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# AMA submission – National Health Amendment (Pharmaceutical Benefits) Bill 2014

The AMA opposes the proposed amendments to the *National Health Act 1953* which will increase patient co-payments and safety net thresholds for the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS).

The rationale behind the amendments is flawed on many levels.

Firstly, the Government's claim that these amendments are necessary to ensure the sustainability of the health care system[1] is false.

The Productivity Commission's *Report on Government Services 2014* found that the PBS had the slowest growth in cost across all areas of health expenditure in the last 10 years to 2011-12. The PBS grew an average of only 0.2% each year.[2] In 2012-13, PBS expenditure actually decreased 2.1% from the previous year[3].

Secondly, the amendments will cost the Government and taxpayers more, rather than deliver savings, if patients delay or do not fill their prescriptions for medicines because of the additional out-of-pocket costs imposed.

According to the Australian Bureau of Statistics, 9% of adults delayed or did not collect their prescriptions in 2010-11[4]. The influence of prescription costs in this behaviour is well documented[5].

In addition, Australian and international research specifically measuring the impact of *increases* to prescription co-payments, overwhelmingly shows that it leads to even poorer patient adherence to prescriptions.

Hynd et al[6] observed that, following an increase in the PBS co-payment in January 2005, there was a significant decrease in dispensing volumes in 12 of 17 medicine categories – anti-epileptics, anti-Parkinson's treatment, combination asthma medicines, eye drops, glaucoma treatment, osteoporosis treatment, proton-pump inhibitors and thyroxine. All of these medications seek to maintain a patient's condition, improve function and quality of life, prevent complications and reduce morbidity and mortality. Hynd also found that social security beneficiaries were particularly impacted by the increase in the co-payment.

A literature review by Eaddy et al[7] identified clear relationships between cost sharing, adherence, and outcomes, with 85% of the reviewed studies on treatments for diabetes, cardiovascular, mental health and pulmonary conditions showing that an increase in patient

share of medication costs was significantly associated with a decrease in adherence. They concluded that plans by decision makers to increase the level of patient cost sharing for prescription drugs to slow the rising cost of health care may be short-sighted and counterproductive because increases in medical utilisation due to poorer outcomes may outweigh the savings from lower prescription drug use.

An international systematic review and meta-analysis of published studies ranging from 1946 to 2012 examining the impact of introducing or increasing a prescription co-payment on publicly insured populations also confirmed increases in objective measures of medicine non-adherence[8].

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

US studies examining downstream health care costs of prescription non-adherence found that the risk of heart attack, stroke and angina doubled for patients who do not adhere to their hypertension medications compared to those that do; and non-adherence to statins and hypertensives is significantly associated with hospitalisations and death[9].

In Australia a typical patient, 'Ms X', with established heart disease (cardiac failure and atrial fibrillation) will need to take a suite of medicines for the rest of her life, e.g dabigatran, frusemide, nebivolol, candesartan, rosuvastatin and isosorbide. Three of Ms X's medicines – dabigatran, nebivolol and rosuvastatin – will be affected by the $5 general co-payment increase[10].

If Ms X needs to fill three co-payment scripts each month, the Government will 'save' $3600 over twenty years in today's dollars. However, if patients like Ms X do not remain on their medications, they may need either a coronary bypass, a stent, or other costly intervention. According to the Independent Hospital Pricing Authority, the 'nationally efficient price' for a coronary bypass in 2013-14 is $28,374[11]. This clearly illustrates the small cost of medicine for first line treatment, even when taken over a long period, compared to the cost of acute treatment.

Australian studies confirm the negative outcomes of co-payments increases, and the particular impact on the most vulnerable in our community – those on low incomes and with chronic medical conditions needing to take multiple medications[12]. This will be compounded by the proposed Medicare co-payments.

Further, the financial costs from missing out on health care go well beyond the health system. People with poorly controlled chronic illness are less likely to earn an income and pay taxes and are more likely to need support from other government services. The implications for Australia of increasing the PBS co-payment and the safety net threshold is therefore of serious economic concern.

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[1] Senator Fiona Nash *Budget Estimates Hansard*, Community Affairs Legislative Committee, Parliament of Australia, 2 June 2014, page 44
[2] Productivity Commission *Report on Government Services 2014* Table EA.7
[3] PBS *Expenditure and prescriptions twelve months to 30 June 2013* http://www.pbs.gov.au/info/browse/statistics#Expenditure
[4] Australian Bureau of Statistics *Year Book Australia 2012* Table 11.24
[5] Ortiz M *Are prescription co-payments compromising patient care?* Australian Prescriber 2013; 36(1):2-3
[6] Hynd A, Roughhead EE, Preen DB, Glover J, Bulsara M. Semmens J. *The impact of co-payment increases on dispensing of government-subsidised medicines in Australia.* Pharmcoepidemiology and Drug Safety 2008 Nov, 17(11):1091-9
[7] Eaddy MT, Cook CL, O'Day K, Burch SP, Cantrell CR *How patient cost-sharing trends affect adherence and outcomes.* Pharmacy and Therapeutics Vol 37 No. 1 January 2012
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[9] Cherry SB et al *The Clinical and Economic Burden of Non adherence with Antihypertensive and Lipid-Lowering Therapy in Hypertensive Patients* Value in Health 2009 12(4):489–497; and *The modelled lifetime cost effectiveness of published adherence-improving interventions for anti-hypertensive and lipid-lowering medications* Value in Health 2010 13(6):685-694
[10] Consumer prices sourced from http://www.pbs.gov.au
[11] Independent Hospital Pricing Authority, coronary artery bypass nationally efficient price for 2013-14 in a public hospital, http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/content/media-2013-02-28-NEP-2013-14-release
[12] Kemp A et al *Impact of cost of medicines for chronic conditions on low income households in Australia* Journal of Health Services Research and Policy 2013; 18(1):21-27