Representing consumers on national health issues

Consumers Health Forum of Australia

Ms Jeanette Radcliffe
Secretary
Community Affairs Legislation Committee
Australian Senate
Parliament House
Canberra ACT 2600

Dear Ms Radcliffe

Please find attached a submission from the Consumers Health Forum of Australia in relation to the Community Affairs Legislation Committee Inquiry into the *National Health Amendment (Pharmaceutical Benefits) Bill 2014.*

We very much appreciate the opportunity to contribute information, on behalf of Australian health consumers, to the Committee's deliberations on this important matter.

Should you require any further information, please do not hesitate to contact Ms Priyanka Rai, CHF Policy Officer

Yours sincerely

Adam Stankevicius
Chief Executive Officer

24 July 2014

Consumers Health Forum of Australia

Submission to the Senate Community Affairs Legislation Committee

Inquiry into the *National Health Amendment (Pharmaceutical Benefits) Bill 2014*

July 2014

Consumers Health Forum of Australia

Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF welcomes the opportunity to provide a submission to the Senate Community Affairs Legislation Committee Inquiry into the *National Health Amendment (Pharmaceutical Benefits) Bill 2014* (the Bill). Our submission draws on extensive consultation with members over recent years in relation to out of pocket expenses and pharmaceuticals issues.

CHF has strongly opposed policies that increase consumer out-of-pocket costs through the imposition of new or increased co-payments. We have raised these concerns consistently through previous submissions to Senate Committee inquiries. CHF's commissioned research on out-of-pocket costs highlights many of the complex and negative aspects of co-payments in health care. (Attachment A). Our call to address the rising consumer burden of healthcare in Australia is supported by this consumer- centred research.

Background

The Pharmaceutical Benefits Scheme (PBS) is the main funding mechanism for prescription medicines in Australia. Currently, the amount paid by consumers varies, up to a maximum of $36.10 for general patients and $5.90 for those with a concession card[1]. Concessional patients receive a greater subsidy and pay less for medicines than general patients. There is also a safety-net which reduces the co-payment once an annual threshold is reached.

The amendments to the Bill now seek to increase the concessional patient co-payment by 80 cents to $6.90, increase the general patient co-payment by $5.00 to $42.70, and continue with annual CPI increases. These amendments will also be accompanied by an increase the concessional safety net threshold by two prescriptions each year and a similar increase in the general patient safety net threshold by 10 per cent each year for four years. From 2016, a new Medicare Safety Net will be introduced with lower thresholds for most people.

The Consumer Impact of Co-Payments

Co-payments compound the existing burden of out-of-pocket costs

Research already makes it clear that existing levels of consumer out-of-pocket payments already comprise over 17% of total health care expenditure in Australia, making consumers the largest non-government source of funding for health goods and services. [2]

According to a recent study by Commonwealth Fund[3], Australian consumers are already contributing a larger part of the health bill than their counterparts in most other developed western countries. Most significantly, 39% of the $24.8 billion of consumer funded health care in 2011-12 was for medicines.[4]

Evidence is emerging that more patients are not filling their prescriptions. According to the Australian Bureau of Statistics, 9% of adults will delay or not collect their prescriptions[5] due to cost.

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[1] Department of Health 2013. Patient charges. Canberra: Department of Health.
[2] Australian Institute of Health and Welfare Health Expenditure Australia 2011/12 2013 AIHW
[3] David Squires Multinational Comparisons of Health Systems Data, 2013 Commonwealth Fund 2013
[4] Australian Institute of Health and Welfare Health Expenditure Australia 2011/12 2013 AIHW
[5] Australian Bureau of Statistics. Year Book Australia 2012. Canberra: ABS; 2012.

In addition; both non-adherence and poor persistence with long-term treatment are well documented in Australia.[6]

The PBS also processed approximately 62 million 'under co-payment' prescriptions in 2012-13. This equates to 22.7% [7]of total prescriptions. Under co-payment drugs are those that fall below the PBS co-payment limit that the Government sets. The proposed amendments are set to take the general co-payment limit higher and along with impact of Price Disclosure policies, this could result in many commonly prescribed medicines falling under the general co-payment.

However, the cost to concessional patients will not change significantly, because their co-payment remains much lower, and few drugs ever fall below the concessional limit. In contrast, general patients may derive significant savings from the lower prices, but only if their drugs are priced under the general co-payment.[8]

It is concerning that a public policy proposal which will have such a significant impact on consumer outcomes, particularly on those that are most disadvantaged, can be proposed without any rigorous data analysis and modelling to ensure that unforseen and perverse consequences of such a policy are identified. [9]

Disproportionate impact on marginalised populations

There is also a growing body of evidence from Australia[10] and other countries[11] 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.

More alarming are the figures that show that an increasing proportion of consumers are delaying or not seeing GPs, specialists and dentists, and delaying or not filling prescriptions because of cost. The final report by the (now disbanded) COAG Reform Council notes that in 2012–13, 8.5% of people given a prescription by their GP delayed or did not fill it due to cost. The figure reported by the Commonwealth Fund is even higher, with statistics reporting that in 2013, 16% of Australians did not fill a prescription; skipped recommended medical tests, treatment, or follow-up; or had a medical problem but did not visit a doctor or clinic in the past year because of cost.[12]

Significantly, in the most disadvantaged areas, 12.4% delayed or did not fill a prescription and this was twice the rate found in the least disadvantaged areas (6.0%). This number also rises sharply for Indigenous Australians, with one-third (34.6%) reporting that they delayed or did not fill a prescription and one in eight (12.2%) delayed or did not go to a GP due to the burden of cost.[13]

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[6] Simons LA, Ortiz M, Calcino G. Persistence with antihypertensive medication: Australia-wide experience, 2004-2006. Med J Aust 2008;188:224-7

[7] Report to Parliament on the Collection of PBS/RPBS Under Co-payment Prescription Data 2012-13

[8] Oritz M. Are prescription co-payments compromising patient care. Australian Prescriber, Vol 36,Feb 2013

[9] Bulkbilling data and co-payment modelling 'missing in action', AHHA June 2014.

[10] Van Doorslaer, Clarke P, Savage E, Hall J. Horizontal inequities in Australia's mixed public/private health care system. Health Policy. 2008 Apr;86(1):97-108. Epub 2007 Nov 14.

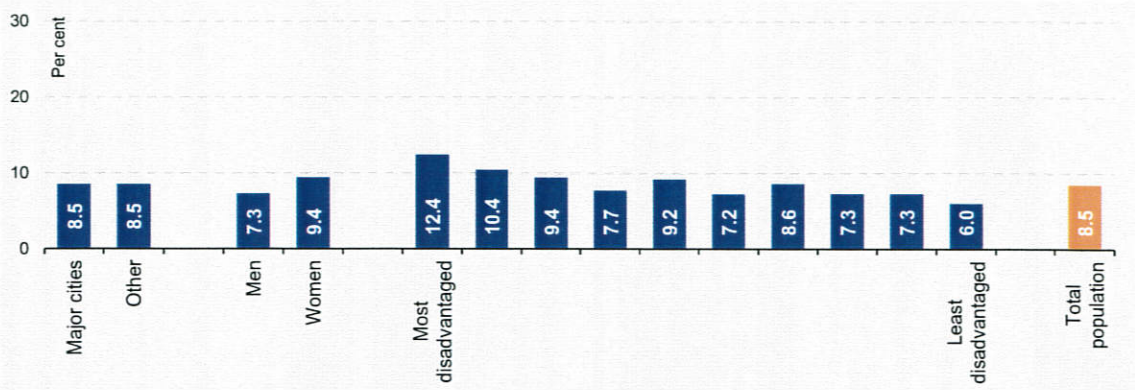
[11] Inequities in access to medical care in five countries: findings from the 2001 Commonwealth Fund International Health Policy Survey. Schoen C, Doty MM.Health Policy. 2004 Mar; 67(3):309-22.

[12] Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally, Commonwealth Fund 2014.

[13] COAG Reform Council, Healthcare in Australia 2012–13: Five years of performance.

This research is also supported by CHF's own national consumer survey[14]. Fully 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.

Figure 1. Proportion of people who delayed or did not fill a prescription in the last 12 months due to cost, 2012–13



Source: COAG Reform Council

These reports are also reflected in the National Health Performance Authority's Healthy Communities Report finding that a range of 5% to 15% of patients in Medicare Local areas reporting that they had delayed or not filled a script because of cost.[15] These are important statistics, considering that through more than 207 million pharmacy services subsidised through the PBS, about 80% are being provided to concessional patients.[16]

This is a dangerous trend, as it will result in not simply the consumer facing the repercussions of inequitable access; it is also the health system which will bear the long term costs of these decisions through the potential for increased admissions to hospital and emergency departments.

Evidence of co-payment outcomes

Studies have shown that following the January 2005 increase in PBS co-payments a significant decrease in dispensing volumes were observed in 12 of the 17 medicine categories, including anti-epileptic medicine, anti-Parkinson's treatments, combination asthma medicines, insulin and osteoporosis treatments[17]. This decrease in utilisation was observed in both general and concessional patients. On the basis of these findings, studies have suggest that the increase in co-payments impacted on patients' ability to afford essential medicines and that it was particularly concerning that despite the PBS safety-net, the co-payment increase had a particular impact on utilisation for concessional patients.[18]

[14] CHF 2014, Health Consumer Out-of-Pocket cost Survey: Results and Analysis.
[15] National Health Performance Authority 2013, Healthy Communities: Australians' experiences with access to health care in 2011–12.
[16] Op. Cit. AIHW 2014.
[17] Kemp A1, Glover J, Preen DB, Bulsara M, Semmens J, Roughead EE. From the city to the bush: increases in patient co-payments for medicines have impacted on medicine use across Australia. Aust Health Rev. 2013 Feb;37(1):4-10. doi: 10.1071/AH11129.
[18] Hynd A, Roughead EE, Preen DB, Glover J, Bulsara M, Semmens J. The impact of co-payment increases on dispensings of government-subsidised medicines in Australia. Pharmacoepidemiol Drug Saf. 2008 Nov;17(11):1091-9. doi: 10.1002/pds.1670.

The latest analysis of Bettering the Evaluation and Care of Health (BEACH) data also supports this hypotheses[19], finding that under the proposed changes to the PBS medication co-payment, the overall cost increase for medications will be higher for concessional patients compared with general patients, despite a lower individual co-payment rate.

The findings from Australian research are also supported by international evidence. A comprehensive USA-based study of more than 10 million prescriptions found that those which had co-payments of $40-$50 dollars were four to five times more likely to remain unfilled compared to those with no co-payments.[20] Research already tells us that to deal with increased costs, patients often reduce or stop taking their medicines [21]and this can have potentially serious health consequences. This failure to take medicines can also lead to increased visits to the doctor and hospitalisations.[22]

Sustainability of the PBS

Consumers also share the Government's concerns about the ongoing sustainability and cost-effectiveness of the PBS. However the impact on consumers should be the paramount consideration for any policy developments relating to the PBS. It is essential that health systems work and deliver outcomes for the people who use, and pay for, the system.

CHF also questions the sustainability crisis that the Government aim to fix through the PBS-co-payment. As reported by the Commonwealth Fund recently, when measuring health spending as a percentage of GDP, Australia has experienced the lowest growth in health spending of any comparable Western nation in the past three decades. [23] While the proportion of total recurrent health expenditure for medicines increased from 11.7% in 2001–02 to 14.2% in 2011–12, this growth has mostly related to medicines for which no government subsidy was paid.[24]

Most importantly, any cuts to PBS also have to be considered in context with other cuts across the health system. With the estimated shifting of $4.8bn in healthcare costs directly to consumers, the access and affordability barriers are set to rise steeply[25] and disadvantaged communities will be left to bear the brunt of this burden.

CHF's Position

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 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.

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[19] Estimated impact of proposed GP, pathology and imaging co-payments for Medicare services, and the increased PBS threshold.Additional cost burden to patients from budget co-payment proposals: BEACH data

[20] Shrank, W. H., Choudhry, N. K., Fischer, M. A., Avorn, J., Powell, M., Schneeweiss, S., Liberman, J. N., Dollear, T., Brennan, T. A. & Brookhart, M. A. 2010 The epidemiology of prescriptions abandoned at the pharmacy. Ann Intern Med, 153, 633-40

[21] Op. Cit. Hynd 2008.

[22] Hsu J, Price M, Huang J, Brand R, Fung V, Hui R, et al. Unintended consequences of caps on Medicare drug benefits. N Engl J Med 2006;354:2349-59

[23] Op. Cit Commonwealth Fund 2014.

[24] Op. Cit. AIHW 2014.

[25] Proposed budget savings of $3.5 billion over five years by reducing MBS rebates from 1 July 2015 by $5 (for standard general practitioner consultations and out-of-hospital pathology and diagnostic imaging services) and allowing the providers of these services to collect a patient contribution of $7 per service. Added to this amount is the savings of $1.3 billion over four years from 1 January 2015 by increasing the Pharmaceutical Benefits Scheme (PBS) co□payments and safety net thresholds.

Any additional co-payment to the PBS will undermine the National Medicines Policy of ensuring that costs should not constitute a substantial barrier to people's access to medicines.

CHF is a strong advocate for consumer-centred health care and increasing consumer out-of-pocket costs undermine the principles of accessible and affordable care. CHF's campaigns have highlighted inequity in our current systems as well as the prevalence of high direct costs facing patients[26] which are stealthily creating a two-tiered health system in Australia. Thus, CHF is strongly opposed to the amendments proposed through this bill.

CHF does not support that any growth in health expenditure should be funded through increased consumer co-payments and higher out-of-pocket costs as there are other opportunities to improve health outcomes and structural efficiency within the health care system. Improving efficiency through more effective community/primary care interventions and enhancing saving measures such as price disclosure, should deliver the financial capacity to reduce (not grow) out-of-pocket costs for consumers.

Any perceived 'over servicing' can arguably be addressed by other measures such as influencing prescribing appropriately, increasing adherence and better medicine management, which have considerably more potential to contain wastage rather than curbing usage of essential medication.

Conclusion

There is good evidence that overall co-payments reduce access to both inappropriate and necessary care and that there is no evidence that they reduce overall health care costs. Therefore, there is a risk that the introduction of additional co-payments to access PBS subsidised medication could adversely impact upon the health of some already marginalised and disadvantaged groups in the community and result in an overall increase in costs to the community.

In order to ensure any changes reflect consumer values and priorities they should be transparent and occur in the context of a community debate. Current proposals to increase individual co-payments are a piecemeal, ideological and ad hoc approach to health funding which does not take into account their context or overall impact on consumers, particularly those in vulnerable groups. However, changes made in partnership with consumers and other stakeholders and based on genuine and comprehensive community consultation and robust research provide a valuable opportunity to improve our current funding arrangements and equip our health system to meet the challenges of the future.

CHF urges the Government to explore alternative areas that can deliver significant savings to the health budget, without adding to the burden the most disadvantaged in our community already face.

[26] Through our Price Disclosure campaigns, we have highlighted limited application of price disclosure measures in Australia, as well as the slower rate of cost reductions compared with other countries.

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Consumers Health Forum of Australia

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian health care consumers. CHF works to achieve safe, quality, timely health care for all Australians, supported by accessible health information and systems.

CHF does this by:

1. advocating for appropriate and equitable health care
2. undertaking consumer-based research and developing a strong consumer knowledge base
3. identifying key issues in safety and quality of health services for consumers
4. raising the health literacy of consumers, health professionals and stakeholders
5. providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making

CHF values:

- our members' knowledge, experience and involvement
- development of an integrated health care system that values the consumer experience
- prevention and early intervention
- collaborative integrated health care
- working in partnership

CHF member organisations reach Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective.

CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice.

PO Box 3099, Manuka ACT 2603 ■ Unit 9, 11 National Circuit, Barton ACT 2600
Tel: (02) 6273 5444 Fax: (02) 6273 5888 Email: info@chf.org.au Web: www.chf.org.au
ABN 82 146 988 927