DHBs to use the information now available to ensure that future fee levels better reflect the magnitude of the subsidy that is being passed on.
30. The Ministry has also put in place a number of mechanisms to ensure low cost access including:
- working closely with DHBs and Interim PHOs to ensure low fees are in place before funding for additional age groups is rolled out
 - a communications campaign informing the public that certain groups should expect low fees if they are enrolled in a PHO
 - evaluation of the strategy, which provides information to enable monitoring and accountability arrangements to track fee levels.
31. As a result of the survey information on fees, the Ministry worked closely with DHBs and their Interim-funded PHOs to ensure that patient fees were suitably reduced before funding for the 65+ age group was rolled out on 1 July 2004. The Ministry communicated clear expectations to DHBs and PHOs that the significant majority of the \$26 per visit subsidy for the 65+ age group should be passed through in the form of reduced fees, or the PHO would not receive the funding on 1 July 2004. All 38 of the affected PHOs complied with this approach. Most fee reductions in individual general practices range from \$18 to \$26. Fee reductions at the lower level of this range were only approved once evidence was received detailing the situations of individual general practices that required a lower level of fee reduction than would ordinarily be acceptable. The Independent Practitioner Association Council, representing a significant number of GPs, accepted the need for the approach adopted for the roll-out of the 65+ age group.

32. The Ministry is also following-up to monitor the removal of CSC-based distinctions for those groups being funded at the higher level.
33. [Withheld under the Official Information Act 1982 sub sections 9(2)(f)(iv) and (g)(i) as these issues are under active consideration]

Low cost prescriptions for Care Plus patients

34. A high priority for the short term is to reduce prescription costs for Care Plus patients to the level paid by High Use Health Card holders i.e. \$3 per item. Without making this change, it will be difficult to move some High Use Health Card patients onto Care Plus. I want to encourage Care Plus as it represents a significant improvement over the High Use Health Card by:
 - more carefully defining the target population
 - providing a higher level of funding per patient for consultations than under the fee-for-service regime
 - providing a managed approach to care including reviews of health status and treatment
 - using an interdisciplinary approach to providing care (e.g. it provides an opportunity for nurses and pharmacists to take a greater role in addition to general practitioners).
35. I propose reducing prescription costs for patients to a maximum of \$3 per item for Care Plus patients from 1 April 2005 at the latest, which is nine months after Care Plus is due to be rolled-out. If system changes can be made more rapidly, I will implement this sooner.

INFLUENZA IMMUNISATION

36. Another area where I propose to increase Government funding in order to improve access and health outcomes is influenza immunisations.
37. The clinical performance indicators for PHOs include two that relate to immunisation: one for childhood immunisations and one for influenza immunisations for older people. I plan to increase the rate of benefit for influenza immunisations from \$11 to \$18 from 1 January 2005 to bring it into line with that paid for childhood immunisations. This will support the achievement of high levels of immunisation and help to keep older people out of hospital.
38. This initiative, by demonstrating the Government's commitment to immunisation, will also support two other key immunisation initiatives: implementation of the meningococcal vaccine strategy and development of the national immunisation register. I intend to make this increase available to all primary providers, whether part of a PHO or not.
39. In addition, at least for PHOs, I propose that immunisation benefits will be subject to the same annual adjustment as the rest of PHO funding. That will

ensure that the real value of these payments is maintained over time and that commitment to achieving high levels of immunisation can continue.

FINANCIAL IMPLICATIONS

40. Once fully implemented, the Strategy was originally estimated to cost \$496m and this estimate has changed only slightly. The amount of \$496m is made up of around \$280m indicatively allocated for 2005/06, plus an additional \$216m to be sourced from within Vote Health. These costs are GST inclusive.
41. As shown in Table 4, there is funding available in the Primary Health Care Strategy funding path of \$263.8m in 2004/05 and \$280m in 2005/06 (GST inclusive). When I last reported to Cabinet on Strategy implementation in September 2003, the 2006/07 and subsequent years fell outside the 3-year Health Funding Package and so were not considered. Since then an allocation has been made to Vote: Health for 2006/07 which allows decisions to be taken that affect the Vote up to and including that year.
42. Based on conservative assumptions of the available funding in Vote Health, the Ministry of Health has planned a path forward to complete the roll-out of low cost access in the 2007/08 year. The 2008/09 year is included in this table for Cabinet's information only.
43. I consider the roll-out as proposed is manageable within the Health Funding Package although it will leave limited flexibility to manage other pressures in the sector in the 2004/05 and 2005/06 years. Details on how these pressures can be managed were presented to Ministers previously.
44. Funding to meet cost increases due to demographic change and other pressures for PHOs, and the inflation adjustment of immunisation benefits, are not included within the Primary Health Care Strategy funding path shown in Table 4 below. They will be met from the components of the Vote: Health baseline set aside for these purposes, namely the Forecast Funding Track and demographics components.

Table 4: Cost and affordability of proposed completion of roll-out

<i>\$m GST inclusive</i>	2004/05	2005/06	2006/07	2007/08	2008/09 ²
Current Primary Strategy funding path	263.80	280.00	280.00	280.00	280.00
Adjustment for differences between actual expenditure and projections ¹	12.8	23.0	26.0	25.3	26.8
Low/reduced cost access for people aged 18-64 through Interim PHOs:					
From current Health Funding Package: 18-24s from 1 July 2005 & 45-64s from 1 July 2006	0.0	17.6	96.4	99.3	100.4
From baselines: 1 July 2007 for 25-44s	0.0	0.0	0.0	64.3	65.0
Other initiatives to improve access:					
Low cost prescriptions for Care Plus patients from Apr 05 at the latest	2.8	5.1	5.3	5.4	5.5
Increase fee for influenza immunizations	4.5	5.6	7.2	7.2	7.2
[Withheld under the OIA 1982 ss. 9(2)(f)(iv) and (g)(i)]					
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[Withheld under the OIA 1982 ss. 9(2)(f)(iv) and (g)(i)]					

1 This includes the effect of a higher than projected rate of enrolment in Access PHOs and reflects continuing growth in PHO enrolment beyond 2005/06.

2 2008/09 is included in this table for Cabinet's information only as indicative of the future funding path for primary health care.

CONSULTATION

45. The Treasury, Department of Prime Minister and Cabinet, Te Puni Kokiri, ACC, Department of Labour, and the Ministries of Social Development, Women's Affairs, Youth Affairs and Pacific Island Affairs have been consulted. The Ministry of Social Development has argued that the 25-44 age group should have priority over the 18-24 age group on the basis that the health of parents (many of whom are in the 25-44 group) is critical for the well-being of their children.

TREASURY COMMENT

46. If the concern is to improve access to primary health care as quickly and effectively as possible, tying the additional funding to specified age bands within the working age population may not have the greatest impact. Allowing Interim PHOs some flexibility in how they apply the funding to improve access, while holding them strongly to account for performance against the strategy's access objectives, would be likely to have a greater impact. This is because:

- PHOs are required to assess local health needs and are likely to know which sub-groups within, say, the working age population have the most urgent need for low cost access; and
 - PHOs are likely to have a better understanding of the barriers to access that operate locally and the types of services needed to overcome these barriers.
47. This approach would be feasible, as the Ministry of Health is currently implementing a fairly sophisticated performance framework for PHOs (with performance indicators and a process for monitoring PHOs against the indicators).
48. The approach would require stronger accountability mechanisms than are currently in place. However stronger accountability is important regardless of how the primary health care strategy is rolled out:
- the paper notes that the average patient fees being charged by Interim PHOs have not reduced as far as expected, for some patient categories;
 - the reasons for the disappointing impact on patient fees are not well understood.
49. This raises the question of how the funding provided to date for PHOs has been used. Given the concern to improve access it may be desirable to have a stronger understanding of this before decisions are taken to roll out additional funding.
50. The formal evaluation of the primary health care strategy will provide some information on how the funding to date has been used, and the impact on access. The evaluation will look at how access is changing for different population groups. Patient utilisation rates by GP practice within each PHO will be examined. The aim is to assess increased or decreased access by patient group, especially groups with historically low levels of access.
51. Initial findings from the evaluation will be available in August 2004 and further findings will be reported in November 2004.
52. We recommend that decision-making on the next phases of implementation is deferred until early 2005. Ministers may then be in a better position to assess:
- future fiscal pressures in the health sector;
 - wider expenditure pressures and priorities for 2005/06 and outyears;
 - why the average patient fees being charged by Interim PHOs have not reduced as far as expected, for some patient categories;
 - how the funding to PHOs to date has been used (drawing on findings from the strategy evaluation that will become available in August 2004 and November 2004); and
 - the mechanisms available to ensure stronger accountability for funding provided to PHOs in future.

HUMAN RIGHTS IMPLICATIONS

53. PHOs are being funded according to the need of their enrolled populations. Because of the known associations between health service need and low income, and Maori or Pacific ethnicity, PHO funding takes these population characteristics into account. Reduced charges for an individual will not depend on their ethnicity.
54. Different charges according to age are similarly related to differences in health need and are clearly permissible under the NZ Bill of Rights Act 1990 and the Human Rights Act 1993 as a matter of public policy. However, three points need to be made in relation to the phasing-in of low cost access by age group:
 - the differentiation by age discussed in this paper is a transitional measure with ultimately all PHO enrolees being able to access low or reduced cost care (over time this strategy roll out covers the whole population)
 - the Access formula is already targeting high need parts of the country to receive low/reduced cost access, regardless of the age of enrolees
 - Care Plus targets people needing intensive management in primary health care, regardless of age or ethnicity.

LEGISLATIVE IMPLICATIONS

55. There are no legislative implications.

REGULATORY IMPACT AND COMPLIANCE COST STATEMENT

56. A regulatory impact statement is not required, as the proposals do not involve an amendment to an Act or Regulations.

GENDER IMPLICATIONS

57. The funding formulae for PHOs recognise the higher needs for women of reproductive age. Women will benefit from improved access that targets high need groups.
58. Maori men have been identified as a high health need group and this population benefits from funding targeted to additional services to improve access to health care in the PHO environment.
59. The lower life expectancy of men relative to women does not currently translate into higher funding to PHOs in respect of their male enrolees. However men's health will benefit from other aspects of Strategy implementation, such as PHO performance indicators for: cardiovascular disease risk, smoking, and coding of ischaemic heart disease. These are health areas where the potential of men to benefit is significantly greater than for women.

DISABILITY PERSPECTIVE

60. People with disabilities are a relatively disadvantaged group in relation to a number of indicators, including employment, income, and access to services. A strong primary health care system is central to tackling inequalities in health and people with disabilities will benefit from improved access, community

involvement in services, and improved co-ordination of care across service areas.

61. In particular, a significant number of older people have disabilities, mainly as a result of chronic illness, and will benefit from low cost access through PHOs from 1 July 2004. Older people with disabilities are also likely to make up a significant proportion of Care Plus patients, and will benefit from this more proactive programme of care.

PUBLICITY

62. I plan to announce the decisions from this paper in July this year. Early advice to the sector is helpful to allow time for planning and to increase confidence and clarity about the extension of low cost access for the public and for Interim PHOs.
63. The National Communications Strategy for PHO awareness incorporates a two-week TV advertisement in April 2004 running parallel to cinema, radio and billboard advertising. The April campaign was centred around messages to do with the vision of integrated primary health care, community involvement and continuity of care. Advertising waves will be repeated every quarter, in line with PHO establishment and the implementation of various new initiatives such as low or reduced cost access for people aged 65 and over.
64. A continuing baseline of other communications includes: the PHO 0800 number; a website including the 'Primarily' newsletter; community newspaper stories; posters; leaflets; and small business cards printed with the 0800 number and the website address.

RECOMMENDATIONS

65. I recommend that Cabinet:
 - 1) **note** that I intend to complete the transition to low cost access to primary health care within 5 years of the 1 July 2002 start of Strategy implementation compared with the 8-10 years initially signalled.
 - 2) **note** that establishment of, and enrolment in, PHOs is ahead of projections and that this higher than expected growth is being managed from within existing baselines.
 - 3) **agree** to implement the roll out of the primary health care strategy through Interim PHOs by moving the:
 - a) 18-24 age group to low cost access from 1 July 2005
 - b) 45-64 age group to low cost access from 1 July 2006
 - c) 25-44 age group to low cost access from 1 July 2007
 - 4) **note** that the 1 July 2005 and 1 July 2006 stages will be funded from the Health Funding Package, and the 1 July 2007 stage will be funded from the 2007/08 Vote: Health Baseline.

- 5) **note** that low cost access will mean that those enrolled in a PHO are entitled to low cost primary health care and low cost pharmaceuticals (maximum co-payment of \$3 per item).
- 6) **note** that the cost of the primary health care roll out in 2008/09 will be \$216.9 million.
- 7) **note** I intend to implement \$3 prescriptions for Care Plus patients from 1 April 2005 at the latest.
- 8) **note** that I intend increasing the fee for influenza immunisations from 1 January 2005 to align it with the benefit paid for childhood immunisations and help keep older people out of hospital, as well as to support other key immunisation initiatives.
- 9) **note** that I intend to provide annual price adjustments for immunisation benefits, at least to PHOs.
- 10) [Withheld under the Official Information Act 1982 sub sections 9(2)(f)((iv) and (g)(i) as these issues are under active consideration]
- 11) **note** the need to ensure that Interim-funded PHOs will be charging reduced fees (unless fees are already low) before additional funding is rolled-out, as happened with the roll-out of the 65+ age group on 1 July 2004.
- 12) **note** the need to ensure all PHOs are meeting requirements to progressively drop the Community Services Card as a means of differentiating fees before additional funding is rolled-out.
- 13) **note** that the proposals are affordable within Vote Health but in 2004/05 and 2005/06 significant new policy and management of other pressures will be tight.
- 14) **agree** that I announce the next stages of the roll-out of low cost access in mid-July this year .
- 15) **note** that advertisements about primary health care developments began in April this year (on television, cinema, radio, and billboards) and that further advertisements will be run every quarter to coincide with implementation phases.

Treasury Alternative Recommendations

- 16) **agree** to defer the decision on the next phases of implementation until early 2005, when Government may be in a better position to assess:
- a) future fiscal pressures in the health sector;
 - b) wider expenditure pressures and priorities for 2005/06 and outyears;
 - c) why the average patient fees being charged by Interim PHOs have not reduced as far as expected, for some patient categories;
 - d) how the funding to PHOs to date has been used (drawing on findings from the primary health care evaluation that will become available in August 2004 and November 2004);
 - e) the mechanisms available to Government to ensure stronger accountability for funding provided to PHOs.
- 17) **direct** officials led by the Ministry of Health to report back by 1 February 2005 on the issues outlined in ((16)c), (16)d)) and (16)e)) above, including proposals to ensure stronger accountability for funding provided to PHOs in future;

Hon Annette King
MINISTER OF HEALTH