Chapter 2

Key issues

2.1 The majority of submitters to the inquiry expressed support for ongoing efforts to maintain the sustainability and cost-effectiveness of the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). Submitters noted that these schemes are an integral part of the Australian health care system and stressed the importance of ensuring equitable, reliable and affordable access to pharmaceuticals for all Australians, with adequate safeguards for the most vulnerable in society.[1]

2.2 Consumers Health Forum of Australia (CHF) stated:

> The PBS is critical to supporting the medicine needs of Australians. With the growing prevalence of chronic conditions and rising out-of-pocket costs, CHF believes that the measures protecting the sustainability of the PBS are essential to consumers, but they do not over-ride fundamental principles of ensuring timely, reliable and affordable access to necessary medicines for all Australians.[2]

2.3 Key issues examined during the inquiry were:

- the sustainability of the PBS and the RPBS;
- the impact of co-payments on vulnerable Australians;
- the impact of co-payments on prescription adherence; and
- alternatives to co-payment increases.

Sustainability of the PBS and the RPBS

2.4 In introducing the Bill, the Minister for Health (Minister), the Hon Peter Dutton MP, noted increasing demand in the Australian health system for access to more services, medicines and more expensive technologies and the need for a whole-of-community approach if the PBS is to grow in a sustainable way. The Minister made particular note of the government's approval of new listings of medicines in 2014, including treatments for breast cancer, melanoma and multiple sclerosis at an expected cost to the PBS of $436 million:

> Funding for new listings is not factored into the forward estimates. It is new money that this government must find every four months to provide access to those medicines, something we have committed to do.

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1 See: Grattan Institute, *Submission 2*; Council of Social Services New South Wales (NCOSS), *Submission 3*; HSU National, *Submission 6*; Consumer Health Forum of Australia, *Submission 8*.

2 *Submission 8*, p. 4.

> But we cannot do that and contain spending without more help, a greater contribution from all Australians who benefit from the PBS.[3]

2.5 Some submitters questioned the necessity for the measures in the Bill. The Australian Medical Association (AMA) noted the findings of the Productivity Commission's *Report on Government Services 2014* that the PBS had the slowest growth across all areas of health expenditure in the ten years to 2011–12.[4]

2.6 The Department of Health (Department) told the committee that over the last 10 years the cost of the PBS had increased by 80 per cent and is expected to increase by between four and five percent annually over the longer term. At the same time, medicines being recommended for listings are becoming significantly more expensive.[5] The Department submitted:

> For example, over the past three meetings the PBAC [Pharmaceutical Benefits Advisory Committee] has recommended on average more than $450 million in new or amended listings per meeting, which equates to $1.4 billion over the forward estimates. That is roughly one-half of the Commonwealth's entire budget for mental health.

2.7 Furthermore:

> The proposed increases to PBS co-payments and safety nets need to be considered in the context of maintaining access for patients to medicines that would otherwise be prohibitively expensive for most Australians, including those with common chronic conditions such as diabetes and cardiovascular disease.[6]

Impact of co-payments on vulnerable Australians

2.8 The Department stated:

> From 1 January 2015, general patients will pay $5 more per subsidised PBS prescription. Concessional patients, including pensioners and veterans, will pay 80 cents more per PBS or RPBS prescription. The safety net threshold for general patients will increase by 10 per cent each year for four years, commencing in 2015. The threshold for concessional payments will increase by two prescriptions each year from the current 60 prescriptions to 62 in 2015 and up to 68 in 2018 and onwards. These increases will occur in addition to the annual Consumer Price Index indexation. General patients who use the average two PBS-subsidised prescriptions per year will pay $10 more in 2015, and very high users will pay $145.30 extra per single, couple or family per year to reach the general patient safety net.[7]

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3 *House of Representatives Hansard*, 18 June 2014.

4 *Submission 4*, p. 1.

5 *Committee Hansard*, 19 August 2014, p. 28.

6 *Submission 12*, p. 3.

7 Department of Health, *Submission 12*, p. 3.

2.9 The committee notes that while there is general acceptance that co-payments are a long standing feature of the PBS and RPBS,[8] a number of submitters expressed concern that an increase in the PBS co-payment may have a disproportionate impact on a number of groups in the community who are already vulnerable to the impact of rising out-of-pocket costs, such as people with chronic illnesses, people on low incomes, older Australians, young families and people living in rural and remote areas.[9]

2.10 Some submitters told the committee that cost was already a barrier for access to medicines. According to The Council of Social Service of New South Wales (NCOSS), 12.8 percent of people in the most disadvantaged socio-economic areas reported medicine costs barriers, as opposed to 6 percent in most advantaged areas.[10] NCOSS noted that for persons experiencing poverty, increased medicine costs can mean having to choose between filling prescriptions and access to other essential services.[11]

2.11 CHF submitted that a recent study by Commonwealth Fund indicates that Australian consumers already contribute more in out-of-pocket costs than their counterparts in most other developed western countries.[12] However, as provided to the committee's Inquiry into Out-of-pocket health costs, international comparisons are difficult to quantify. For example, in some analysis, out-of- pocket health costs for pharmaceuticals includes vitamins and supplements.[13] The CHF argued that the measures in the Bill could compound the vulnerability of some Australians, who suffer from long term chronic illness, are on low incomes or who live in rural or remote Australia.[14]

2.12 Departmental representatives told the committee that PBS safety nets are designed to provide assistance to those patients and their families who require a large number of PBS or RPBS items and apply to a family unit regardless of the composition of that family unit:

> When a patient or household reaches the safety net threshold within a calendar year, they qualify to receive PBS or RPBS items at the concessional rate for general patients or free of charge for the rest of the year for concessional patients. Certain members of the community, such as those holding pensioner concession cards are eligible to receive PBS

8 See for example: Pharmacy Guild of Australia, *Submission 1*, p. 1.

9 See for example: Youth Affairs Council of South Australia, *Submission 5*, p. 5; Consumers Health Forum of Australia, *Submission 8*, p. 2; Council of Social Service NSW, *Committee Hansard*, 19 August 2014, p. 2.

10 *Submission 3*, p. 3.

11 *Submission 3*, p. 3.

12 *Submission 8*, p. 1.

13 Ms Felicity McNeill, *Committee Hansard*, 19 August 2014, p. 28

14 *Submission 8*, p. 2.

> subsidised prescriptions at a reduced rate and for free after they reach the safety net threshold.[15]

2.13 The Department told the committee that the price of 70 percent of PBS prescriptions used by general patients will not change under these measures. The price of PBS medicines that are already priced below the general co-payment will not increase under the proposed measures, as no PBS subsidy is payable on these prescriptions.[16] Concessional patients and high users of PBS prescriptions will pay a maximum additional cost of $61.80 per year before receiving their remaining medicines for that year for free. The Department stated:

> In 2012-13 that represented over one in five prescriptions subsidised free of charge irrespective of whether the medicine cost $50 or $1,500.[17]

2.14 The Department advised that Aboriginal and Torres Strait Islander people will continue to be able to access support under the Remote Area Aboriginal Health Services Programme and the Closing the Gap arrangements.[18] Additionally, a bulk billing incentive is available in rural and regional areas to support out of pocket health costs for people in those communities.[19]

Impact of co-payments on prescription adherence

2.15 Some submitters questioned whether the increases in co-payments may result in unintended consequences due to the inability of some patients to fill their prescriptions due to rising costs. Submitters expressed concern that this may result in severe health consequences for vulnerable patients and increased health expenditure in the longer term as well as consequences for the pharmaceutical sector.

2.16 The Grattan Institute (Institute) submitted that there was evidence to suggest that co-payments stop patients from obtaining the medicines recommended by their doctors. The Institute presented data that indicated more than 15 percent of adults surveyed report that they did not take their medicine due to cost pressures.[20] The Institute did confirm that their evidence was based on a comparison of a small proportion of medicines listed under the PBS.[21] The Institute suggested that lowering co-payments would have a positive effect, due to the lower costs associated with fewer hospital visits over the long term, due to the successful management of chronic illnesses.[22]

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15 *Committee Hansard*, 19 August 2014, p. 29.

16 *Submission 12*, p. 4.

17 *Submission 12*, p. 4.

18 *Submission 12*, p. 4.

19 Department of Health, *Strengthening Medicare*, http://www.health.gov.au/internet/budget/publishing.nsf/content/budget2014-factsheet-strengthening-medicare, (accessed 21 August 2014).

20 *Submission 2*, p. 4.

21 *Committee Hansard*, 19 August 2014, p. 19.

22 *Submission 2*, p. 4.

2.17 However, the Department stated that the evidence provided by some submitters could not be relied upon due to complexity of issues influencing data outcomes:

> One of the reasons for this is that the surveys that were done at the time only looked at data relating to payments over the co-payment levels – so where people were paying a contribution to the medicine and government was making a payment as well. It has not allowed for the fact that a number of drugs went under the general co-payment, and we actually found that there was an increase in the use of these drugs.[23]

2.18 The AMA pointed to Australian and international research which it said demonstrates increases in co–payments leads to poorer adherence to prescriptions which would cost taxpayers and the government more in the long term.[24]

2.19 Medicines Australia submitted that, like any price increase, an increase in the rate of co-payment and safety net thresholds would result in a reduction in consumer utilisation of medicines. Medicines Australia said:

> Missing medicines and interrupting treatment may lead to adverse patient outcomes and potentially avoidable medical interventions, including hospital admissions. Reducing the appropriate use of medicines can result [in] significant additional expenditure in other parts of the healthcare system.[25]

2.20 The Pharmaceutical Society of Australia argued the Bill may result in an unnecessary burden being placed on community pharmacists. They submitted the co-payment increases, together with the proposed Medicare co-payment, would result in:

> ...a situation where [vulnerable patients] need to make a financial decision about seeking medical attention or continuing with their medications instead of focusing on their health. Pharmacists' primary role is as medicines experts and they should not be put into a position where they need to counsel patients about managing their medicine use based on financial pressures.[26]

2.21 In its submission the Department noted the limited hard evidence available to support claims that an increase in the co-payment will lead to poor adherence:

> Many submissions to this and the previous inquiry have claimed there is significant evidence that demonstrates patients are already not fulfilling scripts due to cost. The fact is there is very little hard evidence to support this claim.[27]

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23 *Committee Hansard*, 19 August 2014, p. 30.

24 *Submission 4*, p. 1.

25 *Submission 9*, p. [1].

26 *Submission 8*, p. 2.

27 *Committee Hansard*, 19 August 2014, p. 29.

Alternatives to co-payment increases

2.22 Some submitters questioned whether it was appropriate to ask consumers to make a higher contribution to the cost of the PBS and RPBS and advocated further structural reform of the PBS as an alternative. Submitters noted the positive impact of price disclosure and suggested expanding this policy.[28]

2.23 The Institute suggested that instead of increasing co-payments, an alternative way to reduce costs associated with maintaining the PBS would be to address apparent disparities in the prices the Australian Government pays for medicines, especially in contrast with New Zealand and parts of the United Kingdom.[29] The Institute argued that matching Australian medicine prices to the prices paid by governments overseas could save the government more than $1 billion a year, in contrast to the measures in the Bill that would only raise $450 million in 2017–18. Further, any additional cost or challenges caused by price changes for community pharmacies could be offset by allowing pharmacies to provide additional services to patients.[30]

2.24 COTA Australia (COTA) expressed support for achieving savings through implementation of a cheaper purchasing policy for medicines on the PBS. COTA told the committee that the government should also undertake a review of:

> ...the cost of prescribing, prescribing habits and more careful examination of the efficacy of drugs rather than taking the easy path of passing health system inefficiencies onto consumers.[31]

2.25 Departmental representatives told the committee that the system that underpins Australia's PBS is internationally recognised for delivering some of the most cost-effective prices for pharmaceuticals in the world:

> So, we really need to look at the system as a whole and the balance we are achieving. I think also we need to be careful of that fact that we are very much focusing on F2 when the Grattan Institute is talking about drugs—that is those that are subject to market competition—versus F1, where drugs are still on patent. Again, the OECD [The Organisation for Economic Co-operation and Development] and a number of other countries recognise that Australia's Pharmaceutical Benefits Advisory Committee and the process that leads to those drug recommendations lead to some of the most cost-effective prices in the world.[32]

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28 Australian Council of Social Service, *Committee Hansard*, 19 August 2014, p. 2.

29 *Submission 2*, p. 9.

30 *Submission 2*, p. 10.

31 COTA, *Submission 10*, p. 4.

32 *Committee Hansard*, 19 August 2014, p. 35. The *National Health Act 1953* provides that listed drugs be assigned to formularies identified as F1 or F2. Generally F1 is intended for single brand drugs and F2 for drugs that have multiple brands, or are in a therapeutic group with other drugs with multiple brands. Drugs on F2 are subject to the provisions of the Act relating to statutory price reductions, price disclosure and guarantee of supply.

2.26 The Department also noted that while numerous reforms to the PBS since 2007 had contributed significantly to reducing the price of medicines, reforms such as price disclosure have an impact on the pharmaceuticals sector. The Department told the committee:

> Care must be taken to ensure that the rising cost of the PBS is not disproportionately borne by any particular partner to the National Medicines Policy.[33]

2.27 The committee concurs with the Department's conclusion that the proposed increases in costs for consumers as a result of measures in this Bill are reasonable, necessary and proportionate given the increasing costs of listing medicines on the PBS and the factors driving PBS growth in the longer term.[34]

Recommendation 1

2.28 The committee recommends that the bill be passed.

Senator Zed Seselja

Chair

33 *Committee Hansard*, 19 August 2014, p. 28.

34 *Committee Hansard*, 19 August 2014, p. 29.