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Primary Care Reimbursement Service

Labour Market & Enterprise Policy Division

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** This paper has been prepared by the Labour Market and Enterprise Policy Division of the Department of Public Expenditure & Reform. The views presented in this paper are those of the author alone and do not represent the official views of the Department of Public Expenditure and Reform or the Minister for Public Expenditure and Reform. The paper was prepared in the context of an on-going budget negotiation process and reflects the data available to the author at a given point in time.*

Abstract

Over the past six years, PCRS expenditure has fluctuated greatly. This is due to a number of moving parts; increased volume coupled with falling unit costs following the implementation of a series of budget measures including both reductions in professional fees and pharmaceutical prices.

Summary of key findings

1. **The rollout of free GP services to under 6s and over 70s will result in an increase of approx. 300,000 GP visit cards and an associated increase in expenditure of €64m.**
2. **Demographic changes represents a small expenditure pressure in the medium term.**
3. **Improving cyclical conditions will continue to play a role in reducing the number of medical cards.**
    - Medical card numbers appear to be on a downward trajectory due to an improving economic climate and reductions in the numbers unemployed. This is coupled with an upward trend in GP visit cards due to the rollout out to under 6s and over 70s.
    - With an average cost of €973 in 2013, medical cards are four times more expensive than GP visit cards. Therefore, the net demographic cost of providing GMS services to a growing and ageing population should be sustainable over the next few years in an improving economic climate.

However, there are a number of pressure points in this area of expenditure:

- Firstly, the hi-tech drugs bill is growing at an average annual rate of 12%. Given that drug schemes encompasses a large portion of the overall bill, further unit price reductions could generate substantial additional savings. Work is underway to prepare a strategy to deliver sustainability in this area over the next few years. However, the pipeline of innovative, more expensive drugs will continue to be a cost pressure into the future.
- Secondly, the LTI scheme is facing a further €20-€30m increase in 2015. This is predominantly driven by increased volume and should stabilise over the next few years. However, further analysis of the cohort of claimants is required to better understand the current upward trend.

Introduction

The Primary Care Reimbursement Service (PCRS) comprised €2.4 billion or 18% of HSE expenditure in 2014. PCRS supports the delivery of primary healthcare by providing reimbursement services to primary care contractors for the provision of health services to members of the public.

In terms of the delivery of primary care services, the PCRS accounts for the bulk of expenditure in this area. However, PCRS expenditure is primarily focused on drugs/pharmacy payments and GP fees. In contrast, €577m was spent on the Primary Care Group in 2014 covering expenditure on primary care professionals directly employed by the HSE, like public health nurses and occupational therapists. The current policy is focused on the rollout of primary care teams.

The objectives of this paper are to:

- Examine trends and key cost drivers on the four main PCRS schemes
- Carry out an in-depth analysis of medical card expenditure
- Discuss significant budget measures implemented
- Draw conclusions for the future trajectory of PCRS expenditure taking into account demographic and cyclical changes and policy developments

Section 1: Expenditure Trends

Over the period 2008 to 2014, PCRS expenditure fell by €294m or 11%. However, this masks considerable variation, with annual increases in 2009 and 2012 combined with signficiant reductions in other years. Given the demand-led nature of the schemes under the PCRS umbrella, this level of cost containment has played a signficiant role in improving the sustainability of this area of expenditure.

Table 1: PCRS Expenditure trend including Local Health Offices, 2008-2014

	2008	2009	2010*	2011	2012	2013	2014
PCRS (€m)	2,798	2,875	2,703	2,517	2,703	2,604	2,504
Annual change (€m)		77	-172	-186	186	-99	-100
Year on year change (%)		3%	-6%	-7%	7%	-4%	-4%

Source: HSE Data Management Reports 2008-2014
* Transfer of the Domiciliary Care Scheme, approx. €100m, to the Department of Social Protection from 2010 onwards.

PCRS expenditure has undergone significant change over the past number of years; coverage has expanded considerably while unit costs for both pharmaceuticals and professional fees have been reduced. Unit cost reductions were achieved through:

1. Reductions in GP and pharmacist fees
2. Pricing agreements with pharmaceutical industry for both on and off patent products
3. Introduction of structural changes to the pharmaceutical market in the form of reference pricing and increased generic substitution

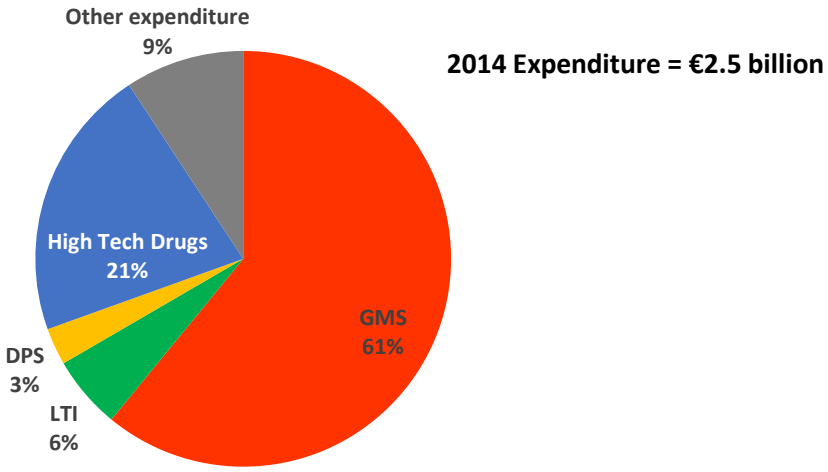
The four main pharmaceutical schemes under the PCRS umbrella (see Figure 1) are analysed in more detail below:

- General Medical Services (GMS) Scheme
- Long-Term Illness (LTI) Scheme
- Drug Payment Scheme (DPS)
- Hi-Tech Drugs Scheme

Pharmaceutical and pharmacy costs dominate PCRS expenditure under various different schemes, comprising approximately 75% of expenditure[1].

[1] Pharmaceutical ingredient costs compose approx. 43% of total PCRS expenditure.

Figure 1: Main PCRS schemes

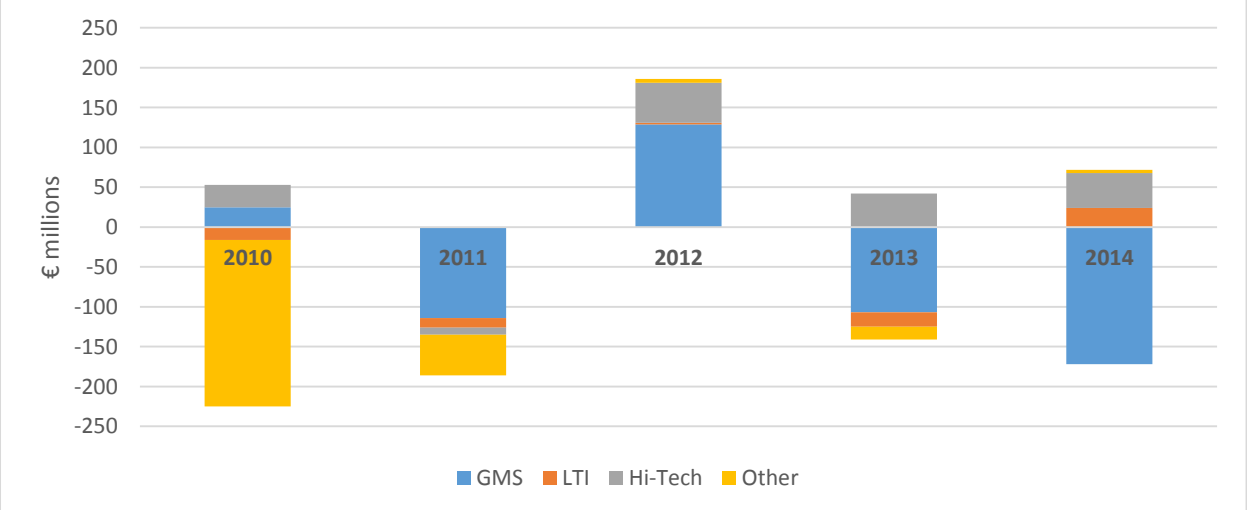


Source: HSE Data Management Report December 2014

Other items of expenditure covered by PCRS include Dental Treatment Services Scheme, Primary Childhood Immunisation Scheme, Methadone Treatment Service, payments to European Economic Area for Irish citizens, Community Ophthalmic Scheme and immunisation for certain GMS eligible persons.

Figure 2 illustrates the component parts of the annual changes in PCRS expenditure[2]. For example, the €100m reduction in PCRS expenditure in 2014 was driven by a €172m decrease in GMS expenditure but increases on both Hi-tech and LTI.

Figure 2: Changes in key PCRS expenditure components



[2] The significant reduction in "Other" expenditure in 2010 is driven primarily by the movement of the Domiciliary Care Scheme to Department of Social Protection.

General Medical Services (GMS) Scheme

GMS scheme provides medical and GP visit cards on the basis of a means test. Medical cardholders receive free access to GP services and pharmaceuticals. GP visit cardholders receive free access to GP services only. As this scheme provides a healthcare safety net, it has undergone significant changes over the past few years.

There was a total of 1.93 million GMS cards in circulation at the end of 2014, 92% of which refer to medical cards and the remainder GP visit cards. Approx. 42% of the population are currently covered by a medical or GP visit card.

Trends

The three main categories of medical card expenditure are GP fees and allowances, pharmacy fees and the ingredient cost of drugs and medicines. Over the period 2008-2014, expenditure fell by €204m or 13%. The most significant reductions achieved were in relation to pharmacy drugs and medicines.

Table 2: GMS Expenditure, 2008-2014

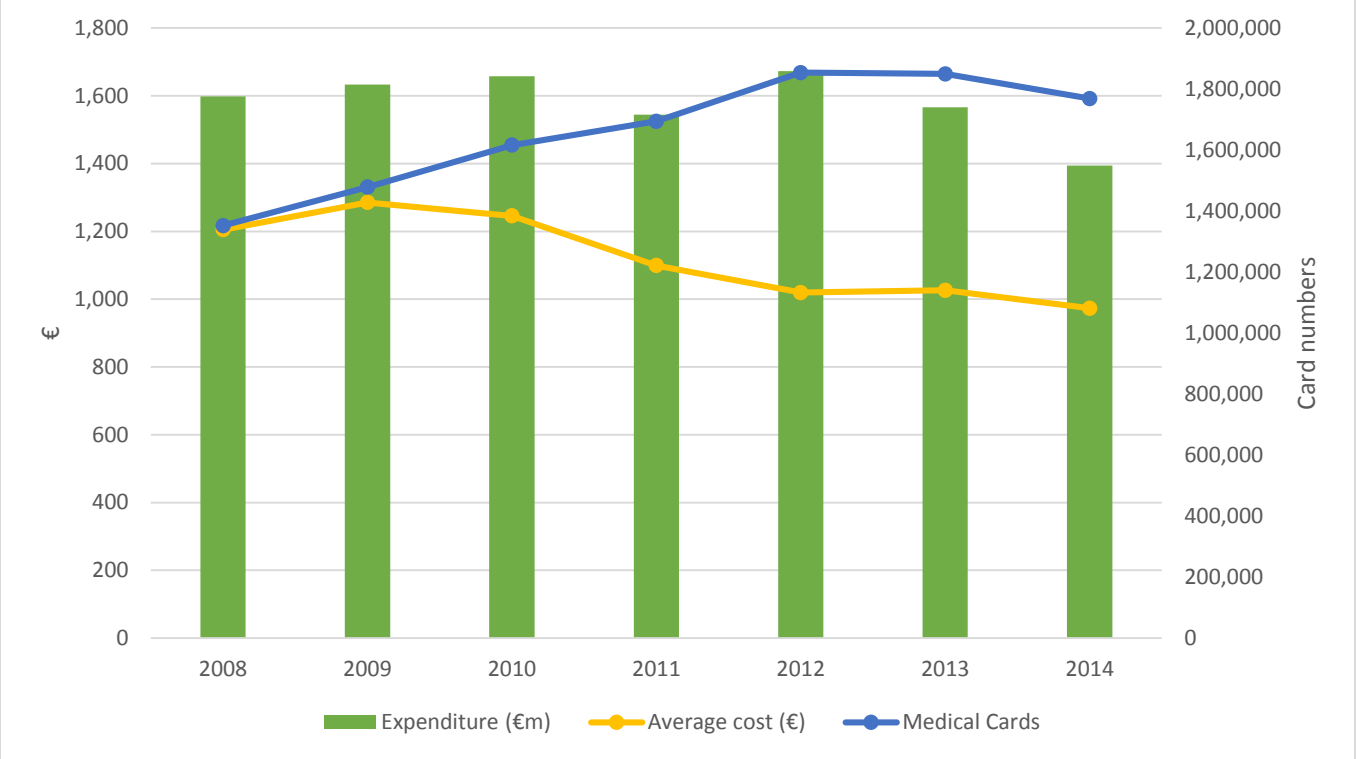
€millions	2008	2009	2010	2011	2012	2013	2014	Change	
GP Fees and Allowances	n/a	454	453	426	444	448	423		
GMS Pharmacy Fees	n/a	194	256	255	279	244	200		
GMS Pharmacy Medicines	n/a	985	949	863	950	874	771		
Total	1,598	1,633	1,658	1,544	1,673	1,566	1,394	-204	-13%

Source: HSE Data Management reports 2009-2014 (2008 data breakdown not available)

There are a number of moving parts in relation to expenditure on this scheme including changes in the number of GMS cards in circulation, changes in the profile of cardholders and reductions in the average cost of card. Specific elements of volume and cost are discussed in more detail below.

Figure 3 illustrates the annual changes in expenditure and the underlying change in volume and the cost of a medical card. It clearly demonstrates the role played by unit cost reductions in mediating the growth in volume.

Figure 3: Medical card trends, 2008-2014



Volume

Medical and GP visit card numbers increased sharply between 2008 and 2012 reflecting the onset of the economic downturn. The cyclical nature of card numbers is due to the automatic eligibility entitlement for those persons whose sole income is derived from social welfare and the reduction in incomes over the recessionary period.

Over the period 2008-2014, the number of medical cards increased by 416,580 or 31%. Medical card number peaked in mid-2013 and have been on a downward trajectory ever since. This is despite the reinstatement of over 15,000 discretionary cards (see Information Box on page 10 for more detail). This trend is also reflected in the growth in the number of GMS prescriptions forms and items.

Metrics	2008	2009	2010	2011	2012	2013	2014	Change	
Medical cards	1,352,120	1,478,560	1,615,809	1,694,063	1,853,877	1,849,380	1,768,700	416,580	
GP visit cards	85,546	98,325	117,423	125,657	131,102	125,426	159,576		
No. of forms (millions)	15.6	16.3	17.5	18.7	19.9	20.1	n/a	4.5	28.6%
No. of items (millions)	48.2	50.7	54.3	57.9	61.9	62.1	n/a	13.9	28.9%

Unit Cost

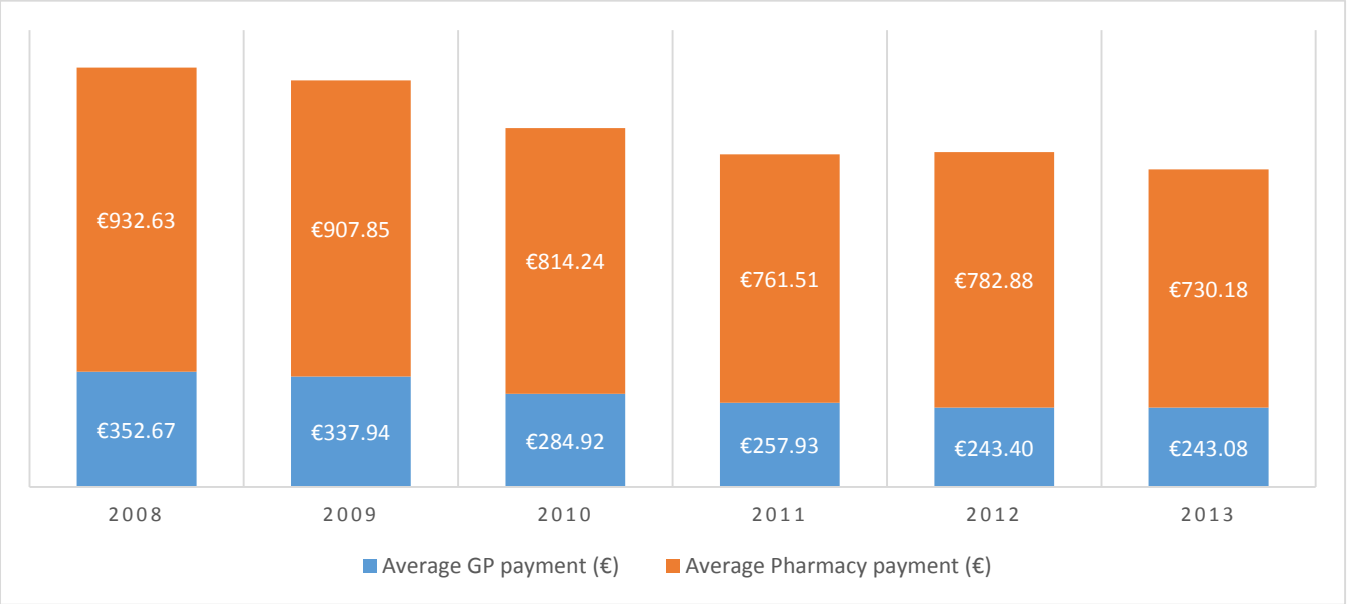
Medical cards cover both GP fees and pharmaceutical costs. Approximately three-quarters of medical card costs relate to pharmacy payments. Therefore the cost differential between medical and GP visit cards is considerable, €730.18 in 2013.

- **GP visit cards are a quarter of the cost of a medical card.**

For the medical card population, the average cost per eligible person fell by €312 or 24% over the period 2008 to 2013. This can be broken down into:

- €202.45 or 22% reduction in the average pharmacy payment, and
- €109.59 or 31% reduction in the average GP payment

Figure 4: Change in weighted average payment per eligible person on GMS scheme, 2008-2013



Source: PCRS Statistical Claims Analysis 2008 – 2013, comparable data for 2014 not available

The reductions achieved are due to:

- Reduced drugs and medicine costs achieved through the introduction of reference pricing for off-patent drugs and the industry pricing agreements for both on and off patent drugs.
- Multiple reductions imposed on pharmacy and GP fees
- Changes to the demographic profile of medical cardholders. This relates to a greater portion of working-age individuals with associated lower average cost.

It is very difficult to isolate the effects of each of these three factors in driving down costs. However, Table 3 illustrates the age distribution of the medical population in 2008 and 2013. The most significant change in the distribution is the increase in the proportion of 16-44 year olds and the reduction in over 70s. The impact of these changes can be estimated by holding the age distribution constant at 2008 levels. This analysis would suggest the greater percentage of working age people has reduced the average cost of a medical card by approximately €100 or 10%.

Table 3: Percentage of medical card cohort in each age category, 2008 and 2013

	2008	2013
Under 5 Years	7%	7%
5-11 Years	10%	11%
12-15 Years	5%	6%
16-24 Years	8%	10%
25-34 Years	10%	12%
35-44 Years	10%	12%
45-54 Years	9%	10%
55-64 Years	10%	9%
65-69 Years	5%	5%
70-74 Years	9%	6%
75 Years and Over	17%	13%

Policy changes

- Overall, the central budget measures implemented have been successful in reducing the average cost of a medical card. This cost reduction has enabled the increase in coverage to be funded from a smaller share of resources than would otherwise have been possible.
- For the GMS scheme, the average ingredient cost per item has fallen considerably, from €18.28 in 2009 to €13.73 in 2013. This underlines the importance of recent price agreement renegotiations with the pharmaceutical industry and the introduction of reference pricing. However, there is a further way to go in terms of realising expenditure per capita levels which are line with some other jurisdictions.

Future outlook

- With improving cyclical conditions, the number of medical cards is falling. There was a net reduction of 80,000 cards in 2014. This trend is continuing in 2015.

- The average cost of a card will likely change into the future, with competing factors at play.
    - 42% of the 80,000 reduction in medical cards in 2014 were persons aged 25-44 years. This may cause the average cost to increase as more working-age people return to work.
    - The cost per item is expected to fall in 2015 which could serve to reduce the average cost of the pharmacy component.
- Due to the decision to rollout free GP access to the over 70s and under 6s cohorts, the number of GP visit cards is on an upward trajectory. However given that GP visit cards are a quarter of the cost of medical card, the cost of this measure is likely to be more than compensated by the savings accruing from a reduction in medical cards.

Information Box - Discretionary Cards

- In some cases, where an individual or family exceeds the income thresholds, a medical or GP visit card may be granted if "undue hardship" is found to exist. The HSE takes various additional circumstances into account that would result in a person's specific illness or conditions placing undue financial pressure on them and their family with regard to the servicing of their medical costs.
- Discretionary medical card comprised **4.2%** of medical card population at the end of 2014
- The number of cards fell in 2012 and 2013 but is now back at 2011 levels.
- Discretionary medical cards comprise 21% of the total GP visit card population. 2013 and 2014 saw increases of 63% and 31% respectively.
- The average cost of a discretionary card is in excess of a regular medical card at **€1,130**.

	2009	2010	2011	2012	2013	2014
Discretionary medical cards	79,625	80,524	74,281	63,126	50,294	74,674
% of total medical cards	5.39%	4.98%	4.38%	3.41%	2.72%	4.22%
Discretionary GP visit cards	17,221	17,501	16,251	15,833	25,793	33,672
% of total GP visit cards	17.51%	14.90%	12.93%	12.08%	20.56%	21.10%

Long-Term Illness (LTI) Scheme

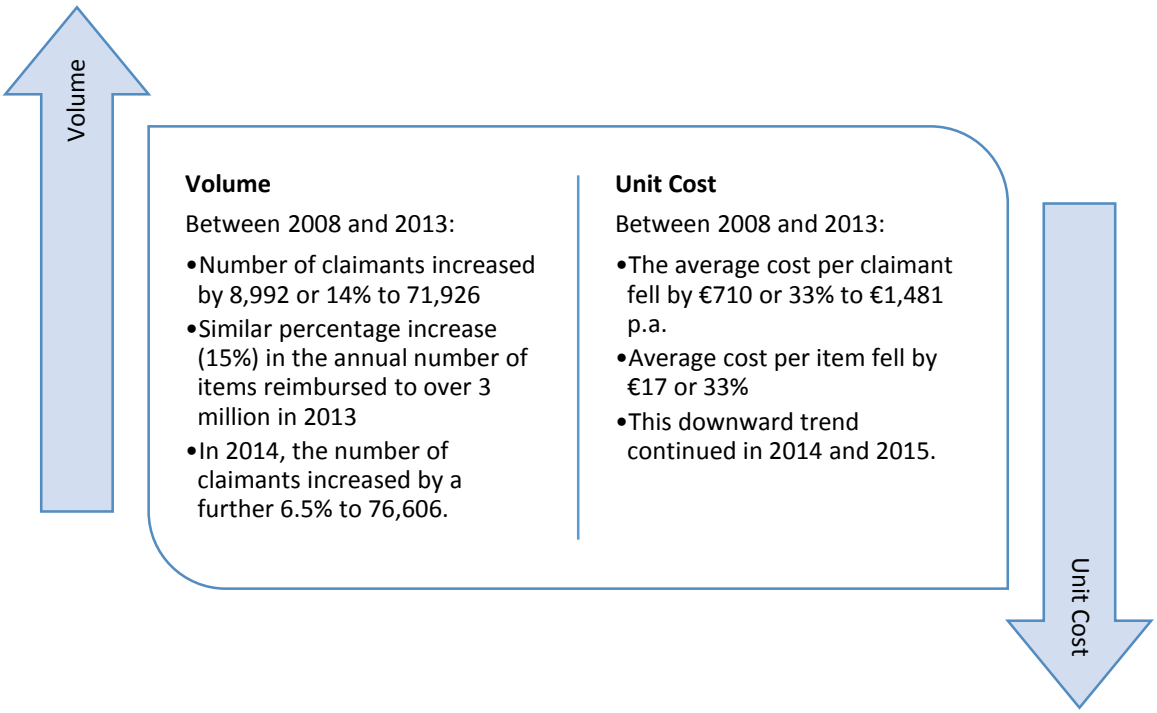
The Long-Term Illness (LTI) Scheme provides people suffering from certain conditions with free drugs, medicines and medical and surgical appliances for the treatment of that condition. The scheme covers 16 illness. Diabetes is the most common disease for which treatment is provided, accounting for 70% of claims.

Trends

Expenditure on the Long-Term Illness (LTI) scheme fell by €44m from a peak in 2009 to a trough of €106m in 2013. Expenditure subsequently increased by €24m in 2014. Unit cost reductions for drugs and medicines have driven this decrease in expenditure. The 2014 increase is solely attributable to an increase in the number of claimants.

€millions	2008	2009	2010	2011	2012	2013	2014	Change	
Allocation	125	135	140	125	123	116	95	-30	-24%
Outturn	137	150	134	122	124	106	130	-7	-5%
Variance	12	15	-6	-3	1	-10	+35		

Source: HSE Data Management Reports 2008-2014



Policy changes

- The main policy development in this space has been the reduction in unit costs achieved. This has been driven by the various pharmaceutical pricing agreements put in place and the introduction of reference pricing.
- There has been no change to the criteria for receipt of an LTI card. However since a 2014 decision by the Ombudsman, ADHD constitutes a mental illness which, in the case of persons under 16 years, gives entitlement to a LTI card[3].

Future outlook

Expenditure in 2014 increased by €24m or 23%. This upward trend is expected to continue in 2015. This increase in expenditure is being solely driven by growth in volume; both the number of claimants and the number of items per claimant. Further investigation of the factors underpinning this growth in volume is required. This will be the subject of a separate paper.

[3]http://www.ombudsman.gov.ie/en/Publications/Investigation-Reports/Health-Service-Executive/Inequities-in-the-administration-of-the-Long-Term-Illness-Card-Scheme/Executive-Summary.html

Drugs Payment Scheme (DPS)

The Drugs Payment Scheme (DPS) provides payment for prescribed drugs, medicines and certain appliances over a maximum of €144 per month for an individual or family.

Trends

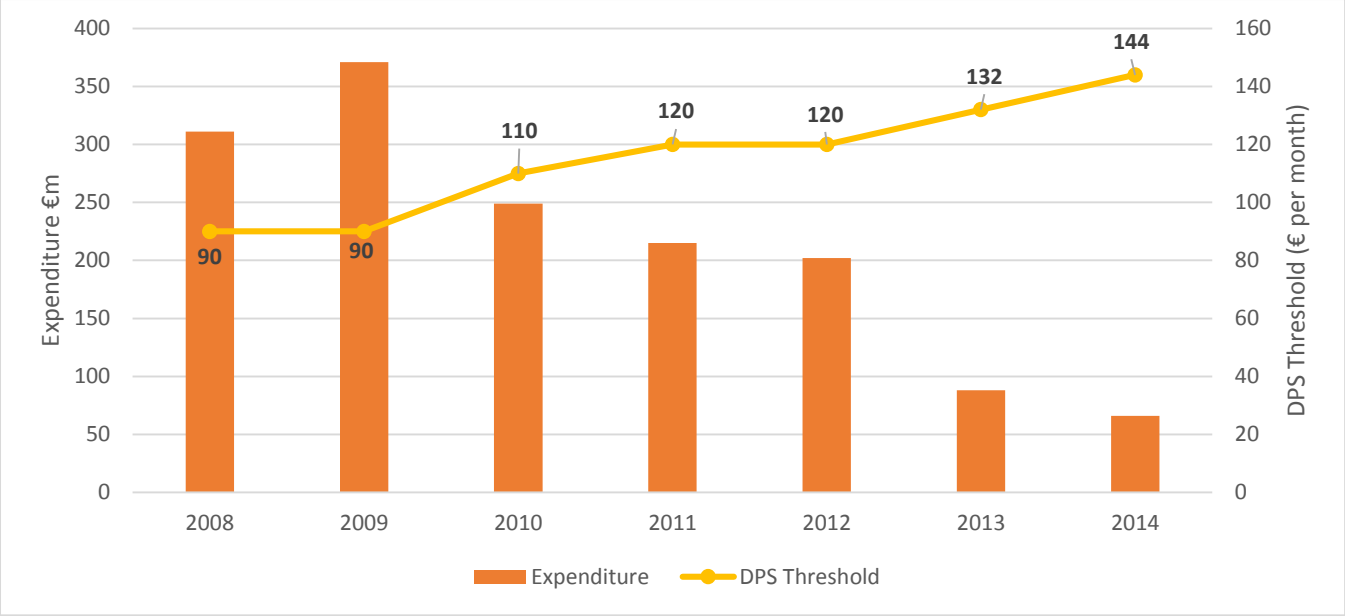
Expenditure on the DPS scheme fell by €245m or 79% over the period 2008-2014. The savings achieved have surpassed the allocation targets.

€millions	2008	2009	2010	2011	2012	2013	2014	Change	
Allocation	308	329	321	284	163	108	70	-238	-77%
Outturn	311	371	249	215	202	88	66	-245	-79%
Variance	3	42	-72	-69	39	-20	-4		

Source: HSE Data Management Reports 2008-2014

Policy changes

- Over a series of budgets, the qualifying monthly threshold for this scheme increased from €90 in 2009 to €144 in 2013.
- In 2013, the threshold was increased from €132 to €144. This marked a tipping point with expenditure subsequently falling rapidly.



Future outlook

- This scheme is likely to remain at 2014 levels given the current threshold.

Hi-Tech Drugs (HTD) Scheme

HTD Scheme provides for the supply and dispensing of high-tech medicines through community pharmacies for which pharmacists are paid a patient care fee of 8%. The rationale for the scheme was the supply of certain drugs in a community setting, which had previously only been available in hospitals.

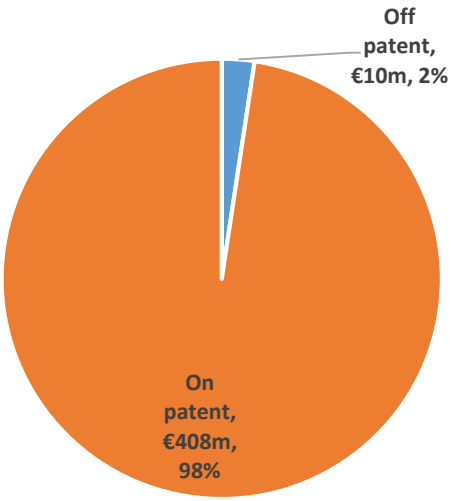
Trends

Over the past six years, expenditure increased by €155m or 47%. The average annual growth rate has been in the order of 12%. In 2013 and 2014, expenditure increased by €42m and €44m respectively.

	2009	2010	2011	2012	2013	2014	Change	
Allocation	300	327	241	292	344	438	138	46%
Outturn	331	359	350	400	442	486	155	47%
Variance	31	32	109	108	98	48		

Source: HSE Data Management Reports 2008-2014

- Expenditure on the Hi-Tech Scheme in 2014 totalled €486m. €418m of this refers to ingredient costs and the remainder to patient care fees.
- The ingredient cost component is a product of drug prices plus a wholesale mark-up of 8%
- The scheme is dominated by on-patent drugs.
- The top 20 drug molecules account for 71% of total expenditure, with the top 10 drugs accounting for 58%. This reflects a high degree of concentration.



Policy changes

- Hi-Tech drugs tend to be new-to-the-market products.
- As part of the most recent industry drugs supply agreement, an annual allocation has been made available for new drugs. However, it would appear that this allocation has been surpassed in some years. This trajectory would appear to be unsustainable and is causing the base of drugs expenditure to increase on annual basis.

Future outlook

- In a no-policy change scenario, there is no sign of cost pressure abating on this scheme given the prospective pipeline of new innovative drugs.
- Going forward, the introduction of new drugs must be clearly linked with defined budgetary parameters. Furthermore, greater analysis of the pipeline of new drugs is also required. This issue will be the subject of a separate analysis.

Future outlook

A number of issues will impact PCRS expenditure in the short to medium term, including:

1. Primary care policy developments
2. Demographic trends
3. Cyclical conditions

Primary Care Policy Developments

The rollout of free GP services to under 6s and over 70s with result in an increase of approx. 300,000 GP visit cards and an associated increase in expenditure of €64m.

As part of Budget 2015, GP visit cards were to be rolled out to all under 6s and over 70s. Department of Health have agreed a package of terms with the HSE and the IMO regarding the contract to be offered to GPs to enable the rollout of free GP services to the under 6s. Approximately 436,000, or 276,000 additional children, will be covered. The total cost of the scheme will be approximately €94m, an annual addition cost of €44m. The main cost driver is a €56 or 81% increase in the capitation fee for this age cohort. The new contract will provide some enhanced services such as Wellness Checks, including checking the height, weight and body mass index (BMI) of children and an Asthma Cycle of Care to carry out reviews of children suffering with asthma.

The annual cost of the rollout of GP visit cards to entire over 70s cohort is estimated at an additional €20m per annum.

Demographic trends

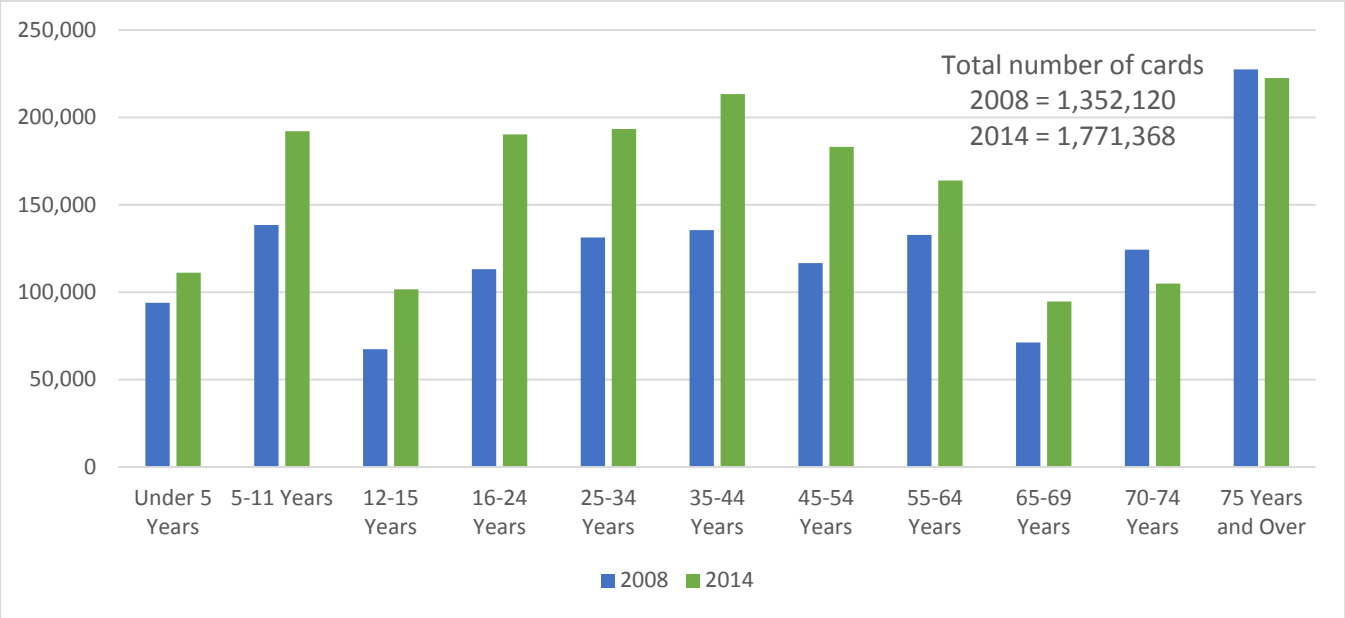
Demographic changes represents a small expenditure pressure in the medium term.

The change in the age profile of medical cardholders is set out in Figure 5. As previously mentioned, the age profile of cardholders has undergone considerable change in the past few years. The main features are:

- The absolute number of elderly cardholders (70+) fell by over 24,000 or 7%. This is despite a 56,000 or 17% increase in this age cohort of the population. There are a number of factors driving this trend. Firstly, the income limit for eligibility for the over 70s cohort was reduced to €500 per week for a single person and €900 per week for a couple effective from January 2014. 81% of the over 70s population is covered by medical card eligibility with a further 29,450 or 8% in receipt of a GP visit card. Secondly, the wealth of this age cohort is increasing. People aged 66-75, are on average 10% wealthier than those aged over 75 (OECD Pensions at a Glance 2013).

- Significant increases in the number of working-age card recipients due to the deterioration in the economic climate. The 16-54 age cohort increased by over 280,000 or 57%.

Figure 5: Age profile of medical cardholders, 2008-2014



Source: PCRS Statistical Claims Analysis 2008, PCRS model 2014

Over the period 2015-2020, the cost of ageing in relation to the GMS scheme is estimated to be small[4].

The extension of GP visit cards to the over 70s and under 6s cohort will impact significantly upon the age profile of GP visit cards in 2015.

- In the medium term, the cohort of under 6s is projected to decrease by 11% (see Table 6 in Appendix).
- The additional annual cost of over 70s GP visit cards is in the order of €20m per annum over the period 2015-2021.This is based on CSO projections and an average card cost of €278.

Cyclical conditions

Improving cyclical conditions will continue to play a role in reducing the number of medical cards.

The large increase in the working age cohort in receipt of medical cards was primarily driven by poor economic conditions and increases in the number of unemployed. This trend is reversing as the economy continues to recover.

[4] The effect of ageing on the LTI scheme is unclear as there is little data regarding the profile of claimants.

Table 4 illustrates the changes which have occurred within the various age cohorts of the medical card population with prime working-age categories undergoing the most significant increases in nominal terms. Further detail on this trend is contained in the appendix.

Table 4: Changes in age structure of medical cardholders, 2008-2014

	2008	2014	Change (2008-2014)	
Under 5 Years	93,851	111,150	17,299	18%
5-11 Years	138,497	192,159	53,662	39%
12-15 Years	67,318	101,568	34,250	51%
16-24 Years	113,122	190,284	77,162	68%
25-34 Years	131,254	193,490	62,236	47%
35-44 Years	135,450	213,431	77,981	58%
45-54 Years	116,711	183,203	66,492	57%
55-64 Years	132,816	163,922	31,106	23%
65-69 Years	71,248	94,752	23,504	33%
70-74 Years	124,283	104,878	-19,405	-16%
75 Years and Over	227,570	222,531	-5,039	-2%
Total	**1,352,120**	**1,771,368**	**419,248**	**31%**

The Live Register (on a seasonally-adjusted basis) peaked in mid-2012 and has steadily fallen since. In addition, employment growth is expected to average 2% over the next four years. Medical card numbers began to decline in mid-2013 and this trend has continued into 2014. At the end of 2014, medical cards numbers were 80,000 less than 2013. It is expected that over the next two to three years this trend will continue. This will be partly driven by long-term unemployed people returning to work as they retain their medical card for a period of 3 years following their re-entry into employment.

Table 5: Employment growth and unemployment rate forecasts, 2015-2018

	Forecast			
	2015	2016	2017	2018
Employment growth (%)	2.2	2.2	1.9	1.9
Unemployment rate	9.6	8.8	8.4	7.8

Source: Stability Programme Update April 2015

Appendix

Table 6: Population projections (CSO M2 F2 scenario)

Age Category	2015	2016	2017	2018	2019	2020		Change	
Under 5 Years	367,604	364,009	356,550	346,235	336,138	326,347		-41,257	-11%
5-11 Years	478,629	489,383	500,035	508,563	513,919	516,609		37,980	8%
12-15 Years	190,558	193,210	196,657	202,109	207,908	213,485		22,927	12%
16-24 Years	531,765	532,734	540,652	554,571	572,361	589,613		57,848	11%
25-34 Years	651,133	624,284	599,232	576,647	557,522	544,687		-106,446	-16%
35-44 Years	721,802	729,217	733,099	733,473	729,590	721,702		-100	0%
45-54 Years	615,862	626,322	637,603	648,962	658,595	667,671		51,809	8%
55-64 Years	491,976	503,142	513,419	523,237	535,010	546,803		54,827	11%
65-69 Years	201,954	205,683	209,003	213,220	216,520	221,213		19,259	10%
70-74 Years	148,867	157,749	166,689	174,555	181,588	187,671		38,804	26%
75 Years and Over	254,004	260,751	268,293	278,025	288,816	300,616		46,612	18%
All	4,654,154	4,686,484	4,721,232	4,759,597	4,797,967	4,836,417		182,263	4%
Annual increase	27,731	32,330	34,748	38,365	38,370	38,450			
	1%	1%	1%	1%	1%	1%			

Table 7: Annual changes in medical card numbers for three different age cohorts

	2008	2009	2010	2011	2012	2013
Total change in medical card cohort	75,942	126,440	137,249	78,254	159,814	37,503
Of which:						
Change in working-age cohort (16-64)	47,487	100,325	87,505	52,754	103,354	47,332
Change in under 16s	21,247	35,631	35,057	17,744	43,984	-4,121
Change in over 65s	7,208	-9,516	14,687	7,756	12,476	-5,708