Barriers remain after scrapping $5 prescription charge

Repeat prescriptions are costly for patients and a poor use of doctors' time

Kathy Spencer

The Government is to be congratulated for removing the $5 co-payment that New Zealanders have been paying at their chemist for each prescription item.

Announcing the change, Health Minister Ayesha Verrall said the $5 co-payment had prevented around 135,000 adults from collecting one or more prescription medicines in 2021/22.

Removing the charge is definitely a step in the right direction. However, many people face other prescription costs and these can be far larger than the $5 co-payment.

Every 3 months, a person taking a medicine long-term has to request a "repeat prescription" from their GP and collect a new supply of medicine from a pharmacy.

The cost of obtaining a repeat prescription varies across GP practices but is typically around $25 per script, or $100 a year.

Hundreds of thousands of New Zealanders take medicines long-term for conditions like high cholesterol or high blood pressure. Statins, for example, are taken by half a million people to reduce cholesterol and lower the risk of heart attack and stroke.

The medicines themselves are often very cheap. Pharmac pays only $6.75 for a year's supply of a 20mg dose of Atorvastatin – a common dose of the most widely-used statin.

Barriers to accessing cheap and effective preventive medicines like statins mean that some people stop taking them, increasing the risk of serious health consequences, including hospitalisations.

For the many older people on multiple medications, keeping their various pills on hand can also be a significant worry.

So, are repeat prescriptions for the management of long-term conditions really necessary and are they a good use of GP time?

Of course, repeat prescriptions have their place: mainly they provide an opportunity for the GP to check a medicine is still appropriate for the patient. Repeat prescriptions can also help prevent abuse of addictive drugs, and limit the waste that occurs if a patient doesn't finish a bottle of pills.

In the case of statins, people stay on them long-term with minimal active monitoring; they aren't addictive; and any savings in reduced waste are outweighed by extra dispensing fees paid to pharmacies by government.

It is never a good idea to have GPs spend time on pointless activities, but particularly so when many people are experiencing long waits for GP appointments and others can't find a GP practice that is enrolling new patients.

It is equally important to be sure that people aren't paying for services that have no clinical benefit.

While repeat prescriptions are clearly a significant source of revenue, there are much better ways to fund GPs than getting them to issue repeat prescriptions needlessly.

Fewer repeat prescriptions would free-up GP time, enabling them to see more patients and perhaps even increase enrolments.

Extra visits and enrolments mean more funding to the GP practice. However, if this didn't make up for the drop in repeat script fees, the difference should be made up through the government's funding formula for Primary Health Organisations.

Monthly dispensing

For some medicines, patients are required to visit the chemist every month to get a new 30-day supply, even though their doctor has prescribed it for 3 months. An example is Nortriptyline which is used to treat many types of persistent pain, including nerve pain.

Again, the medicine itself is cheap, costing Pharmac less than $10 a year for the 10mg dose commonly prescribed.

The main reason for monthly dispensing of drugs like Nortriptyline is a concern about overdose, either by the patient or perhaps by a family member. However this risk arises with even one month's supply and could be managed by having the GP assess whether a patient can safely have a 3-month supply of medicine on hand.

No-one seems to be taking sufficient account of the stress and inconvenience for patients with chronic pain who are required to visit their pharmacist each and every month, possibly for the rest of their life.

It's not difficult to connect the dots between these restrictions and the mountain of prescriptions awaiting collection that I have just observed at my local chemist, and the queues of people waiting to collect scripts seen in some retirement communities.

What needs to happen?

New Zealand regulations dictate that most medicines can only be prescribed for 3 months at a time, while oral contraceptives can be prescribed for 6 months.

In 2011 the government proposed doubling these limits to 6 months for most medicines, and 12 months for oral contraceptives. That change was deferred, but could now be dusted-off and implemented.

Meanwhile, the Director-General of Health could use an existing regulation to authorise a longer prescription period for classes of patients, such as those on medicines for ongoing, stable conditions.

For medication that is currently dispensed monthly, Pharmac should allow GPs to choose a longer dispensing period when they consider it safe.

It shouldn't be that hard to implement these changes, saving considerable time for our over-worked GPs and pharmacists, and a lot of money, time and stress for people taking medication long-term.

Kathy Spencer was a Deputy Director-General in the Ministry of Health, a General Manager in ACC, and a Manager in the Treasury.