



## **AUSTRALIAN WOMEN'S HEALTH NETWORK**

**Submission to the Senate Community Affairs  
Legislation Committee**

**National Health Amendment (Budget Measures -- Pharmaceutical  
Benefits Safety Net) Bill 2005**

**Health Legislation Amendment Bill 2005**

**12 October, 2005.**

**National Health Amendment (Budget Measures -Pharmaceutical Benefits Safety Net) Bill 2005.**

The Australian Women's Health Network is extremely concerned that medicines are being priced out of the reach of increasing numbers of ordinary Australians. This issue is of particular concern to women because they use more hospital and medical services and medicines than men, partly in fulfilling their reproductive roles and partly because they live longer, using more services in old age. Moreover, they experience more episodes of illness. Affordability of medicines is thus crucial to women.

Women are also subject to greater economic insecurity. They are overrepresented among low income groups and women headed families are the most economically disadvantaged in the country. Women also need to access health services and medicines on behalf of the people they provide care for: children, parents, neighbours and friends, many of whom are themselves economically vulnerable.

The Australian Women's Health Network is alarmed that price barriers are being *intentionally* erected in the path of access to medicines. For at least 10 years, the price of pharmaceuticals has been increased at a rate considerably faster than that of inflation, a policy designed partly to control the rate of increase in the Commonwealth government's expenditures on the Pharmaceutical Benefits Scheme (PBS). The increasing cost to consumers over a decade was greatly exacerbated in January, 2005, when the price of filling a prescription was increased by approximately 30 per cent, a hike supported by both major political parties.

The **National Health Amendment (Budget Measures-Pharmaceutical Benefits Safety Net) Bill 2005** will intensify this trend. The legislation proposes to progressively increase PBS safety net thresholds each year for the next four years for both general and concessional users. These increases will be in addition to the annual price rises based on the CPI. The result will be an increase of approximately 15 per cent in the charges paid before the threshold cuts in. The changes, of course, are targeted to impact upon those people who are so ill that they need well above average levels of medication.

Increasing the out-of-pocket expenses that people must pay will certainly help to control PBS inflation because, as international studies show, it will stop particular people from buying medicines. However, it will not meet the objectives of the PBS which Mr Pyne outlined in his Second Reading Speech in the House of Representatives on 14 September 2005. In that speech, Mr Pyne said that "the aim of the pharmaceutical benefits scheme is to ensure that Australians have affordable access to high-quality necessary medicines..." Far from achieving this objective, the legislation will increase the many cost barriers already embedded in the Australian health system, which prevent citizens accessing medicines and many other health services.

A wide range of studies across OECD countries in the last three decades demonstrates beyond doubt that when consumers have to pay out-of-pocket expenses for services,

including medicines, they use fewer services.<sup>1</sup> However, not all consumers are equally affected. User charges do not prevent high income people from buying services but they do seriously inhibit access for the poor and, in some cases, for low to middle income earners as well. As population health studies show, there is a very strong correlation between low income and ill health. Studies by the United States Institute of Medicine<sup>2</sup> show that low income uninsured people, including pregnant women, the newborn and children, are prevented from seeking hospital, medical and other services by cost barriers, that they use fewer services and that they experience more ill health.

Specifically in relation to Australian pharmaceutical use, a five country study done two years ago by an independent American research team found that 23 per cent of Australians did not get prescriptions filled because of cost and another 9 per cent of people skipped doses *to make their medications last longer*.<sup>3</sup> We draw to the Committee's attention the fact that these barriers to access existed *before* this year's 30 per cent increase in patient copayments and point out that if the survey were repeated now, access barriers would turn out to be much higher.

The Australian Women's Health Network is gravely concerned about the impact on women of these findings and alarmed that the current legislation will exacerbate the situation even further. By raising the PBS safety net thresholds, the policy will impact adversely on those groups of low income people who need access to health services the most: sick people who are high users of medicines. In addition to having serious implications for equity, the policy may, in the end, save little or no money. There is considerable evidence that people who go without services, including medicines, may become unnecessarily ill and impose high costs on the health system, including avoidable hospitalisation. As Maynard and Bloor argued recently in relation to pharmaceuticals, "a common access problem is under use of available cost-effective drug interventions".<sup>4</sup>

The policy of using higher pharmaceuticals copayments to try to reduce public expenditures by deterring access is the easy way out for governments. It is well-known that low income consumers, especially the young and the frail aged, the groups so adversely affected by such policies, are unlikely to have sufficient political resources to bring their problems to public attention.

Rapidly escalating public expenditures for pharmaceuticals is a problem for governments throughout the OECD and has been addressed in a variety of ways in

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<sup>1</sup> For reviews of this literature see, for example, Richardson, J. *The Effects of Consumer Copayments in Medical Care*, National Health Strategy, Background Paper No 5, Australian Government Printing Service, Canberra, 1991; Rice, T. and Morrison, K. "Patient Was Sharing to Medical Services: A Review of the Literature and Implications for Health Care Reform", *Medical Care Review*, Vol 51, No 3, 1994; Newhouse, J.P. *Lessons from the RAND Health Insurance Experiment*, Harvard University Press, Cambridge, 1993; Gray, Gwendolyn, *The Politics of Medicare*, University of New South Wales Press, Sydney, 2004, Chapter 6.

<sup>2</sup> Marwick, Charles, "A Total of 58 Million Americans Lack Health Insurance", *British Medical Journal*, Vol 325, Issue 7366, 2002, p 678.

<sup>3</sup> Blendon, Robert et al "Inequities in Health Care: A Five Country Survey", *Health Affairs*, Vol 21, Issue 3, 2002, pp 182-86.

<sup>4</sup> Maynard, Alan and Bloor, Karen, "Dilemmas in Regulation of the Market for Pharmaceuticals", *Health Affairs*, Vol 22, No 3, 2003, pp 31-41.

different countries. Policies have attempted to influence and educate providers by making up to date information available and putting clinical practice guidelines in place. The number and types of medicines eligible for reimbursement have been carefully selected to provide good value for money, along with budget holding mechanisms, profit and price controls and cost effectiveness controls. These measures operate on the *supply* side and have the advantage of not inhibiting access for the low income sick, whereas the policy being proposed in this legislation operates on the *demand* side, with its serious impact on access for the most vulnerable groups. If the aim of the PBS is, as Mr Pyne says, to provide affordable access to medicines, then supply-side restraint policies must be developed to replace an approach which controls expenditures by restricting the access of the poorest and sickest groups in our community.

The Australian health system already has serious access problems caused by high levels of user charges. Increasingly expensive medicines will serve only to exacerbate the situation further. User charges for medical services are prevalent throughout the system, especially for specialist services. Bulk billing rates have fallen most in low income areas and are highest in well off inner city areas. The poorer and sicker people are, the less likely they are to be able to find a bulk billing doctor. The safety nets introduced in 2004 do not always help those who need services the most as they may not be able to find the money to reach the threshold.

The Australian Women's Health Network notes with frustration that little progress is being made towards a genuinely comprehensive and preventive health system which would include improved services for those with poor health or special needs. People with special needs exist in large numbers in Australia and include indigenous women, men and children; those with disabilities; refugee women; those suffering from depression, anxiety and other forms of mental illness; and older people. Women make up the majority of older people and the vast majority of the oldest cohorts. The increase in user charges for medicines which will be introduced if the National Health Amendment (Budget Measures-Pharmaceutical Benefits Safety Net) Bill 2005 is passed, will greatly exacerbate the current situation and will adversely affect those on low incomes in terms of unnecessary ill health and financial anxiety. By causing higher levels of otherwise unnecessary hospitalisation, it may even increase, rather than decrease, Australia's total health expenditure bill.

The Australian Women's Health Network calls for a reconsideration of the National Health Amendment (Budget Measures-Pharmaceutical Benefits Safety Net) Bill 2005 and for the development of policies to promote responsible prescribing patterns and medicine use instead of the shortsighted approach of increasing PBS safety net thresholds.

## **Health Legislation Amendment Bill 2005**

The Australian Women's Health Network is concerned about the additional powers being sought by the Minister for Health under this legislation in relation to the professional services provided in specified circumstances for which medical benefits are payable. According to the wording of one of the proposed new subsections to section 19(A), the Minister is to have the power to determine services for which Medicare benefits *are not payable*. Clearly, the intention is for the Minister to be able to reduce, rather than add to, the list of reimbursable items.

According to the Second Reading Speech, made by Mr Pyne, Health Parliamentary Secretary, the Minister needs this power to allow "swift action" to be taken in circumstances where the government never intended items to be reimbursable under Medicare or which the government does not wish to fund through Medicare.

The Australian Women's Health Network is particularly concerned, that under, the new arrangements, it seems that the Minister will be able to make determinations without the benefit of the expert advice of the Medical Services Advisory Committee. Under the Act as it stands now, the Minister cannot make regulations relating to professional services, except in accordance with the recommendations of an expert committee, the forerunner to the present Medicare Services Advisory Committee. The requirement to consult the expert committee, we understand, is being removed from the act. We wonder about the conditions under which the new power will be used and why the government thinks there is a need for it. Although there is provision in the Legislative Instruments Act for decision-makers to consult relevant parties, we understand that failure to consult does not invalidate action.

The role of Medical Services Advisory Committee is to advise the Minister on the scientific evidence relating to the safety, effectiveness and cost effectiveness of new medical technologies and procedures and of the advisability of their inclusion for funding under Medicare. Typically, scientific evidence is contradictory and inconclusive when it relates to innovations that have not yet stood the tests of time and rigorous study. It is difficult to imagine why a Minister would want the power to make decisions on such complex issues without the assistance of advice from scientific experts.

The accountability mechanisms that operate in Westminster systems of government are not particularly strong and, under certain circumstances, Prime Ministers and Cabinet members have very wide powers. It is surely against Parliamentary best practice that a Minister should have absolute power to make single-handed determinations about the technologies and procedures in respect of which Medicare benefits will not be payable.

The Australian Women's Health Network is concerned to ensure that extensive consultation will take place in relation to the services and procedures reimbursable under Medicare and insists that decisions must be made on the basis of the best scientific advice available, not simply Ministerial prerogative.

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