The Senate

Community Affairs Legislation Committee

National Health Amendment (Pharmaceutical Benefits) Bill 2014 [Provisions]

August 2014

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ISBN 978-1-76010-076-6

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MEMBERSHIP OF THE COMMITTEE

44th Parliament

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Participating members for this inquiry

Senator Richard Di Natale	Victoria, AG
Senator the Hon. Jan McLucas	Queensland, ALP
Senator Claire Moore	Queensland, ALP

TABLE OF CONTENTS

Membership of the Committee iii

List of Recommendations vii

Chapter 1

Referral 1

Purpose of the Bill 1

Conduct of the inquiry 1

Background 1

Key provisions of the Bill 2

Consideration by other committees 2

Acknowledgement 3

Note on references 3

Chapter 2

Key issues 5

Sustainability of the PBS and the RPBS 5

Impact of co-payments on vulnerable Australians 6

Impact of co-payments on prescription adherence 8

Alternatives to co-payment increases 10

Dissenting Report from the Australian Labor Party

The bill unnecessarily targets pensioners and low and middle income earners ... 13

The changes do nothing to contribute to the sustainability of the PBS 15

Greens' Senators Dissenting Report

Flawed rationale 19

Impact on patients 20

Appendix 1

Submissions and additional information received by the Committee 23

Appendix 2

Public hearings 25

LIST OF RECOMMENDATIONS

Recommendation 1

2.28 The committee recommends that the bill be passed.

Chapter 1

Referral

1.1 On 19 June 2014, the Senate referred the provisions of the National Health Amendment (Pharmaceutical Benefits) Bill 2014 (Bill) to the Community Affairs Legislation Committee (committee) for inquiry and report by 26 August 2014.[1] The reporting date was subsequently extended until 27 August 2014.

Purpose of the Bill

1.2 The Bill proposes to amend the *National Health Act 1953* (Cth) (Act) to increase patient co-payments and safety net thresholds for the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). These changes are in line with broader budget measures announced as part of the 2014–15 Budget.

1.3 The Minister for Health (Minister), the Hon Peter Dutton MP, stated that the measures are an example of the government protecting the best interests of Australians and making necessary decisions to improve Australia's budget position.[2]

1.4 The PBS and RPBS advance Australians' interests through access to subsidised medicines. Co-payments and safety net thresholds have been features of the schemes for many years.[3]

Conduct of the inquiry

1.5 Details of the inquiry, including a link to the Bill and associated documents were placed on the committee's website.[4] The committee also wrote to 41 organisations and individuals, inviting submissions by 23 July 2014. Submissions continued to be accepted after that date.

1.6 The committee received 12 submissions which are listed at Appendix 1. All submissions were published on the committee's website.

1.7 The committee held a public hearing on 19 August 2014 at Parliament House in Canberra. A list of witnesses who appeared at the hearing is at Appendix 2, and the *Hansard* transcript is available through the committee's website.

Background

1.8 The PBS and RPBS provide access for Australians to necessary medicines through the Australian Government's National Medicines Policy (NMP). The aim of

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1 *Journals of the Senate*, No. 33—19 June 2014, pp 914 – 915.

2 *House of Representatives Hansard*, 18 June 2014, p. 6.

3 National Health Amendment (Pharmaceutical Benefits) Bill 2014, *Explanatory Memorandum*, p. 2.

4 See: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs

the NMP is to optimise health outcomes through the provision of medicines and services supported by government subsidies.[5]

1.9 The PBS was established as a limited scheme in 1948, providing Australian citizens with access to a range of medicines for the treatment of illnesses. The PBS is administered under the National Health Act 1953 (Cth). The PBS currently provides for access to subsidised medicines to Australian residents who hold a valid Medicare card, with co-payments required for most medicines. Most medicines available under the PBS cost more than the amount required as a co-payment.[6]

1.10 From 1 January 2014, most medicines available under the PBS cost $36.90 or $6 with a valid concession card, with the Australian Government paying the rest of the cost.

1.11 The RPBS contains additional medicines and services at concessional rates for the treatment of eligible veterans, war widows/widowers and their dependents. Persons eligible for RPBS may also apply for approval of medicines and services not listed under either scheme.[7]

Key provisions of the Bill

1.12 The Bill is comprised of five schedules, each containing provisions with staggered commencement dates over the period 2015–2019:

1.13 The Bill includes measures that:

- increase co-payments by $5.00 for general patients and by 80 cents for concessional card holders, with effect from 1 January 2015;[8]
- increase the concessional safety net threshold by two prescriptions each year for four years, from 2015 to 2018;[9] and
- increase the general patient safety net threshold by 10 per cent each year for four years, from 2015 to 2018.[10]

Consideration by other committees

1.14 The bill has been considered by both the Senate Standing Committee for the Scrutiny of Bills (Scrutiny Committee) and the Parliamentary Joint Committee on Human Rights (Human Rights Committee).

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5 Department of Health, *About the PBS*, http://www.pbs.gov.au/info/about-the-pbs (accessed 2 July 2014).

6 Department of Health, *About the PBS*, http://www.pbs.gov.au/info/about-the-pbs (accessed 18 July 2014).

7 Department of Veterans' Affairs, *Repatriation Pharmaceutical Benefits Scheme*, http://www.dva.gov.au/service_providers/doctors/Pages/rpbs.aspx (accessed 2 July 2014)

8 Item 3 of Schedule 1 Bill, paragraphs 99G(2)(a) and 99G(2)(b).

9 Item 1 of Schedule 1 and Item 1 of Schedules 2, 3, and 4.

10 Item 3 of Schedule 1 and Item 1 of Schedule 5; *Explanatory Memorandum*, p. 1.

1.15 The Scrutiny Committee made no comment on the provisions of the bill.[11]

1.16 The Human Rights Committee expressed concern that, notwithstanding assurances in the Explanatory Memorandum, the Bill may result in retrogressive consequences, especially for people accessing or reliant upon social security payments,[12] and sought clarification from the Minister as to whether increases in co-payments for medicines under the PBS and RPBS are compatible with the right to health.[13]

Acknowledgement

1.17 The committee thanks those organisations who made submissions and who gave evidence at the public hearing.

Note on references

1.18 References to the committee *Hansard* are to the proof *Hansard*. Page numbers may vary between the proof and the official *Hansard* transcript.

11 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest No. 7*, 25 June 2014, p. 34.

12 Parliamentary Joint Committee on Human Rights, *Eighth Report of the 44th Parliament; Bills introduced 2 – 19 June 2014; Legislative Instruments received 31 May – 6 June 2014*, p. 24.

13 Parliamentary Joint Committee on Human Rights, *Eighth Report of the 44th Parliament; Bills introduced 2 – 19 June 2014; Legislative Instruments received 31 May – 6 June 2014*, p. 24.

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

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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

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

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

Dissenting Report from the Australian Labor Party

1.1 Labor Senators do not see merit in this bill and oppose it in its entirety without amendment.

1.2 The increased cost of medicines and changes to the Pharmaceutical Benefits Scheme (PBS) Safety Net will see reduced adherence to medicine regimes.

1.3 The Bill has the potential to negatively impact on patients' health and result in significant additional costs to the health system.

1.4 This position is supported by the Community Affairs References Committee's inquiry into Out-of-pocket costs in Australian healthcare with its report recommending that the Government not proceed with further co-payments.

1.5 The Community Affairs References Committee also recommended that 'the Government review the impact and effectiveness of existing safety nets to ensure that current safeguards provide adequate protection of the most vulnerable in the community'.

1.6 The Government should not pursue changes to the PBS Safety Net that will make it more difficult to access and add to the healthcare costs of vulnerable Australians.

1.7 Taken with the pressure from additional out-of-pocket expenses resulting from Medical Benefits Schedule (MBS) co-payments and changes to that safety net, as well as changes to income support, the changes proposed in this Bill will have a deleterious effect on the health of vulnerable patients, especially the aged and individuals and families on low and middle incomes.

1.8 Labor Senators note the Parliamentary Joint Committee on Human Rights' concern that the Bill may result in retrogressive consequences, especially for people accessing or reliant upon social security payments.[1]

1.9 Labor Senators are extremely concerned that the Department of Health was unable to provide a submission to the Committee before its public hearing and note this limited the ability of Senators to question the Department on its evidence. Labor Senators are concerned by the trend developing in this respect and hope it will not develop as a long-term issue.

The bill unnecessarily targets pensioners and low and middle income earners

1.10 The Consumers Health Forum provided the Committee with evidence of more patients not filling their prescriptions due to cost. The CHF cited ABS data that 9 per

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1 Parliamentary Joint Committee on Human Rights, *Eighth Report of the 44th Parliament*, p. 24.

cent of adults delay or do not collect their prescriptions due to cost. Particularly, CHF noted:

> There is also a growing body of evidence from Australia and other countries that a number of groups in the community are particularly vulnerable to the impact of rising out-of-pocket costs, including: people with chronic illness; people on low incomes; people living in rural and remote areas; young families; and older Australians.[2]

1.11 The CEO of the Public Health Association Australia stated that the measures are inequitable and will affect society's most vulnerable members. Mr Moore stated:

> The people to whom this is most important are the vulnerable, such as Aboriginals and Torres Straight Islanders, people from low socio-economic backgrounds or from non-English speaking backgrounds and the elderly.

1.12 The Pharmacy Guild of Australia noted:

> Increases to PBS co-payments and safety nets may discourage patients from purchasing their prescribed medicines, leading to non-adherence to a medication regime… Any increase in price signals should be accompanied by a greater commitment to the funding of well-targeted medication management and support services, focused on those patients in greatest clinical need who have the highest risk of non-adherence to their medicines.[3]

1.13 The Pharmaceutical Society of Australia provided the Committee with evidence that it:

> is concerned that patient co-payments, even before the increases proposed in this Bill take effect, have reached such a high level that there is a danger of patients foregoing some of their necessary medications due to cost…
>
> Coupled with the proposed MBS co-payment for GP visits, out-of-hospital pathology and diagnostic imaging services, vulnerable patients may be forced into a situation where they need to make a financial decision about seeking medical attention or continuing with their medications instead of focusing on their health.[4]

1.14 This evidence is supported by evidence from COTA that:

> Not filling a prescription is only part of the story. For a number of years the COTAs ran a peer education program on the Quality Use of Medicines. Anecdotal evidence from the peer educators showed that many older people were not able to afford all their medications, even at the concessional rate, and so they developed a range of strategies to manage the costs. These included reducing the dosage of medications e.g. only taking a medicine

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2 *Submission 8*, p. 2.

3 *Submission 1*, p. 3.

4 *Submission 7*, p. 2.

> every other day instead of daily, dropping some completely, and sharing medications with other people.[5]
>
> The proposed increases in co-payments will probably increase the numbers of people who do not fill prescriptions. Whilst that may give the Government the short-term savings it is looking for on the PBS expenditures, it has the potential to drive up other health costs in the longer term.[6]

1.15 The Grattan Institute provided supplementary information that further demonstrated clear evidence of demand for pharmaceuticals declining when the price increases and cited numerous academic analyses that ‘confirm that the conclusion we reached, that price increases would be likely to increase the number of unfilled prescriptions’.[7]

The changes do nothing to contribute to the sustainability of the PBS

Pharmaceutical Allowance

1.16 When a PBS co-payment of $2.50 was introduced for pensioners in 1990 a Pharmaceutical Allowance of $2.50 per week was introduced concurrently. The Pharmaceutical Allowance increased in line with increases to the PBS co-payment and in effect this meant pensioners had the cost of one prescription per week offset. This nexus was broken in 1997 by the Howard Government when the PBS co-payment increased with no concurrent increase to the Pharmaceutical Allowance. The Pharmaceutical Allowance is presently $6.20 per fortnight for individuals and $3.10 per fortnight each for couples.[8]

1.17 There is no additional compensation for pensioners and other vulnerable Australians contained in this Bill, nor are there any other Bills being considered, that would deliver this compensation.

Safety Net

1.18 The increase in the safety net to 68 scripts per year for concessional patients should be considered in the context of other health cuts and additional out of pocket costs, as well as evidence of non-adherence to medicines under current safety net arrangements.

1.19 COTA provided evidence to the Committee that:

> Many people living only on the age pension actually live from pension day to pension day, as do people who are on the much lower Newstart allowance and other payments there is not much left over at the end of a fortnight, particularly if you are single and particularly if you are not a

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5 *Submission 10*, p. 3.

6 *Submission 10*. p. 4.

7 *Supplementary Submission 2*, p. 3.

8 http://www.pbs.gov.au/info/healthpro/explanatory-notes/front/fee#1

> homeowner. If you are a single, older woman living in private rental accommodation you really have not got very much discretionary income. If something goes up by 80c it seems like nothing to us, but they might have to get four or five scripts in that week and each one of them will cost them an extra 80c until they get up to the safety net threshold. If you are looking at four or five scripts then you are looking at $5. That is a significant amount of a pensioner's income. It is at that point, the evidence shows us, that people do not fill them all; that they do not take the action. They might delay going to the doctor, particularly if they have to pay the $7 co-payment before they then get asked to pay an extra co-payment for any medications that that doctor prescribes for them.[9]
>
> …
>
> people do things like taking their medication half as many times as they should, sharing medications, not getting rid of medications that are out of date because they do not want to pay for the next one and generally, just as we have heard, not getting a script filled when they should.[10]

1.20 The proposal to increase the general safety net from $1421 by 10 per cent plus the consumer price index over the next four years will take it out of reach for the majority of Australians.

1.21 The Grattan Institute argued the threshold for general patients would rise by nearly half over four years and the threshold for concessional patients by 15 per cent. Under these changes the Grattan Institute pointed to significantly reduced support for sicker people who need more drugs.[11]

Price Disclosure

1.22 Changes made by the previous Labor Government through expanded and accelerated simplified price disclosure have resulted in significant savings and more funding being available for the listing of new medicines.

1.23 These savings undermine the Government's argument that the PBS is not sustainable.

1.24 The Parliamentary Budget Office demonstrated that PBS expenditure is projected to slow from its historical real growth of 2.4 per cent annually to 0.3 per cent annually over the medium term, further demonstrating the sustainability of the PBS.

1.25 The Chief Executive Officer of the Pharmacy Guild of Australia, Mr David Quilty told the Committee the Guild estimated the savings from price disclosure to 2020 are about $20 billion.[12]

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9 *Committee Hansard*, 19 August 2014, p. 9.

10 *Committee Hansard*, 19 August 2014, p. 9.

11 *Submission 2*, p. 1.

12 *Committee Hansard*, 19 August 2014, p. 25.

1.26 In its submission the Department of Health noted that between 2010-11 and 2011-12 there was a reduction in PBS expenditure of 2.1 per cent.[13]

1.27 Mr Richard Bartlett, an Acting Deputy Secretary with the Department of Health noted the savings from simplified price disclosure are expected to be over $9 billion by 2016-17, and that these reforms have contributed directly to making medicines cheaper for consumers.[14]

1.28 The Pharmaceutical Society of Australia noted in its submission that outlays under the PBS are projected to remain stable at around 0.07 per cent of GDP over the period to 2020.[15]

1.29 The $1.3 billion proposed to be realised through this Bill will not be invested back into the PBS but into the medical research future fund. This does nothing to contribute to the sustainability of the PBS.

1.30 Labor Senators do not concur with the Department and committee's conclusion that the proposed increases in costs for consumers are reasonable, necessary or proportionate.

Recommendation 1

1.31 Labor Senators recommend that the Senate reject the National Health Amendment (Pharmaceutical Benefits) Bill 2014.

Senator Carol Brown **Senator Nova Peris OAM**

Senator the Hon Jan McLucas **Senator Claire Moore**

13 *Submission 12*, p. 7.

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

15 *Submission 7*, p. 2.

Greens' Senators Dissenting Report

1.1 Greens members of the Community Affairs (Legislation) Committee consider that the majority report on this Bill ("the Report") does not accurately reflect the adverse impacts on consumers and the general health and well-being of Australians from increasing patient co-payments and safety net thresholds for the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS).

Flawed rationale

1.2 The Government's claim that the health system is unsustainable and that increasing co-payments will reduce so-called unnecessary health care is not supported by the evidence. Evidence presented to this inquiry and also to the *Inquiry into out-of-pocket costs in Australian healthcare* and a report by the independent Parliamentary Budget Office confirms that health costs account for only a small proportion of forecast budget growth.

1.3 The PBO report also found spending on medical benefits accounts for just 1.8 per cent of the projected growth in government spending over the next decade, while spending on public hospitals accounts for just 1.4 per cent.[1]

1.4 The Australian Medical Association (AMA) submission stressed that:

> The rationale behind the amendment is flawed on many levels … the Government's claim that these amendments are necessary to ensure the sustainability of the health care system is false.[2]

1.5 The Grattan Institute also submitted that the rationale behind the proposed savings measures is flawed and that savings to the health budget could be found in ways that are safer for the public and fairer for Australians:

> Co-payments are defended on the ground that charging more will stop people seeking unnecessary care. This is a dubious argument in general, as people are not qualified to assess their own health – that's why we have health professionals.
>
> The argument is even weaker when it comes to prescribed medicines. PBS co-payments apply to medicine that a doctor has ordered. Unless the doctor is wrong, the medicine is necessary. If the government thinks doctors are getting it wrong, the solution is not to charge patients more. It is to improve prescribing practices.
>
> These changes will put people's health at risk and do little to balance the budget. They would only raise an estimated $450 million in 2017-18 and

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1 Sydney Morning Herald, 23 Aug 2014.

2 *Submission 4*, p. 1.

> this money is earmarked for a medical research fund, not the budget bottom line.
>
> There are much fairer and safer ways to cut PBS spending.[3]

1.6 Out-of-pocket expenses are increasing and the rise in costs for primary health care and medication that is prescribed by a medical practitioner, or is used for health prevention, is making health care inaccessible and unaffordable for many Australians.

1.7 The Committee heard evidence from Australia's leading health experts that increasing the cost of medications will put patient's health at risk. The Grattan Institute presented research showing that:

> There is strong evidence that out-of-pocket costs stop people getting health care, including necessary care … International literature and Australian experience show that increases in out-of-pocket costs mean that fewer people take the medicine their doctor has prescribed.[4]

1.8 The AMA presented international research showing 'downstream' health care costs and increased risks for patients who do not take prescribed medication. Meta-analysis examining the impact of introducing or increasing prescription co-payment confirmed increases in medicine non-adherence.

> Failure to take medicines leads to higher levels of illness and increased visits to the doctor and hospitalisations.[5]

1.9 It was disappointing that the Department of Health did not acknowledge the research, data and evidence of medical experts and recognised researchers showing that increasing prescription co-payments results in poorer outcomes for patients.

Impact on patients

1.10 Those experiencing socioeconomic disadvantage would be the most adversely affected by a co-payment increase.

1.11 The Grattan Institute stated that any short term financial benefits arising from the co-payment would be negatively off-set by the inaccessibility of primary health care, which would result in patients requiring more complicated and expensive treatment over the long term.[6]

1.12 Most submissions acknowledged and accepted a system of co-payments in the Australian health system, however there was overwhelming criticism of the measures contained in the Bill, which would result in negative health impacts for individuals.

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3 *Submission 2*, p. 1.

4 *Submission 2*, p. 1.

5 *Submission 4*, p. 2.

6 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*.

1.13 The Council of Social Service of NSW (NCOSS) stated that the proposed measures:

> … are regressive and place the biggest financial burden on low-to-middle income people who already experience the greatest burden of illness and disease. Cost barriers to medicines will lead to more preventable and expensive health problems and increased costs to the health system longterm. Evidence demonstrates the proposed changes will disproportionately impact on people experiencing poverty and disadvantage.[7]

1.14 COTA Australia also raised concerns that the proposed measures in the Bill would have a disproportionate impact on older people and exacerbate existing barriers to access:

> [M]any older people have complex and chronic conditions, requiring multiple medications and frequent visits to doctors. Older people are more likely to go to the doctor, more likely to see a specialist and more likely to be an inpatient in a hospital than younger people. This increases the likelihood they will be using some medications, either long term for chronic conditions or to deal with short-term medical conditions.
>
> Older people will incur these increases at the same time as the Government is planning to introduce co-payments for GP visits and related diagnostic tests and decrease the value of the pension through changes to indexation and other initiatives.[8]

1.15 COTA Australia also noted that an increased co-payment would be a barrier to accessing health care, especially prescription medication:

> There are a number of studies looking at the affordability of medicines as a barrier to access. The ABS survey of 2010-2 estimated that 1 in 10 people delayed getting a prescription filled because of the cost. For older people this figure was lower at around 3 per cent which is due to older people being able to access concessional medications, either as a pensioner or through the Commonwealth Seniors Health Card.[9]

1.16 Consumers Health Forum Australia submitted that the measures in the Bill would have a disproportionate impact on marginalised populations:

> There is also a growing body of evidence from Australia and other countries that a number of groups in the community are particularly vulnerable to the impact of rising out-of-pocket costs, including: people with chronic illnesses; people on low incomes; people living in rural and remote areas; young families; and older Australians.[10]

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7 *Submission 3*.

8 *Submission 10*, pp. 3-4.

9 *Submission 10*, p. 3.

10 *Submission 8*, p. 2.

1.17 Consumers Health Forum Australia provided further evidence to show that rising out-of-pocket costs mean some people delay health care and even essential medications:

> ...two thirds of respondents to CHF's survey indicated that they had at some point delayed seeing a medical professional, and almost half of them (47 per cent) cited cost as a contributing factor.[11]

1.18 The Grattan Institute presented evidence that the measures in the Bill would result in fewer patients adhering to their medication regimes. The Grattan Institute presented data indicating that some respondents are already reporting that out-of-pocket costs for medicine is a problem, with more than 15 per cent of surveyed (and sick) adults reporting that they did not take their medicine due to cost pressures.[12]

1.19 Further evidence that consumers facing cost pressures would delay or not fill prescriptions was provided by the Australian Medical Association (AMA). Their submission stated that higher co–payments would result in more Australians delaying or not filling their prescriptions appropriately, which would cost taxpayers and the government more. They also noted the Australian and international research that demonstrates increases in co–payments leads to poorer adherence to prescriptions.[13]

Recommendation 1

1.20 Greens Senators recommend that the Senate does not pass the National Health Amendment (Pharmaceutical Benefits) Bill 2014

Senator Rachel Siewert **Senator Richard Di Natale**

11 *Submission 8*, p. 3.

12 *Submission 2*, p. 4.

13 *Submission 4*, p. 1.

APPENDIX 1

Submissions and additional information received by the Committee

Submissions

1 Pharmacy Guild of Australia
2 Grattan Institute (plus a supplementary submission)
3 NSW Council of Social Service
4 Australian Medical Association
5 Youth Affairs Council of South Australia
6 HSU National
7 Pharmaceutical Society of Australia
8 Consumers Health Forum of Australia
9 Medicines Australia
10 COTA Australia
11 Society of Hospital Pharmacists of Australia
12 Department of Health

Additional Information

1 Information about the interpretation of The Organisation for Economic Co-operation and Development (OECD) data on co-payments, from Grattan Institute, received 26 August 2014

Answers to Questions on Notice

1 Answers to Questions on Notice received from Australian Council of Social Service, 19 August 2014
2 Answers to Questions on Notice received from Pharmaceutical Society of Australia, 21 August 2014
3 Answers to Questions on Notice received from Department of Health, 26 August 2014

APPENDIX 2

Public hearings

Tuesday, 19 August 2014

Parliament House, Canberra

Witnesses

Australian Council of Social Service
VASSAROTTI, Ms Rebecca, Acting Deputy Chief Executive Officer

Council of Social Service of New South Wales
FROST, Ms Solange, Senior Policy Advocate

COTA Australia
ROOT, Ms Josephine, National Policy Manager

Grattan Institute
BREADON, Mr Peter, Health Fellow

Pharmaceutical Society of Australia
EMERSON, Dr Lance, Chief Executive Officer

Pharmacy Guild of Australia
QUILTY, Mr David James, Executive Director
SINCLAIR, Mr Paul Gregory, President, New South Wales Branch

Department of Health
BARTLETT, Mr Richard, Acting Deputy Secretary
CREECH, Mr Paul, Assistant Secretary, Pharmaceutical Benefits Division
McNEILL, Ms Felicity, First Assistant Secretary, Pharmaceutical Benefits Division