Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 01

OUTCOME 2 – Access to Pharmaceuticals

Topic: Establishment of Therapeutic Groups

Hansard Page: CA 94

Senator Fierravanti-Wells asked:

1. When did the Minister make the request to PBAC for advice on the establishment of each of the therapeutic groups:
   (a) angiotensin converting enzyme (ACE) inhibitors
   (b) dihydropyridine calcium-channel blockers (CCB)
   (c) H2 receptor antagonists (H2RA)
   (d) statins
   (e) angiotensin II receptor antagonists (ATRA)
   (f) proton pump inhibitors (PPI)
   (g) HMG Co-A reductase inhibitors higher potency (Statins-HP)
   (h) venlafaxine & venlafaxine derivatives
   (i) oral bisphosphonates – osteoporosis
   (j) oral bisphosphonates – Paget disease.

Answer:

Please see answer to Question on Notice No 04 (CA98).

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 02

OUTCOME 2 – Access to Pharmaceuticals

Topic: Establishment of Therapeutic Groups

Hansard Page: CA 95-96

Senator Fierravanti-Wells asked:

1. When did the Minister make the request to PBAC for advice on the establishment of each of the therapeutic groups:
   (a) angiotensin converting enzyme (ACE) inhibitors
   (b) dihydropyridine calcium-channel blockers (CCB)
   (c) H2 receptor antagonists (H2RA)
   (d) statins
   (e) angiotensin II receptor antagonists (ATRA)
   (f) proton pump inhibitors (PPI)
   (g) HMG Co-A reductase inhibitors higher potency (Statins-HP)
   (h) venlafaxine & venlafaxine derivatives
   (i) oral bisphosphonates – osteoporosis
   (j) oral bisphosphonates – Paget disease.

Answer:

Please see answer to Question on Notice No 04 (CA98).

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 03

OUTCOME 2 – Access to Pharmaceuticals

Topic: Establishment of Therapeutic Groups

Hansard Page: CA 96

Senator Ryan asked:

1. In relation to each of the therapeutic groups, did the Minister's direction to the PBAC arise from a recommendation from the Department that preceded the Minister's actual direction to the PBAC?
   (a) angiotensin converting enzyme (ACE) inhibitors
   (b) dihydropyridine calcium-channel blockers (CCB)
   (c) H2 receptor antagonists (H2RA)
   (d) statins
   (e) angiotensin II receptor antagonists (ATRA)
   (f) proton pump inhibitors (PPI)
   (g) HMG Co-A reductase inhibitors higher potency (Statins-HP)
   (h) venlafaxine & venlafaxine derivatives
   (i) oral bisphosphonates – osteoporosis
   (j) oral bisphosphonates – Paget disease.

Answer:

Please see answer to Question on Notice No 04 (CA98).

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 04

OUTCOME 2 – Access to Pharmaceuticals

Topic: History of Therapeutic Group policy

Hansard Page: CA 98

Senator Moore asked:

1. History of how the therapeutic groups policy first came about and when, including advice around the process of the formation of each of the groups, subsequently, particularly focusing on consultation.
   (a) angiotensin converting enzyme (ACE) inhibitors
   (b) dihydropyridine calcium-channel blockers (CCB)
   (c) H2 receptor antagonists (H2RA)
   (d) statins
   (e) angiotensin II receptor antagonists (ATRA)
   (f) proton pump inhibitors (PPI)
   (g) HMG Co-A reductase inhibitors higher potency (Statins-HP)
   (h) venlafaxine & venlafaxine derivatives
   (i) oral bisphosphonates – osteoporosis
   (j) oral bisphosphonates – Paget disease.

Answer:

The Therapeutic Groups policy was announced in the 1997-98 Budget and has been in operation since 1 February 1998. The policy operated under administrative rules until 1 August 2007, when a legislative framework for the policy was enacted as part of the PBS Reform amendments to the *National Health Act 1953*.

1998 Therapeutic Groups
The four therapeutic groups commencing in 1998 (ACE, CCB, H2RA & Statins) originated as a Departmental policy proposal as part of the 1997-98 budget process. The policy proposal was supported by the then Government and announced in the 1997-98 Budget.

No stakeholder consultation was undertaken prior to the policy being announced in the 1997-98 Budget. However, as the policy was new there was subsequently a range of post-Budget consultation, both in relation to the specific groups to be formed, but equally on the operations of the policy. For example, as a result of these consultations, the original policy intention was modified to include provision, via the PBS authority mechanisms, for patients with legitimate clinical reason for needing a higher priced medicine within a therapeutic group to obtain it without additional cost to the patient (the exemption policy).

The Government sought advice from the Pharmaceutical Benefits Advisory Committee (PBAC) and in the context of a broader consultation strategy on the development of this first time policy, the Department consulted with representatives from peak industry, medical and consumer bodies, including the PBAC, the Consumer Health Forum, the Royal Australian College of Physicians, the Royal Australian College of General Practitioners, the Royal Australia & New Zealand College of Psychiatrists, the Australian Medical Association and the Australian Pharmaceutical Manufacturers Association (now Medicines Australia).

The Government also funded an education campaign. Further details are at Question on Notice 09 (CA 111).

2007 Therapeutic Groups
The 2007 therapeutic groups were based on PBAC advice sought in November 2001 and December 2001.

With respect to the Proton Pump Inhibitiors (PPIs) group, the then Minister sought the advice of the Pharmaceutical Benefits Pricing Authority (PBPA) in April 2005 about the reference pricing policy already applying to these drugs. This advice was sought in part because representations had been received from sponsors of some of the PPI drugs expressing an interest in having their drugs placed in a therapeutic group in order that they might apply a therapeutic group premium to offset the consequences of reference pricing based price reductions. This necessitated the PBPA considering the advice of the PBAC on the suitability of these drugs being placed in a therapeutic group.

In November 2006 the sponsors were advised that the PPIs group would be formed.

With respect to the ATRAs, the then Minister sought the advice of the PBAC in November 2001 on the formation of this group prior to it being formed. Consultation was undertaken with the sponsors of the affected medicines from the time of the PBAC recommendation in 2001 through to the formation of the group in 2007. Specifically, the sponsors of the affected medicines made several submissions to the PBAC seeking a recommendation that the drugs were not suitable for inclusion in a therapeutic group. PBAC continued to reaffirm its advice that the ATRA Group could be formed.

The discussions with industry on the formation of the PPI and ATRA therapeutic groups also coincided with the more comprehensive consultation being undertaken on the broader policy of PBS Reform.

2009 Therapeutic Group
The proposal to form the Higher Potency-Statins (Statins HP) therapeutic group was initiated by the Department as part of the 2009-10 Budget process. A range of savings proposals were put forward to the Minister by the Department, including a proposal for a Statins HP group. The Minister then submitted this proposal, among others, for Government consideration. The Government agreed that the therapeutic group be formed, subject to the advice of the PBAC.

In March 2009 the Department requested advice from the PBAC about the proposal to form a new Higher Potency Statins therapeutic group. The intention to form a Statins HP group was announced on 12 May 2009 (Budget night). However, the group was not formed until 1 September 2009, after consultation with relevant sponsors as outlined on page 16 of the Department's submission to the Senate Standing Committee on Community Affairs Inquiry into Access to Pharmaceuticals.

2010 Therapeutic Groups

Following on from the 2009-10 Budget process, but included as a part of the 2009 Mid Year Economic and Fiscal Outlook (MYEFO) the Government announced its intention to form the venlafaxine & desvenlafaxine derivatives and oral bisphosphonate: osteoporosis and the oral bisphosphonate: Paget disease therapeutic groups on 2 November 2009.

Government agreement to the formation of further therapeutic groups had been given following consideration of possible savings proposals put forward by the Department as part of the Budget process. The Department sought the PBAC's advice on the potential to form the venlafaxine & desvenlafaxine derivatives therapeutic group at the March 2009 PBAC meeting and PBAC advice on the potential to form the oral bisphosphonate: osteoporosis and the oral bisphosphonate: Paget disease therapeutic groups was sought at the June 2009 PBAC meeting.

After the 2 November 2009 MYEFO announcement of intention to form the therapeutic groups, the Department commenced a consultation process with the affected companies and key stakeholder bodies, including Medicines Australia as detailed in the submission to the Senate Standing Committee on Community Affairs Inquiry into Access to Pharmaceuticals.

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 05

OUTCOME 2 – Access to Pharmaceuticals

Topic: Therapeutic Groups Budget papers - 1998

Hansard Page: CA 101

Senator Moore asked:

Could we get the Budget papers from 1998 from your department when they originally announced the budget measure for therapeutic groups? Can we get the budget papers about how it is presented, the proposed savings, over what period and what was the intent of the legislation?

Answer:

The Therapeutic Groups Premium policy was first announced in the 1997-98 Budget and has been in operation since 1 February 1998.

The 1997- 98 Budget and other relevant papers are attached:
Attachment A – relevant pages, Portfolio Budget Statements 1997-98.
Attachment B – Budget Paper Number 2, Part 1, Outlays Measures,
Health and Family Services.
Attachment C – relevant pages, Budget 1997-98.
Attachment D – Detailed Portfolio Reviews, Health and Family Services, May 1997.

The Therapeutic Groups Premium policy operated under administrative rules from its inception until 1 August 2007, therefore there was no legislation accompanying the policy.

Portfolio Budget Statements 1997-98

7 Therapeutic group premiums

Financial implications:

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
-41.4	-157.5	-173.8	-188.7

Purpose of the measure:

To extend the practice of price premiums beyond generic brands of a drug to groups of drugs which, while not identical chemically, are very similar in clinical effect. A low-priced drug in the group will set a benchmark, and the price difference for higher priced drugs will be paid by the patient. The measure is an extension of the Minimum Pricing Policy, which applies to products that are chemically identical but sold under different brand names.

Expected implementation strategies for the measure:

The drug groups affected include: ACE inhibitors, Calcium Channel Blockers, and beta blockers (all used for treating cardiovascular diseases); Selective Serotonin Reuptake Inhibitors (SSRIs) for treating depression; some drugs for lowering blood cholesterol; and H_1 receptor antagonists for the treatment of peptic ulcers.

Implementation will take effect on 1 February 1998 and will draw on professional and clinical advice.

Funding of $4 million in 1997-98 will be provided to assist pharmacists with the costs of properly advising the community about the details of the measure and other aspects of the cost-effective use of medicines, including the availability of alternative brands.

A two year education campaign including a telephone helpline service will also be funded under this measure. A full economic evaluation of the whole measure will be undertaken in the year 2000.

Impact of the measure:

While Australia's health care system provides excellent equity of access to health care for the community, it is important to ensure that the people who use the system - both doctors and patients - take cost into account in reaching treatment decisions. This measure will encourage greater price competition between suppliers and changes in prescribing patterns.

This measure will affect all general and concessional beneficiaries and will also apply to eligible veterans and their dependants in respect to the Repatriation Pharmaceutical Benefits Scheme, who use drugs in the nominated category.

Budget 1997-98
Budget Paper No 2
Part 1 Outlays Measures
Health and Family Services

Therapeutic group premiums

Function: Health

Financial Implications ($m)

		1997-98	1998-99	1999-00	2000-01
	Health and Family Services	-41.4	-157.5	-173.8	-188.7
	Veterans' Affairs	-2.8	-9.4	-10.0	-10.7
	TOTAL	-44.2	-166.8	-183.8	-199.4

Explanation

From 1 February 1998, the Government will only subsidise a set base price within certain therapeutic groups (drugs which while not identical chemically have very similar clinical effects). The price difference between higher priced drugs within the group and the base price would be paid by the patient as a therapeutic group premium. The drug groups affected include anti-depressants, drugs for treating hypertension, high cholesterol and anti-ulcer drugs.

This policy is an extension of the Minimum Pricing Policy, which applies to products that are chemically identical but sold under different brand names. Savings are generated through not paying the Pharmaceutical Benefit subsidy for drug prices above the set base price in a therapeutic group. This in turn should generate efficiencies through:

- increased price competition in the pharmaceutical industry in order to maintain market share; and
- increased doctor and patient price consciousness, leading to the prescribing of the cheaper drugs within the therapeutic group.

A two year education campaign including a telephone helpline service will be funded under this measure. Funding of $4 million in 1997-98 will also be provided to assist pharmacists with the costs of properly advising the community about the details of the measure and other aspects of the cost-effective use of medicines, including the availability of alternative brands. A full economic evaluation of the whole measure will be undertaken in the year 2000.

These changes will also apply to eligible veterans and their dependants in respect to the Repatriation Pharmaceutical Benefits Scheme.

7 Therapeutic group premiums

Financial implications:

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
-41.4	-157.5	-173.8	-188.7

Purpose of the measure:

To extend the practice of price premiums beyond generic brands of a drug to groups of drugs which, while not identical chemically, are very similar in clinical effect. A low-priced drug in the group will set a benchmark, and the price difference for higher priced drugs will be paid by the patient. The measure is an extension of the Minimum Pricing Policy, which applies to products that are chemically identical but sold under different brand names.

Expected implementation strategies for the measure:

The drug groups affected include: ACE inhibitors, Calcium Channel Blockers, and beta blockers (all used for treating cardiovascular diseases); Selective Serotonin Reuptake Inhibitors (SSRIs) for treating depression; some drugs for lowering blood cholesterol; and H_2 receptor antagonists for the treatment of peptic ulcers.

Implementation will take effect on 1 February 1998 and will draw on professional and clinical advice.

Funding of $4 million in 1997-98 will be provided to assist pharmacists with the costs of properly advising the community about the details of the measure and other aspects of the cost-effective use of medicines, including the availability of alternative brands.

A two year education campaign including a telephone helpline service will also be funded under this measure. A full economic evaluation of the whole measure will be undertaken in the year 2000.

Impact of the measure:

While Australia's health care system provides excellent equity of access to health care for the community, it is important to ensure that the people who use the system - both doctors and patients - take cost into account in reaching treatment decisions. This measure will encourage greater price competition between suppliers and changes in prescribing patterns.

This measure will affect all general and concessional beneficiaries and will also apply to eligible veterans and their dependants in respect to the Repatriation Pharmaceutical Benefits Scheme, who use drugs in the nominated category.

1997-1998

Table 3: 1997-98 Budget Measures affecting the portfolio's programs

The 1997-1998 Portfolio Budget Statements, informs Senators and Members of Parliament of the proposed allocation of resources to portfolios outcomes and their objectives and targets including the agencies within the Health and Family Services portfolio.

This table summarises the effects on outlays and revenue of 1997-98 Budget Measures. The table lists the title of each measure and details its effect by Sub-program for the three forward years to 2000-2001.

Sub-program	Measure	Estimated Effect on Outlays DoF price adjusted			
		1997-98	1998-99	1999-00	2000-01
		$m	$m	$m	$m
1.1, 2.3	National Public Health - Continuation of Public Health Programs	11.5	22.3	0.0	0.0
1.1, 2.1	Hepatitis B Pre-Adolescent Immunisation Delivery Program	0.2	0.4	0.5	0.5
1.1, 2.1	Restructure arrangements for funding services related to the provision of methadone	0.0	-1.9	-7.8	-9.6
2.1, 2.3	Public education campaign for private health insurance and Health Insurance Commission restructuring	3.5	0.5	0.3	0.0
2.1, 2.3	Pilot study of alternative funding arrangements for rural obstetric services	0.0	0.0	0.0	0.0
2.1, 2.2, 6.2, 6.5, 7.3	Efficiencies in Whole of Government Information Technology Infrastructure	0.0	-1.9	-11.0	-10.5
2.2, 5.1	Revised arrangements for carers of adults and children with disabilities	-0.3	20.4	22.8	25.7
5.1, 5.2	Targeted support for people with dementia and their carers	2.5	2.5	2.6	2.6
1.1	Funding mechanism for the purchase of essential vaccines	2.6	3.9	3.9	4.0

	including Hepatitis B vaccine				
1.2	Development of a National Food Hygiene Standard	0.9	1.7	1.2	0.0
1.2	Supplementation of the Australia New Zealand Food Authority funding base	0.7	1.8	1.6	1.3
1.2	*More Time for Business* - Government Small Business Statement	0.3	0.0	0.0	0.0
1.3	Strengthening Australia's health and medical research workforce	0.8	1.4	2.3	2.6
2.1	Revised process for Medicare Benefits Schedule listing and review	1.5	0.5	-0.5	-3.1
2.1	Link treatment benefit eligibility to pension rate	0.0	-0.1	-0.1	-0.1
2.1	Introduction of electronic commerce for Medicare claiming	-0.1	0.1	11.7	16.4
2.1	Addressing anomalies in entitlements for veterans deployed overseas	-0.1	-0.2	-0.3	-0.4
2.1	Combine General Practice Evaluation Programs and adjust to reflect current spending levels	-2.0	-2.0	-2.1	-2.1
2.1	Adjust Medicare benefits when more than one person is treated during a home visit	-2.0	-3.5	-3.7	-3.8
2.1	Adjust Medicare benefits for some optometrical consultations	-7.8	-13.9	-14.8	-15.5
2.1	Refocusing the General Practice Strategy on outcomes	-34.4	-28.0	-37.9	-39.9
2.2	National Prescriber Service	0.4	-8.1	-8.0	-7.9
2.2	Introduce a Bonus Plan for persons deferring retirement	0.0	-0.6	-1.7	-2.5
2.2	Extend the period of the income test for the 'low income' Health Care Card from four to eight weeks	0.0	-1.7	-1.8	-1.8
2.2	Delisting medicine items for less serious medical conditions from the Pharmaceutical Benefits Schedule	-10.9	-29.7	-33.4	-37.6

2.2	Therapeutic group premiums	-41.4	-157.5	-173.8	-188.7
2.3	Extension of funding for palliative care	14.7	0.0	0.0	0.0
2.3	Initiatives to stimulate microeconomic reform in management of acute health care and information technology and performance measurement	6.1	11.7	12.7	9.8
2.3	National Rural and Remote Health Support Program	2.0	3.6	5.5	6.3
2.4	Renewal of the National Mental Health Strategy	0.2	7.5	11.8	9.0
4.1	Reform of school age care	5.0	5.1	2.5	-1.3
4.1	Increase supply of family day care places	0.7	1.7	3.3	5.1
4.1	Work for the Dole Initiative	0.5	0.1	0.0	0.0
4.1	Pay Childcare Assistance fortnightly in arrears	0.0	-32.5	-3.1	-3.2
4.1	Broadbanding other family and children's services	-3.0	-6.4	-6.6	-6.8
4.1	Improve targeting of Children's Services Program to work related care	-4.4	-16.0	-25.4	-34.9
4.1	A Planning System to influence the location and supply of new child care places with annual limit of 7000 new private places for 1998 and 1999 only	-9.7	-41.8	-72.3	-83.1
4.2	Revised arrangements for emergency relief funding	0.7	1.9	3.0	9.5
5.1	Carers' support and information	1.2	2.3	2.3	2.4
5.3	Residential aged care structural reform - Additional funding for systems development	4.4	0.9	0.2	0.2
5.3	Best practice grants for dementia specific facilities	0.6	0.0	0.0	0.0
6.3	Additional accommodation support places for people with disabilities and their families	5.9	11.8	18.0	18.3
6.4	Funding for National Telephone Typewriter Relay Service	0.0	-7.9	-7.9	-8.0

6.5	Replacement of speech processors for children with cochlear implants	0.6	0.4	0.4	0.5
7.1	Support for social and economic micro-simulation modelling	0.1	0.3	0.3	0.3
	Sub-total	-60.3	-273.1	-305.2	-346.2
Measures announced previously					
2.1	Comprehensive National Immunisation Strategy	3.3	3.3	3.3	3.4
2.2	Amendments to migrant two-year waiting period for social security payments	8.1	0.9	2.8	2.8
	TOTAL	-48.9	-268.9	-299.1	-340.0

Page last modified: 13 May, 1997

1997-1998

2.2: Pharmaceutical benefits

The 1997-1998 Portfolio Budget Statements, informs Senators and Members of Parliament of the proposed allocation of resources to portfolios outcomes and their objectives and targets including the agencies within the Health and Family Services portfolio.

Sub-program Performance Assessment

1. Revised arrangements for carers of adults and children with disabilities

Financial implications:

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
-0.3	-1.6	-1.7	-1.9

This measure also affects Sub-program 5.1, Community Care and Support for Carers, and is fully described in the Portfolio Overview under the heading Explanations of Budget Measures affecting more than one Sub-program, Item 7.

2. Efficiencies in Whole of Government Information Technology Infrastructure

Financial implications:

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
0.0	-0.1	-1.0	-0.9

This measure also affects Sub-programs 2.1, Medicare Benefits and General Practice Development; 6.2, Commonwealth Rehabilitation Service; 6.5, Hearing Services; and 7.3, Information Services and is fully described in the Portfolio Overview under the heading Explanations of Budget Measures affecting more than one Sub-program, Item 6.

3. National Prescriber Service

Financial implications:

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
0.4	-8.1	-8.0	-7.9

Purpose of the measure

To establish a dedicated prescriber support service that will provide medical practitioners with prescribing information, advice and support to achieve more effective prescribing practices.

Expected implementation strategies for the measure

Prescribing is the main treatment option in primary health care throughout Australia and is a major government subsidised health service. Much effort is going into achieving rational prescribing through education initiatives.

The Prescriber Service is expected to commence in March 1998 with nearly $6 million per annum to be provided for a dedicated prescriber decision support service to advise and service the needs of doctors in all regions of Australia, and to manage a Quality Prescribing Research and Innovations grants program to identify and develop effective approaches and resources.

The drug groups that will be targeted initially include peptic ulcer treatments, antibacterials, psycholeptics, analgesics and antihypertensives.

An evaluation is to be undertaken by December 2000.

Impact of the measure

This service will help the medical profession develop best practice clinical standards for prescribing medicine. It will provide doctors with up-to-date information about their prescribing patterns, and access to individually tailored educational resources to support evidence-based, cost-effective and quality prescribing.

Savings from the service in the Pharmaceutical Benefits Scheme are based on improvement in GP prescribing practice which will lead to reductions in overprescribing and/or innappropriate prescribing in a number of drug groups.

4. Introduce a Bonus Plan for persons deferring retirement

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
0.0	-0.6	-1.7	-2.5

This measure has implications across the Social Security and Veternas' Affairs portfolios and flow on effects on the Pharmaceutical Benefits Scheme.

Purpose of the measure

The concept of a Bonus Plan for deferring retirement was set out in the election document, *Meeting Our Commitments*.

The measure encourages greater self provision by older persons, promotes continued participation in the workforce and achieves Budget savings.

Expected implementation strategies for the measure

Under the measure a bonus will be provided to all those who continue to work while they defer take-up of the Age or Service Pension. The Bonus is a lump sum paid at the time of receipt of the pension. It increases for each full year of deferral for work (of at least 25 hours per week) up to a maximum of 5 years.

The amount of the bonus will be equivalent to 9.4% of the Annual Age or Service Pension entitlement (excluding add ons such as Rent Assistance) at the time of take up for each year of deferral. The actual amount paid will hence vary according to the amount of pension to which the person is entitled, and the number of years for which the pension is deferred. For those deferring for the maximum of 5 years, the lump sum will, for example, be equivalent to 47% of annual pension entitlements at the time of take up.

As such workers will not obtain a Pensioner Concession Card, they will not be eligible for benefits under

the PBS at the concessional rate and would continue to access the PBS at the general patient rate.

Impact of the measure

It is estimated that around 22,000 people who are eligible for the bonus will defer their receipt of Age or Service Pension in 1998-99 and that the average length of deferral will be three years.

5. Extend the period of the income test for the 'low income' Health Care Card from four to eight weeks

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
0.0	-1.7	-1.8	-1.8

This measure impacts on the Social Security portfolio and has a flow on effect on the Pharmaceutical Benefits Scheme.

Purpose of the measure

By calculating the the average income over a longer period, this measure will assist in preventing the manipulation of income by some claimants, especially casual workers, in order to obtain eligibility for the Health Care Card. This will improve targeting of Health Care Cards to those in real financial need.

Expected implementation strategies for the measure

Under this measure the period over which average weekly income is measured to qualify for a low income Health Care Card will be extended from the current four weeks to eight weeks. The resulting decrease in the number of persons holding Health Care Cards will mean that these persons will not be eligible for access to benefits on the Pharmaceutical Benefits Scheme at the concessional rate. Such persons will be treated as general patients under the scheme.

Impact of the measure

It is estimated that the measure will result in a reduction in the number of persons gaining access to low income Health Care Cards of around 4,600 per year.

6. Delisting medicine items for less serious medical conditions from the Pharmaceutical Benefits Schedule

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
-10.9	-29.7	-33.4	-37.6

Purpose of the measure

To delete from the Schedule of Pharmaceutical Benefits a number of medicines which generally can be purchased without a prescription for the treatment of common gastro-intestinal problems; an anti-inflammatory liniment for pain relief of sprains and muscle strains; a number of preparations that used to be mixed by pharmacists, but which are now mostly being supplied in a pre-packaged form by manufacturers; and two prescription antifungal products.

Expected implementation strategies for the measure:

A number of medicines will be delisted from the Pharmaceutical Benefits Scheme (PBS) on the basis that they are:

- for less serious medical conditions, most of which do not require a prescription to access;

- items prepared by pharmacists where the commercial equivalent has been, or will be deleted from the PBS schedule; and
- antifungal products used for nail infections which are generally not serious in nature.

Impact of the measure

The PBS lists pharmaceutical products necessary for significant medical conditions in the community. The medications proposed for delisting are generally used to treat minor ailments and most can be bought over the counter and are relatively inexpensive.
Savings will also accrue through reduced expenditure on the subsidisation of prescribing costs and pharmacy dispensing fees.

This change also applies to eligible veterans and their dependants in respect to the Repatriation Pharmaceutical Benefits Scheme.

7. Therapeutic group premiums

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
-41.4	-157.5	-173.8	-188.7

Purpose of the measure

To extend the practice of price premiums beyond generic brands of a drug to groups of drugs which, while not identical chemically, are very similar in clinical effect. A low-priced drug in the group will set a benchmark, and the price difference for higher priced drugs will be paid by the patient. The measure is an extension of the Minimum Pricing Policy, which applies to products that are chemically identical but sold under different brand names.

Expected implementation strategies for the measure

The drug groups affected include: ACE inhibitors, Calcium Channel Blockers, and beta blockers (all used for treating cardiovascular diseases); Selective Serotonin Reuptake Inhibitors (SSRIs) for treating depression; some drugs for lowering blood cholesterol; and H_2 receptor antagonists for the treatment of peptic ulcers.

Implementation will take effect on 1 February 1998 and will draw on professional and clinical advice.

Funding of $4 million in 1997-98 will be provided to assist pharmacists with the costs of properly advising the community about the details of the measure and other aspects of the cost-effective use of medicines, including the availability of alternative brands.

A two year education campaign including a telephone helpline service will also be funded under this measure. A full economic evaluation of the whole measure will be undertaken in the year 2000.

Impact of the measure

While Australia's health care system provides excellent equity of access to health care for the community, it is important to ensure that the people who use the system - both doctors and patients - take cost into account in reaching treatment decisions. This measure will encourage greater price competition between suppliers and changes in prescribing patterns.

This measure will affect all general and concessional beneficiaries and will also apply to eligible veterans and their dependants in respect to the Repatriation Pharmaceutical Benefits Scheme, who use drugs in the nominated category.

8. Amendments to migrant two year waiting period for social security payments

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
8.1	0.9	2.8	2.8

This amendment to a 1996-97 Budget measure of the Social Security portfolio has a financial implication for the Pharmaceutical Benefits Scheme (PBS), as well as within the Social Security portfolio.

Purpose of the measure

In 1996 the Government announced that it would introduce a measure to require newly arrived migrants other than refugees and humanitarian migrants to wait for two years before they could become eligible for social security payments. The measure aimed to provide an incentive for migrants to Australia to ensure that they could provide for their own income support.

The measure would have applied a two year waiting period to most Social Security payments. A two year waiting period was also applied for access to Health Care Cards access to which is usually dependent on being in receipt of most types of Social Security Benefits and the Commonwealth Seniors Health Card.

In addition the measure removed the existing exemption from a waiting period for spouses whose partner had been an Australian resident for at least 26 weeks before their arrival.

Legislation to effect the measure was included in the Social Security Legislation (Newly Arrived Residents Waiting Periods and Other Measures) Bill 1996 introduced into Parliament in March 1996. The Senate requested a number of amendments to this Bill, some of which were accepted by the Government and subsequently passed into legislation.

The costs set out above reflect the loss of savings to the Pharamceutical Benefits Scheme against the original measure announced by the Government, including delaying its date of implementation.

Impact of the measure

In a full year the amended measure will result in an average of 21,000 migrants serving a two year waiting period before being able to receive most Social Security payments and consequently be eligible for concessional benefits under the PBS.

Page last modified: 13 May, 1997

http://www.aph.gov.au/library/pubs/budget/1997-98/1997-98BR10.HTM

Budget Review 1997-98

Detailed Portfolio Reviews

May 1997

8 Health and Family Services

8.1.1 Public Health Development and Programmes
8.2.1 Medicare Benefits and General Practice Development
8.2.2 Pharmaceutical Benefits
8.2.3 Acute Care
8.4.1 Children's Services
8.5.1 Community Care and Support for Carers
8.6.3 Commonwealth/State Disability Agreement

1997–98 BUDGET REVIEW			INFORMATION AND RESEARCH SERVICES	
PORTFOLIO			**HEALTH AND FAMILY SERVICES**	
SUB-PROGRAM			8.1.1 Public Health Development and Programs	
OUTLAYS				
AMOUNTS $ MILLION			1996–97 ESTIMATE	243.0
			1997–98 ESTIMATE	231.9
SIGNIFICANT BUDGET MEASURES				
	EFFECT OF MEASURE ON BUDGET OUTLAYS $ MILLION			
MEASURE	1997–1998	1998–1999	1999–2000	2000–2001
Continuation of Public Health Programs	11.5	21.1	0.0	0.0
Funding for methadone services	0.0	-1.9	-7.8	-9.6

COMMENT

Continuation of National Public Health Programs

In the 1996-97 Budget, the Government announced that it would seek to broadband eight public health programs into a single National Public Health Program. Funding for some elements of the National Public Health Program, including the National Women's Health Program, the National Breast Cancer Centre, Health Australia (Tobacco Minimisation Strategy) and Hepatitis C Surveillance and Education was due to expire during 1997-98 and 1998-99. Although this measure will provide ongoing funding for each of these programs, a detailed breakdown of funding for each program is not yet available.

The framework for the funding and delivery of the National Public Health Program will be provided under the new Public Health Agreements currently under negotiation between the

Commonwealth and each State and Territory. A Public Health Agreement is expected to be signed by the Commonwealth Government and each State and Territory Government by 1 July 1997 and will cover the period 1997-98 to 1998-99. Ongoing funding has therefore been provided for only the next two financial years. Under the proposed Public Health Agreement, funding by way of Specific Purpose Payments will no longer be provided for each element of the National Public Health Program. Rather, the Commonwealth Government will allocate a block grant to each State and Territory for the delivery of all elements of the program.

Restructure Arrangements for Funding Services Related to the Provision of Methadone

This measure removes Commonwealth funding for methadone services from Medicare and proposes instead to fund these services under the National Public Health Program. The rationale for these new arrangements is a perceived level of inappropriate use of consultations and urinalysis services under Medicare. Under the new arrangements, Medicare benefits will no longer be available for consultations with private medical practitioners and for urinalysis relating to methadone clients. The proposed new funding arrangements will provide funding to the States and Territories on the basis of an annualised allocation per private methadone patient. This allocation will be calculated from the average number of private patients treated in each State and Territory during the previous 12 months, with adjustments for inflation and growth in the number of patients. The payment is intended to cover assessment, stabilisation and ongoing treatment.

This measure will not be implemented until 1 November 1998, following trials to test its feasibility. The trials are expected to commence in September 1997 and will be evaluated prior to negotiations with the States and Territories over the new funding arrangements. The measure will cost some $49.8 million over the three years from 1998-99, but this cost is expected to be offset by savings to Medicare of $69.1 million over the same period. The net savings are included in the above table of significant Budget measures.

Immunisation

The 1997-98 Budget includes several initiatives aimed at improving Australia's immunisation rate against preventable communicable diseases. In February 1997, the Commonwealth Government announced a package of initiatives aimed at increasing Australia's low level of immunisation. This package includes a two-pronged approach which links age-appropriate immunisation status with entitlement to a range of income support payments, including Maternity Allowance, Childcare Assistance and the Childcare Cash Rebate and provides incentives to general practitioners for increasing the level of immunisation coverage. Readers are directed to the Press Release by the Minister for Health and Family Services of 25 February 97 for details of these and other initiatives included in the new National Immunisation Strategy (Immunise Australia). These measures are estimated to impose costs of $13.3 million on the Health and Family Services portfolio over the four years from 1997-98 but are estimated to save some $24.6 million in the Social Security portfolio over the same period. The measures will commence on 1 January 1998.

A Hepatitis B Pre-Adolescent Immunisation Delivery Program, together with a new funding mechanism for the purchase of essential vaccines, including hepatitis B, have also been funded in the 1997-98 Budget. These initiatives provide specific funding for the delivery of hepatitis B vaccine (HBV) in the school setting. Under these measures, the Commonwealth Government will provide funding for the vaccine and will also contribute up to 50% of the additional costs of delivering the vaccinations in schools. The States and Territories will be responsible for the delivery of the program and provision of the remaining funding. The Commonwealth will provide more than $14 million over the four years from 1997-98 for the

purchase of the vaccine ($3.9 million in a full year) and a further $5.6 million over four years towards the costs of delivering the vaccinations ($1.6 million in a full year).

Funding for vaccines is provided under the National Childhood Immunisation Program (NCIP), which is one of the elements of the National Public Health Program. The new arrangements under which funding will be provided to the States and Territories for the purchase of HBV will also apply to future funding approvals for new vaccines as each is listed on the National Health and Medical Research Council's Standard Childhood Vaccination Schedule.

1997–98 BUDGET REVIEW			INFORMATION AND RESEARCH SERVICES	
PORTFOLIO			**HEALTH AND FAMILY SERVICES**	
SUB-PROGRAM		8.2.1 Medicare Benefits and General Practice Development		
OUTLAYS				
AMOUNTS $ MILLION			1996–97 ESTIMATE	6674.5
			1997–98 ESTIMATE	6984.3
SIGNIFICANT BUDGET MEASURES				
	EFFECT OF MEASURE ON BUDGET OUTLAYS $ MILLION			
MEASURE	1997–1998	1998–1999	1999–2000	2000–2001
Refocus General Practice Strategy on outcomes	-34.4	-28.0	-37.9	-39.9
Revised process for Medicare Benefits Schedule listing and review	1.5	0.5	-0.5	-3.1
Introduction of electronic commerce for Medicare claiming	-0.1	0.1	11.7	16.4
COMMENT				

Refocussing the General Practice Strategy on Outcomes

A key element of the General Practice Strategy, the Better Practice Program (BPP) was launched in November 1994 to provide an alternative to fee-for-service as a means of remunerating general practitioners (GPs). The focus of the BPP was the provision of quality patient care and aimed to encourage continuity of care for patients, improved after-hours care and home visits. The BPP has not enjoyed universal support amongst GPs and has been strongly opposed by the Australian Medical Association (AMA). Despite this opposition, the number of medical practices participating in the BPP has grown steadily, from 104 in February 1995 to 735 in May 1995, 1638 in November 1995 and 1822 in November 1996. However, average payments under the BPP have remained a very minor proportion of the remuneration of GPs.

The Government announced in January 1997 that a review of the BPP would be conducted and a discussion paper was issued to stimulate debate on alternative options for change. This measure announces that the Government intends to conduct discussions with the medical profession for a change in the focus of the BPP as part of a wider review of the General Practice Strategy. The review is expected to lead to a refocussing of the BPP away from the operational aspects of general practice and more towards the medical outcomes of patient care. The review is also expected to result in a restructuring of payments to general practitioners under the BPP. This measure is expected to commence on 1 February 1998 and is projected to save some $140 million from the forward estimates over the four years from 1997-98.

Revised process for Medicare Benefits Schedule Listing and Review

This measure proposes a change in the process by which new and emerging medical procedures and technologies are evaluated prior to listing on the Medicare Benefits Schedule (MBS). This measure proposes the establishment of a new Medicare Services Advisory Committee (MSAC) to both assess new procedures and reassess existing procedures covered by MBS items, although its principal function will be to advise the Minister for Health and Family Services on the inclusion of new items in the MBS. Membership of the new MSAC is yet to clarified, as are the respective roles of the MSAC and the existing Medicare Benefits Advisory Committee and Medicare Benefits Consultative Committee.

The key policy change contained in this measure is the proposal to use evidence-based medicine as the means of assessment of the safety, efficacy and cost effectiveness of new and existing medical procedures. Where insufficient evidence exists to fully assess a new procedure, this measure proposes that interim listing may be considered for the service in order to permit further research. Some funding, albeit limited, will be available for this purpose. This measure applies an evaluation and assessment process including an emphasis on cost-effectiveness which is similar to that used in the scrutiny of new pharmaceutical products prior to their listing on the Pharmaceutical Benefits Schedule. This measure will involve estimated outlays of $15 million over the four years from 1997-98, however savings against Medicare are expected to result in an overall saving of $1.5 million over the same period. The measure is expected to commence in February 1998.

Introduction of Electronic Commerce for Medicare Claiming

This measure proposes the introduction of electronic claiming of Medicare benefits directly from doctors' surgeries. Previously, only bulk-billed claims could be lodged in this way. It will be possible for patients to lodge electronically both a patient claim (where the bill has been paid) and a pay doctor claim (where the bill has not been paid). In the case of a patient claim, the refund cheque will be sent to the patient's home address. Doctors' surgeries are expected to commence their participation in the expanded electronic claiming system towards the end of 1997.

Savings from the more efficient payment of Medicare benefits will obviate the need for closure of Medicare offices in rural areas, however some 40 Medicare offices in metropolitan areas are to be closed by March 1998.

This measure is expected to result in increased outlays of $28.1 million over the four years from 1997-98, due to the increased costs to Medicare benefits because of reduced payment delays from electronic claiming. However, the Budget papers note that 'these are short term costs only and will not be relevant when the new system is fully implemented' (Health and Family Services Portfolio, *Portfolio Budget Statements 1997-98*: 124). Savings from this measure are also expected to offset some of the costs of the proposed separation of Medibank Private from the Health Insurance Commission.

PORTFOLIO **HEALTH AND FAMILY SERVICES**

SUB-PROGRAM 8.2.2 Pharmaceutical Benefits

OUTLAYS

AMOUNTS $ MILLION

1996–97 ESTIMATE	2527.4
1997–98 ESTIMATE	2820.4

SIGNIFICANT BUDGET MEASURES

	EFFECT OF MEASURE ON BUDGET OUTLAYS $ MILLION			
MEASURE	1997–1998	1998–1999	1999–2000	2000–2001
Therapeutic group premiums	-41.4	-157.5	-173.8	-188.7
Delisting medicines	-10.9	-29.7	-33.4	-37.6

COMMENT

The Pharmaceutical Benefits Scheme (PBS), which provides subsidised access to a wide range of pharmaceutical drugs and preparations, has experienced significant rates of growth in outlays over recent years, despite several policy initiatives during the 1990s designed to curb such growth. While each initiative has limited the rate of growth in outlays in the short term, the trend over the longer term has seen a return to high rates of growth. Key drivers of growth in PBS outlays include an increasing trend in the prescribing of newer and often higher cost, drugs and the ageing of the population. A possible related factor is the increasing number of people covered by the concessional category (currently at around one third of the population) which accounts for some 80% of the cost to Government of the PBS.

The Sub-program is estimated to provide substantial savings against the forward estimates in 1997-98 and over the out-years to 2000-01. The 1997-98 Budget introduces several initiatives aimed at reducing the rate of growth in PBS outlays to more sustainable levels and follows several measures introduced in the 1996-97 Budget, which were estimated to save in excess of $650 million from the forward estimates over the four years from 1996-97. Significantly, the Budget papers forecast that following a substantial reduction in the trend growth rate in 1998-99, PBS outlays will again return to high levels of growth from 1999-2000.

Therapeutic Group Premiums

This measure introduces a significant policy change to the administration of the PBS and is expected to save in excess of $560 million over the four years to 2000-01. The measure follows, and extends, earlier policy decisions to encourage the substitution of some brand name drugs with generic, chemically equivalent drugs. The measure will affect six groups of drugs: angiotensin-converting enzyme (ACE) inhibitors, Calcium Channel Blockers, and beta blockers (all used in the treatment of cardiovascular disease), Selective Serotonin Re-uptake Inhibitors (SSRIs) used in the treatment of depression, some drugs used to lower blood cholesterol, and H2 receptor antagonists which are used in the treatment of peptic ulcers. A low-priced drug in each of the six drug groups will set the benchmark price which the Government will subsidise for the category and where a more expensive drug is prescribed, the patient will pay the difference in price. Precisely how high this extra cost will be is yet to be established. The Government reportedly estimates that the average difference in the prices of drugs in each group is $4.00, while the largest difference in price is about $14.00 for one particular drug. In its Budget media releases, the Government announced its expectation that competition will restrict the price premium to approximately $2.00. The significant difference between the new therapeutic price strategy and the existing generic substitution policy is that the drugs in each of the six groups described above are not chemically equivalent but rather have similar clinical activity.

The Pharmacy Guild of Australia supports the introduction of the therapeutic group premium initiative, noting that while some patients will pay more for some pharmaceuticals, 'the successful implementation of therapeutic group premiums should result in savings so that a wider range of lifesaving drugs can be provided through the Pharmaceutical Benefits Scheme' (Pharmacy Guild of Australia, Media Release, 13 May 1997). Various types of benchmark pricing or reference pricing schemes are operating in other countries, including Germany, Canada (British Colombia) and New Zealand. The Canadian Cardiovascular Society reportedly opposes the recent expansion of British Colombia's reference-based pricing (RBP) scheme to include ACE inhibitors and dihydropyridine calcium channel blockers, claiming that 'savings have not been achieved in other countries that have introduced RBP schemes'. The Society argues that 'supporters of RBP point to the savings for the drug plans, but fail to consider the additional costs to hospital and physician reimbursement Budgets' (*Scrip*, 4 February 1997: 15).

In setting its subsidy at the level of one drug in each therapeutic group, the Government aims to achieve a greater degree of awareness on the part of doctors and patients of the cost of some commonly prescribed pharmaceuticals. This measure is expected to commence on 1 February 1998, following advice from the Pharmaceutical Benefits Advisory Committee (PBAC).The Minister for Health and Family Services has indicated that legislation will not be required for implementation of the initiative. This measure will also apply to eligible veterans and their dependents under the Repatriation Pharmaceutical Benefits Scheme (RPBS). A full economic evaluation of this measure is to be undertaken in the year 2000.

Delisting Medicines

Several drugs will be deleted from the PBS under this measure, which is estimated to save some $112 million over the four years from 1997-98. Some $75 million of this total is expected to be saved through the delisting of two prescription antifungal products used to treat minor nail infections. The drugs to be delisted are generally prescribed for the treatment of minor conditions and many can be bought over the counter for prices in the range $2.45 to $9.65. Concessional category patients who currently pay a maximum co-payment of $3.20 per PBS prescription will experience increased charges for these items. The introduction of this measure reinforces the view that the primary rationale of the PBS is to subsidise access to pharmaceuticals used in the treatment of significant medical conditions. The measure also applies to the RPBS and is expected to take effect from 1 January 1998, following advice from PBAC. This measure will not require legislation for its implementation.

1997–98 BUDGET REVIEW			INFORMATION AND RESEARCH SERVICES	
PORTFOLIO			**HEALTH AND FAMILY SERVICES**	
SUB-PROGRAM			8.2.3 Acute Care	
OUTLAYS				
AMOUNTS $ MILLION			1996–97 ESTIMATE	51013
			1997–98 ESTIMATE	56745
SIGNIFICANT BUDGET MEASURES				
	EFFECT OF MEASURE ON BUDGET OUTLAYS $ MILLION			
MEASURE	1997–1998	1998–1999	1999–2000	2000–2001
Extension of funding for palliative care	14.7	0.0	0.0	0.0
Microeconomic reform	6.1	11.7	12.7	9.8
COMMENT				

Extension of Funding for Palliative Care

Funding for the four-year Palliative Care Program (PCP) was due to cease on 30 June 1997. This measure proposes to extend funding for the PCP for a further 12 months and provides $14.7 million for this purpose. Funding for the PCP in 1997-98 is to be provided to the States and Territories at the same level in real terms as was allocated in 1995-96. Considerable controversy followed the Government's announcement of a 10 % efficiency saving from the PCP in the 1996-97 Budget. This controversy developed further in 1996-97 due to discussion of the adequacy of palliative care funding and services during the euthanasia debate. Funding for palliative care beyond 1997-98 is to be considered in the context of negotiations between the Commonwealth and the State and Territory Governments over the new Medicare Agreements. The current Medicare Agreements are due to cease on 30 June 1998.

Microeconomic Reform Information Technology and Performance Measurement Initiatives

Several initiatives are proposed under this measure, which is designed to reduce costs and improve services for acute care hospital patients through improved management of the public acute care sector. The current Medicare Agreements contain several initiatives aimed at improving the performance of acute care hospitals. The initiatives in the 1997-98 Budget build upon and extend earlier initiatives and are focussed on three main areas: microeconomic reform, information technology, and performance information.

In the area of microeconomic reform, ways to improve the involvement of patients in their health care will be investigated. Examples could include the representation of consumers on hospital planning committees and their involvement in focus groups. Types of acute care which can be substituted by innovative services will also be investigated under this initiative.

National standards and specifications for electronic forms of patient records, electronic decision systems and electronic links between medical providers are proposed to be developed as part of this initiative. Issues of privacy and confidentiality are identified as key components to be resolved.

The Commonwealth Government is already working with the States and Territories and other stakeholders to develop indicators which can be used to monitor the current performance of the acute hospital sector as well as its progress towards reform. For example, the Steering Committee for the Review of Commonwealth-State Service Provision has produced two reports to date on *Government Service Provision*, which have included an evaluation of the performance of the public acute hospital sector in each State and Territory. The most recent report, for 1997, noted that 'more work is needed to produce valid and nationally comparable effectiveness and efficiency indicators for public acute hospitals' (p. xxxi). New funding provided under this Budget measure is expected to 'allow refinement of the indicators of hospital system performance and the treatment of specific conditions' (Health and Family Services Portfolio, Budget Fact Sheet No. 8).

The initiatives under this measure are proposed to be delivered in cooperation with the States and Territories and are expected to involve outlays by the Commonwealth of some $40.3 million over the four years from 1997-98.

PORTFOLIO **HEALTH AND FAMILY SERVICES**

SUB-PROGRAM 8.4.1 Children's Services

OUTLAYS

AMOUNTS $ MILLION		
1996–97 ESTIMATE	1113.0	
1997–98 ESTIMATE	1199.0	

SIGNIFICANT BUDGET MEASURES

	EFFECT OF MEASURE ON BUDGET OUTLAYS $ MILLION			
MEASURE	1997–1998	1998–1999	1999–2000	2000–2001
Reform of school age care	5.0	5.1	2.5	-1.3
Childcare Assistance paid in arrears	0.0	-32.5	-3.1	-3.2
Broadbanding of services	-3.0	-6.4	-6.6	-6.8
Limit non work related childcare	-4.4	-16.0	-25.4	-34.9
Limit allocation of private places	-9.7	-41.8	-72.3	-83.1

COMMENT

The 1996-97 Budget introduced a series of structural changes to the Children's Services Program which redirected the financial responsibility for childcare more clearly on to the service user and which resulted in greater competitive neutrality between the private and not-for-profit service providers. These changes resulted in an average national weekly childcare cost increase to families with one child in care of about $20 and an estimated national reduction in child care centre use of about 20% (Health Insurance Commission, Monthly Program Statistics, March 1997). Childcare centre use is now of a similar level to that of early 1996.

This year's Budget continues this approach and redirects financial assistance away from non-work-related child care. It brings subsidy levels for after school care into line with payments for care in long day care centres, limits the growth of private sector child care places for the next two years and alters the timeframe and location for the provision of new Family Day care places. It also introduces payment of Childcare Assistance in arrears from 1 January 1999.

These measures will save the Commonwealth Government $292.6 million over the next four years.

The measures likely to have the greatest impact are those relating to the limits proposed to be placed on both non-work-related childcare assistance and private sector places which are eligible for childcare assistance.

The first of these measures introduces a limitation of 20 hours a week on financial assistance provided for non-work-related access to community and private long day care centres, family day care, outside school hours and vacation care services. The existing limitation is 50 hours a week.

Families wishing to access these services for more than 20 hours a week will receive no additional financial assistance unless they undergo a similar work test to that presently used in determining eligibility for Childcare Cash Rebate.

The measure may result in a reduction in the level of community based activity undertaken by families. It may also reduce the level of non-institutional personal development which presently occurs, and may encourage more formal training and work related activity.

The other measure limits the growth in private sector child care places to 7000 a year for the 1998 and 1999 calendar years. This figure equates to the anticipated labour market

participation growth over the next two years by parents with young children. The Government estimates that total private sector demand growth over this period will be 22 000 places.

The 1996-97 Budget measures have had the effect of reducing the use of private and community sector childcare facilities, to the extent where many are reportedly becoming financially non-viable. It is inevitable that there will be facility closures over the next two years as market forces and demographics have their impact. The Government has stated it intends to encourage allocation of the 14 000 private sector places which will be eligible to attract Childcare Assistance in high need areas.

The issue will be what happens to the estimated 8000 private sector childcare places which will be required, but which will not attract Childcare Assistance eligibility. One possible result may be a continuation of the recent trend, of further reduction in the national numbers of two working parent families. (ABS Publication 6220.0 shows that there has been an increase of about 17% in women exiting the workforce because of childcare reasons.)

1997--98 BUDGET REVIEW			INFORMATION AND RESEARCH SERVICES	
PORTFOLIO			**HEALTH AND FAMILY SERVICES**	
SUB-PROGRAM			8.5.1 Community Care and Support for Carers	
OUTLAYS				
AMOUNTS $ MILLION			1996–97 ESTIMATE	646.3
			1997–98 ESTIMATE	698.4
SIGNIFICANT BUDGET MEASURES				
	EFFECT OF MEASURE ON BUDGET OUTLAYS $ MILLION			
MEASURE	1997–1998	1998–1999	1999–2000	2000–2001
Changes to disability carer arrangements	0.0	22.0	24.5	27.6
COMMENT				

While the Budget measure provides for an increase of $74.1 million over the next four years in community carer support, this measure largely reflects changed administrative arrangements designed to better target assistance to carers. It redirects funds away from child disability allowance (CDA) payments and into domiciliary nursing care benefits (DNCB) paid to carers providing for aged and disabled people in their homes. There are also some minor changes in associated pharmaceutical benefits and carer payments.

The following table illustrates the net financial effect of the combined measures and illustrates the shift form CDA to DNCB (community carer support).

Program	*Measure*	*1997-98*	*1998-99*	*1999-2000*	*2000-01*
2.2	Pharmaceutical Benefits	-0.3	-1.6	-1.7	-1.9
2.3	Carer Payments	0.0	3.6	4.4	4.5
2.6	Child Disability Allowance	-7.5	-25.3	-29.6	-35.0

5.1	Community Carer Support	0.0	22.0	24.5.	27.6
TOTAL		-7.8	-1.3	-2.4	-4.8

The net financial effect of the revised arrangements across the Health and Family Services and Social Security portfolios is a reduction in outlays of $17.3 million over four years. As well as this, carers of non-disabled adults will be eligible for part of the increased community carer support funds and may access these funds at the expense of carers of people with disabilities.

1997–98 BUDGET REVIEW — INFORMATION AND RESEARCH SERVICES

PORTFOLIO — **HEALTH AND FAMILY SERVICES**

SUB-PROGRAM — 8.6.3 Commonwealth–State Disability Agreement

OUTLAYS

AMOUNTS $ MILLION

1996–97 ESTIMATE	310.1
1997–98 ESTIMATE	316.4

SIGNIFICANT BUDGET MEASURES

	EFFECT OF MEASURE ON BUDGET OUTLAYS $ MILLION			
MEASURE	1997–1998	1998–1999	1999–2000	2000–2001
Additional accommodation support	5.9	11.8	18.0	18.3

COMMENT

There has been very strong sector pressure for increased supported accommodation places to be made available for people with disabilities. This Budget provides for the Commonwealth to make available an additional $54 million over the next four years towards the cost of an additional 500 supported accommodation places.

Provision of accommodation is a State and Territory responsibility under the existing program arrangements. The effectiveness of this Budget proposal rests with the capacity and willingness of State and Territory Governments to contribute their $162 million share of the additional costs of providing the accommodation places.

The increase in supported accommodation places as outlined in the Budget is subject to the successful renegotiation of the Commonwealth-State Disability Agreement.

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Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 06

OUTCOME 2 – Access to Pharmaceuticals

Topic: Agenda – Pharmaceutical Benefits Advisory Committee (PBAC)

Hansard Page: CA 109

Senator Ryan asked:

1. If the PBAC were, of its own accord – not due to a request from the Minister – undertaking some work on therapeutic groups, would that appear on the PBAC agenda?
2. What would be the criteria for this to appear or not appear on the agenda?

Answer:

1. Yes.

2. A list of the submissions being considered at each regular PBAC meeting is published on the Department of Health and Ageing website (www.health.gov.au) and the Pharmaceutical Benefits Scheme website (www.pbs.gov.au) around six weeks before the meeting. The only items not included in the published list are those that meet one of the following criteria:

- Agenda items that relate to manufacturer submissions that concern the price of a PBS item alone;
- Agenda items referred to the PBAC by the Minister in confidence; and
- Items that are included in the Late Papers to the PBAC as they are received after the agenda has been finalised.

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 07

OUTCOME 2 – Access to Pharmaceuticals

Topic: Medicines Australia evidence

Hansard Page: CA 110

Senator Fierravanti-Wells asked:

Evidence was given earlier about a medication (commitment) given to Medicines Australia by the then opposition – now the Government – in relation to reviewing the 10-20% threshold. As part of the brief to the incoming government, was that one of the issues that would have been covered?

Answer:

No.

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 08

OUTCOME 2 – Access to Pharmaceuticals

Topic: Definition of 'interchangeable at an individual patient level'

Hansard Page: CA 110

Senator Fierravanti-Wells asked:

1. What is the definition, or is there a definition in legislation of what is 'interchangeable at an individual patient level.'

Answer:

The requirement in the legislation is that the inclusion of a drug in a therapeutic group is based on the expert advice of the Pharmaceutical Benefits Advisory Committee (PBAC) that drugs are interchangeable at the individual patient level. This is the definition in the legislation.

Interchangeable at the patient level means that the independent expert PBAC judges that some drugs are very alike and work just as well as one another for the vast majority of people.

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 09

OUTCOME 2 – Access to Pharmaceuticals

Topic: Education campaign - Therapeutic Groups

Hansard Page: CA 111

Senator Fierravanti-Wells asked:

1. Could you outline the provisions that were made by the then government to an education campaign to minimise confusion and risks to patients, which I understand was done at the time of introduction (of therapeutic groups in 1997-1998).

Answer:

Funding of $4 million was provided to assist pharmacists with the costs of advising the community about details of the measure in the 1997 – 98 Budget which established the Therapeutic Groups Premium policy.

A two year education campaign including a telephone hotline service was also funded. The Budget papers do not detail the funding allocated for this education campaign.

The education campaign included:

- Direct mailings to prescribers of PBS medicines;
- A telephone help line service;
- A health professionals and consumer groups information kit;
- Consumer leaflets for distribution by medical practices and pharmacies;
- Articles in the Health Insurance Commission (now Medicare Australia) Forum and other professional and consumer group newsletters; and
- An insert in the Schedule of Pharmaceutical Benefits, which at the time, was distributed free-of charge to doctors and community pharmacies at each update.

A number of these information resources continue through to the present time including the Schedule of Pharmaceutical Benefits which is available electronically on www.pbs.gov.au or via subscription from CanPrint Communications Pty Ltd, the Department of Health website, www.health.gov.au, the Medicare Australia website, www.medicare.gov.au and commercially available doctor's prescribing software and product information compendia such as MIMs Australia.

Finally, the consumer access portal of the pbs.gov.au website also includes information on therapeutic group policy and the drugs contained in therapeutic groups.

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 10

OUTCOME 2 – Access to Pharmaceuticals

Topic: Consultant - Therapeutic Groups

Hansard Page: CA 111

Senator Fierravanti-Wells asked:

Dr Whiteford is still in the Department and given the evidence that he previously gave, was he at any point a consultant in relation to the therapeutic groups that are now being formed which clearly involve antidepressant drugs as well?

Answer:

No. The Government received advice from the Pharmaceutical Benefits Advisory Committee.

Community Affairs References Committee

ANSWERS TO QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Consumer Access to Pharmaceutical Benefits
7 May 2010

Question no: 11

OUTCOME 2 – Access to Pharmaceuticals

Topic: Advice for practitioners

Hansard Page: CA 112

Senator Moore asked:

1. What is the process for advising practitioners, particularly general practitioners, about how these systems work? Is that coming through PBAC? Is that coming through the Department? Is that coming through Medicare? Where do people go to understand the process to know what drugs are listed, what costing process is used and how a therapeutic group operates, particularly while already operating in the system?

Answer:

Please see the answer to Question on Notice No 09 (CA 111).