PRESCRIPTION ACCESS INITIATIVE

Petition of Nikki Turner on behalf of United Community Action Network and the Child Poverty Action Group: Removing prescription charges for Community Service Card holders

1. Introduction

1.1. Prescription Access Initiative ("PAI") is grateful for the opportunity to make submissions on the Petition of Nikki Turner on behalf of United Community Action Network and the Child Poverty Action Group: Removing prescription charges for Community Service Card holders ("the Petition").

1.2. PAI is a group of like-minded pharmacists who believe that:

1.2.1. all people in Aotearoa New Zealand should be enabled and supported to reach the highest attainable standard of hauora/health and wellbeing; and

1.2.2. to reach the highest attainable standard of hauora/health and wellbeing, it is essential that all people can exercise choice, and access the highest-level medicine related care in Aotearoa New Zealand.

2. PAI supports removal of prescription charges on fully-subsidised medicines

2.1. PAI:

2.1.1. supports and confirms the reasons for the Petition, and the Petitioner's concern;[i] and

2.1.2. further submits that prescription charges (also known as "co-payments") on fully-funded medicines should be removed for *all patients in Aotearoa New Zealand (*and not only patients who are Community Service Card holders).

2.1.3. PAI's reasons for its position are that prescription charges:

2.1.3.1. are a significant barrier to accessing medicines for many New Zealanders, especially during the current cost of living crisis with people experiencing increasing significant hardship.

2.1.3.2. negatively impact medicines equity, access to medicines, patient choice, continuity of care, medicines adherence, health outcomes and costs to the wider health system.

These factors are closely intermingled; a change in one factor is likely to affect one or more of the other factors. Therefore, a positive (or negative) change in one factor is likely to encourage a positive (or negative) change in the other factors.

2.1.4. PAI submits that removing prescription charges would support and enable people to reach the highest attainable standard of health and wellbeing as follows.

Increasing access

2.1.4.1. There is considerable evidence showing that prescription charges act as a barrier to medicines access, and that removing prescription charges would therefore increase medicines access.[ii]

2.1.4.2. We note that PHARMAC recognises in its aim *"To eliminate inequities in access to medicines by 2025"* that medicine affordability is negatively affected by "prescription cost e.g. co-payment...prescription subsidy cost".[iii]

2.1.4.3. Such a barrier to accessing medicines can lead to issues discussed further below, including medicines non-adherence, decreased continuity of care, increased costs in other areas of the health system and exacerbated inequities between groups of people.

2.1.4.4. Removing prescription charges would increase medicines access by encouraging patients, who may not otherwise be able to afford to pay the prescription charges, to collect their prescriptions or to collect them without delay.[iv]

Increasing equity

2.1.4.5. Medicines equity has been defined as *"The absence of avoidable, unfair or remediable difference in funded medicine access among groups of people, whether those groups are defined socially, economically, geographically, or by other means of stratification."*[v]

2.1.4.6. The impact of prescription charges is greater for some groups. For instance, according to the Ministry of Health's Annual Update of Key Results 2021/22, Pacific and Maori adults were 2.7 and 2.8 times as likely as non-Pacific and non-Maori adults respectively to **not** have collected a prescription due *to cost*.[vi]

2.1.4.7. As referred to above, PHARMAC acknowledges that prescription costs affect inequities.[iii]

2.1.4.8. Non-collection of medicines (or delay in commencing treatment due to delayed collection of prescription medicines) due to prescription charges can

compound existing inequalities and disparities which arise due to people's social, economic, demographic, geographical or other status.

2.1.4.9. Removing prescription charges would improve equity, and prevent exacerbation of existing inequities, by enabling consistent access to medications regardless of patients' social, economic, demographic, geographical or other status.

2.1.4.10. A recent article based on a study in Aotearoa New Zealand[iv] focused on the option of "zero co-payments".

2.1.4.11. The results of the study suggested, in line with the abovementioned factors, that prescription charges exacerbate ethnic health inequities, are damaging the health of vulnerable groups and are likely to increase overall healthcare costs.

2.1.4.12. The authors significantly concluded that :
"Eliminating a small co-payment appears to have had a substantial effect on patients' risk of being hospitalised. Given the small amount of revenue gathered from the charges, and the comparative large costs of hospitalisations, the results suggest that these charges are likely to increase the overall cost of healthcare, as well as exacerbate ethnic inequalities."

Increasing continuity of care

2.1.4.13. To enable and encourage people to reach the highest standard of health, it is vital that they have continuity of care throughout their healthcare journey. Continuity of care includes people having access to, and using, medicines as prescribed for treatment of their health conditions.

2.1.4.14. When prescription costs act as a barrier to accessing medicines, and patients therefore do not use their medicines as prescribed, continuity of care is harmed. This results in a deterioration in their health.[vii]

2.1.4.15. There is also evidence to show that patients reduce their interaction with primary care if they know they cannot afford prescribed medicines,[iv] and therefore continuity of care is further diminished.

2.1.4.16. Removal of prescription charges would encourage increased continuity of care due to patients continuing their interactions with health care providers in the knowledge that they can afford their medicines, and by using their medicines as prescribed.

Increasing medicines adherence

2.1.4.17. Medicines adherence[viii] is a significant factor in ensuring effective treatment of conditions, especially ongoing conditions such as respiratory, heart and mental health conditions.

2.1.4.18. By acting as a barrier to medicines access, prescription charges reduce medicines adherence due to patients not collecting or using their medicines as prescribed,[ix] and due to their continuity of care being negatively impacted.

2.1.4.19. Removing prescription charges as a barrier to medicines access would encourage medicines adherence[x] and therefore improve patient health outcomes, leading to more efficient use of health-related resources and reduced costs in other areas of the health system.

Encouraging better use of resources

2.1.4.20. Health practitioners (including prescribers and pharmacy professionals) are currently faced with issues arising to due to patients not accessing or using medicines as prescribed. With removal of prescription costs (resulting in improved medicines adherence) health practitioners could better focus their resources on counselling and advising patients on issues unrelated to medicines non-adherence.

2.1.4.21. Pharmacy teams are highly accessible health professionals,[xi] and have the expertise to advise and counsel patients in respect to their medications and ailments (as well as interact with prescribers of medications). Pharmacies resources would be much better directed to counselling patients rather than enduring the administrative burden of explaining and collecting the prescription charges.

2.1.4.22. Hospitals, General Practices, and other Prescribers, are experiencing considerable workforce and other pressures, which have been exacerbated since the COVID-19 pandemic. Pharmacies can assist with alleviating some of these pressures by providing patients with timely and easily accessible advice, and by providing other services eg vaccinations. However, if patients are not collecting their prescriptions due to the prescription charges, the opportunities for pharmacies to engage with, and advise patients, are reduced or removed.

2.1.4.23. Evidence also shows that removal of prescription charges could result in overall savings to the health system including by reducing the risk of a person being hospitalised.[iv]

Enabling and supporting patient choice

2.1.4.24. A 2021 Australian study[xii] distinguished between:

(1.) pharmacies which have adopted a price promotion (PP) business strategy and "In order to be able to discount prices PP pharmacies use reduced staff/sales ratios and larger floor spaces devoted to the sale of non-medicinal products", and

(2.) pharmacies with a high services business strategy "whose business strategy aims to practice patient-centred care with a focus on providing high service levels, rather than relying on a heavily discounted price."

Most pharmacies in Aotearoa New Zealand which do not currently collect the prescription charges arguably fall into the former category.

One of the pharmacy chains in Aotearoa New Zealand not currently collecting prescription charges identified itself in the Australian setting as being *"the market leader"* of a pharmacy business model of *"large, high volume, lower margin pharmacies offering deep price discounts."*
They state that this type of model compares with *"high service pharmacies offering detailed personal health advice and testing services, in addition to retail distribution of medicines and health products"*.[xiii]

There have been a number of incidents of public health providers and their employees directing patients to pharmacies which do not collect the prescription charges. It could be implied that this is a tacit acknowledgement that prescription charges negatively impact access and equity as described above.

Price promotion strategies cannot sufficiently meet needs of all members of every community due to (but not limited to) the following reasons:

2.1.4.24.1. geographical disparities: the business model of such corporations (high retail sales) does not support them going into lower-populated areas, giving rise to geographical disparities in access.

2.1.4.24.2. decreased continuity of care: When a patient finds their preferred pharmacy unaffordable and therefore uses a pharmacy which can choose not to collect the prescription charge, the continuity of care they receive is affected. This disrupts or ends essential trusted relationships between patients and pharmacists in their local communities.

2.1.4.24.3. The 2021 Australian study referred to above[xii] showed that respondents attending pharmacies with a price promotion business strategy was predictive of lower perceived service quality and poor medication adherence.

2.1.4.24.4. There is anecdotal evidence that patients will use pharmacies which do not collect the co-payment until they reach the exemption in accordance with the Prescription Subsidy Scheme.[xiv] There is evidence that medication adherence is lower when patients use multiple pharmacies.[xv] Lower medication adherence due to changing pharmacies during treatment, especially by those who have high prescription numbers and therefore assumedly high health needs, will have a detrimental effect on the patient, and increasing demands on the health system.

2.1.4.25. Some patients in Aotearoa New Zealand may have the "option" of using a pharmacy with a "price promotion business strategy" or a pharmacy with a "high services business strategy". However, arguably, it may not seem like a real "option" for those patients when the issue of cost of prescriptions is added into the mix. If patient choice is removed or reduced due to a cost consideration (ie prescription charges), it could lead to decreased continuity of care and reduced medicines adherence, as described above.

3. Rationale for prescription charges

3.1 We note comments in Health Report 20180836[xvi] in considering pharmacy prescription charges that:

> *28. Any review of the policy needs to be firmly grounded on the reasons for having a co-payment in the first place:*
> *a. ensuring patients have access to safe and appropriately funded medicines*
> *b. improving health outcomes by improving patient buy-in to courses of treatment*
> *c. reducing costs to taxpayers.*
>
> *29. On the other hand the Ministry would also want to consider the broader health system, including:*
>
> *a. how co-payments impact on access to medicines*
>
> *b. whether co-payments deter necessary use of medicines*
>
> *c. the role of co-payments where it exceeds the cost of a medicine*
>
> *d. whether any proposed changes to co-payment policy would impact government expenditure in other areas of the health system or broader government (eg Disability Allowance)*
>
> *e. the impact of universal versus targeted subsidies and exemptions.*

3.2 We further note the comment in Health Report 20180836[xvi] that targeted removal is less expensive but "*it is more complex to implement at a systems level and requires substantive changes to Ministry payment systems and pharmacy vendor systems.*"

3.3 We submit that a targeted removal of prescription charges, whilst being an improvement on current policy, would be unlikely to achieve the necessary increases in the potential benefits explained above.

3.4 Targeted removal could result in some people falling through the cracks due to "administrative exclusion (nonparticipation due to organisational factors, as opposed to eligibility status)[xvii] or because "they do not successfully navigate bureaucratic processes."[iv] Targeted removal would also result in more resource intensive systems for pharmacies, which in turn would affect pharmacies' abilities to interact with, and advise, their patients.

3.5 We note from the conclusion of the article by Norris, P. et. al.[iv] that:

> "*The study strongly suggests that for people on low incomes, even small co-payments with a low ceiling can result in use of more expensive healthcare. In New Zealand, we strongly recommend that the $5 prescription co-payments be removed for those with high health needs and low incomes, or be scrapped entirely. The latter solution would be administratively simpler and avoid the risk that those with very high needs miss out because they do not successfully navigate bureaucratic processes.*"

4. Conclusion

4.1. We confirm our submission that prescription charges on fully-funded medicines should be removed for all patients in Aotearoa New Zealand, for the above reasons.

4.2. Whilst we recognise fiscal constraints, we submit that there is considerable evidence supporting removal of prescription charges.

4.3. There seems to be no evidence supporting the idea that prescription charges "*...ensure patients have access to safe and appropriately funded medicines*" and are "*improving health outcomes.*" [xvi]

However, as we submit, there is much evidence supporting our position that removal of the prescription charges will increase access to medicines and equity, increase patient choice, increase medicines adherence, encourage better allocation of resources and encourage continuity of care.

With respect to a purely monetary consideration of "*reducing costs to taxpayers*"[xvi] we note that this claim is simplistic, and there is considerable evidence to support the claim that removing the prescription charges will result in savings (monetary and otherwise) in other parts of the health system, and the community as a whole.

Burdening households with prescription charges due to cost-saving policies are resulting in decreased health outcomes and unnecessary increased pressure on the health system. Especially in a cost of living crisis, as we are currently experiencing, the impact and effects on people of continuing to require them to bear the prescription charges are potentially devastating.

We urge that the issue is considered in the interests of supporting and enabling all people of Aotearoa New Zealand to reach the highest attainable standard of hauora/health and wellbeing, and not considered simplistically in financial terms with no foresight for future benefits and gains to the health of all people of Aotearoa New Zealand.

Policy-makers in Wales, Scotland and Northern Ireland introduced free prescriptions in 2007, 2011 and 2010 respectively. We believe that Aotearoa New Zealand should follow suit in the interests of all its people.

5. PAI would welcome the opportunity to make an oral submission, or to discuss this matter further.

Prescription Access Initiative

Dated this 28th day of April 2023

Effects of the patient co-payment in the words of community pharmacists

A man ... didn't pick up meds because of the price. he didn't tell anyone (even his whānau). Then one day he had a massive stroke.

A young man unable to pay for his flucloxacillin prescription [...] ended up in hospital on iv antibiotics for a few days.

A patient [...] had been "eeking out" what they had of their anti-depressant / anti anxiety medicine because of script cost, and ended up coming in as they had worsening anxiety and were struggling.

I knew someone who frequently chose between groceries and her insulin. [...] She was losing her sight because of poor diabetes control.

It is heartbreaking to see patients trying to choose which medicine is most important.

We get kids sent in to collect prescriptions so often, because they know we can't say no to a kid.

People are in a ping pong type system between primary and secondary health ie they get sicker if they do not collect scripts then end up in prison, hospital, other care facilities [...]. Happens all the time

I feel helpless and sad because I know the medicine will make them better

I have heard a parent say to their child, "Its either medicine or food, we can't afford both"

We had a chap with diabetes have 2 separate toe amputations!!

We had one particularly volatile patient (now in prison) and if his wife didn't get his medication he would yell at her in the pharmacy (and we suspect worse at home). We haven't charged the family for anything since witnessing this.

One of our patients had a gout flare up because he couldn't afford to collect his allopurinol, he then had to take time off work, something he really couldn't afford. The whole situation, the pain, the added financial stress, and the knock on effect on his employer and workplace could have been easily prevented.

So many times when they collect their scripts and their card is declined they get whakamā and say they will be back after they've been to the bank... but they never return.

Some are embarrassed, some cry, some only pickup a few of the 'more important ' ones. We have several clients who are taking 15 to 20 meds so it is a big cost for their first yearly script.

...And effects of the cyclone-related co-payment waiver

Patients were happier and were more engaging [during the waiver], asking more questions about their conditions and medications, eager to get better.

Our shelves aren't full of uncollected prescriptions as patients can take what they need.

It's been amazing to see the difference - it has had a much more significant impact during this time than what I ever thought it would.

Quotes from forthcoming ICPG/ PAI survey report: *"It is devastating": 'Patient co-payment' prescription fees and their effect on communities, as witnessed by community pharmacists*

[i] Page 1, Letter of Professor Nikki Turner (Health Spokesperson CPAG) and Debbie Leyland (Chair, UCAN) dated 16 January 2023 to the Chair and Members of Petitions Committee, New Zealand Parliament.

[ii] Atlas of Healthcare Variation domain on health service access (Health Quality & Safety Commission); Carswell, S., Donovan, E., Pimm, F., Equitable access to medicines via primary healthcare – a review of the literature, September 2018; Norris P, Tordoff J, McIntosh B, Laxman K, Chang SY, Te Karu L. Impact of prescription charges on people living in poverty: A qualitative study. Res Social Adm Pharm. 2016 Nov-Dec;12(6):893-902.

[iii] Achieving medicine access equity in Aotearoa New Zealand: towards a theory of change; https://pharmac.govt.nz/about/access-equity/access-equity-what-does-it-mean-for-pharmac/

[iv] Norris, P., Cousins, K., Horsburgh, S. et al. Impact of removing prescription co-payments on the use of costly health services: a pragmatic randomised controlled trial. BMC Health Serv Res 23, 31 (2023).

[v] PHARMAC – Achieving Medicine Access Equity in Aotearoa New Zealand, Towards a Theory of Change.

[vi] Ministry of Health. Annual Update of Key Results 2019/20: New Zealand Health Survey. Wellington: Ministry of Health; 2020.

[vii] Jatrana S., Richardson K,, Norris P., et al Is cost-related non-collection of prescriptions associated with a reduction in health? Findings from a large-scale longitudinal study of New Zealand adults. BMJ Open 2015;5:e007781.

[viii] The World Health Organization's adherence project adopted the following definition of adherence to long term therapy "the extent to which a person's behaviour – taking medication...corresponds with agreed recommendations from a healthcare provider" E.Sabate, World Health Oganization (Eds.), Adherence to :Long-Term Therapies: Evidence for Action, World Health Organization, Geneva (003), p.198.

[ix] Gibson TB, Mark TL, Axelsen K, Baser O, Rublee DA, McGuigan KA. Impact of statin copayments on adherence and medical care utilization and expenditures. Am J Manag Care. 2006 Dec;12 Spec no.:SP11-9. PMID: 17173486.

[x] Cong M., Chaisson J., Cantrell D., Mohundro B. L., Carby M., Ford M., Liu M., Kemp L. S., Ouyang J., Zhang Y., Williams H. C., Vicidomina B. V., Nigam S. C. Association of co-pay elimination with medication adherence and total cost. Am J Manag Care. 2021 Jun;27(6):249-254; Jimenez M., Alvarez G., Wertheimer A., Lai L., Koh L., Martinez D., Hijazi B., Weinstein M. The Effect of Zero Copayments on Medication Adherence in a Community Pharmacy Setting. Innov Pharm. 2019 Aug 31;10(2):10.24926/iip.v10i2.1633..

[xi] Tsuyuki R.T., Beahm N.P., Okada H., Al Hamarneh Y. N. Pharmacists as accessible primary health care providers: Review of the evidence. *Canadian Pharmacists Journal / Revue des Pharmaciens du Canada*. 2018;151(1):4-5.

[xii] Stephen Carter, Ricki Ng, Sarira El-Den, Carl Schneider, Low Perceived service quality in community pharmacy is associated with poor medication adherence, Patient Education and Counseling Volume 104, Issue 2, 2021.

[xiii] Chemist Warehouse Submission to the Inquiry into the establishment of a pharmacy council and pharmacy ownership in Queensland – July 2018.

[xiv] "The Prescription Subsidy Scheme sets a limit on the number of prescriptions that a family needs to pay for each year. A family can have a PSC once they've paid for 20 funded prescriptions a year. The year runs from 1 February to 31 January." https://pharmac.govt.nz/medicine-funding-and-supply/what-you-need-to-know-about-medicines/collecying-and-paying-for-medicines.

[xv] Impact of Multiple Pharmacy Use on Medication Adherence and Drug Interactions in Older Adults with Medicare Part D.

[xvi] Official Information Act request Ref H202205430

[xvii] Brodkin, E. Z., Majmundar, M., Administrative Exclusion: Organizations and the Hidden Costs of Welfare Claiming, Journal of Public Administration Research and Theory, Volume 20, Issue 4, October 2010, Pages 827-848.