

Supplementary submission

Senate Standing Committees on Community Affairs

National Health Amendment (Pharmaceutical Benefits) Bill 2014 Inquiry

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International comparison of out-of-pocket costs

About 19 per cent of Australian health expenditure is sourced from out-of-pockets. Across all OECD countries, including quite low-income ones, this is about the average. However, compared to similar OECD countries (those within 20% of Australia in terms of GDP per head), Australia has a very high reliance on out-of-pocket costs to finance health care. This is the measure Grattan Institute used in its submission to the out-of-pocket costs inquiry (see Figure 1 of our submission).

The question raised in the hearing was whether Australia still has a high ranking when identical out-of-pocket components are used across countries. It was suggested that once comparisons are on a like-for-like basis, Australia ranks much lower, possibly around the middle of the pack.

We have seen no evidence showing that the data for Australia varies significantly from the data for other countries. The OECD does not appear to break down the composition of out-of-pocket expenditure in detail. We have sought more information from the OECD and are awaiting a response.

However, we are unaware of any analysis which removes components of out-of-pocket expenditure and as a result has Australia ranked around the middle of high-income nations. The other ranking mentioned in the hearing seems to be a simple ranking against all OECD countries, using the existing OECD measure, not a measure with any addition or subtraction of different types of out-of-pocket costs.

It seems unlikely that differences in definitions would shift Australia from being one of the highest-ranked wealthy nations to the middle or lower end of wealthy nations. As mentioned above, we are investigating this further.

Price elasticity of prescription medication

Departmental evidence suggested that there was no clear evidence that demand for pharmaceuticals declines when their price increases. The international systematic review that we reported showed that the overwhelming majority of studies found such an effect. In fact only 2 out of 18 studies (we mistakenly reported there were 19 studies in our submission) showed no effect. It is not reasonable to describe this evidence as “mixed”.

The Department also questioned an Australian study which found a decrease in dispensing for statins and proton pump inhibitors after a co-payment increase in 2005. Their own analysis shows an increase in dispensing for these drugs. They argued that their finding differed from the study because the Department had access to data on dispensing below the co-payment

threshold. However, the study explicitly excluded items below the co-payment in 2006 from their analysis:

“Observed dispensing for 2004 was adjusted to remove the low-dose products that fell below the co-payment thresholds in 2006 (i.e. those priced under \$29.50) as these items were not included in the 2006 data capture. Had these low-dose products not been removed from the 2004 data the effect of the 2005 co-payments increase would have been exaggerated. The proportion of dispensing removed from 2004 observed figures was 0.1% of statins and 0.6% of PPIs.”

Kemp, A., Glover, J., Preen, D. B., Bulsara, M., Semmens, J., & Roughead, E. E. (2013). From the city to the bush: increases in patient co-payments for medicines have impacted on medicine use across Australia. *Australian Health Review*, 37(1), 4-10.

In fact, the difference is likely due to the study adjusting for pre-2005 prescription growth trends. By contrast, the Department seems to have simply used prescribing at two points in time (2004 and 2006) not adjusted for the underlying trend. Finding growth in prescribing with this simple method does not demonstrate that the co-payment increase had no effect. The co-payment would be expected to *slow* growth in prescribing, not leave raw prescribing levels at the same level. Therefore, the more sophisticated analysis of Kemp et al provides a better estimate of the co-payment impact.

Further, there have been two recent doctoral theses which examined the interaction of price and volume. Their conclusions are as follows:

“The results ... show that the demand for PBS medicines is significantly influenced by two of the policy instruments controlled by the Government. On the one hand demand increases more than proportionately to the steadily increasing number of medicines made available through the operation of the PBS listing procedures. As the PBAC makes available more choice among medicines to treat particular diseases and introduces medicines for diseases previously untreated or poorly treated, doctors prescribe these for their patients reducing the burden of disease. On the other hand demand is reduced when Governments increase the amount patients are required to pay for these medicines and to a lesser extent when manufacturers change the premium they add to the base dispensed price.

For General Non-Safety Net (GNSN) patients the patient price elasticity is in the range -1.1 to -1.4, while for Concessional Non-Safety Net (CNSN) patients it is significantly lower in the range -0.5 to -0.9. The situation is less clear with General Safety Net (GSN) patients although analysis using detailed data suggests an elasticity of -1.4.”

Sweeny, K. "Accounting for Growth in the Pharmaceutical Benefits Scheme."
PhD thesis, Victoria University 2008., p270

“The analyses showed that the introduction of the new patient copayments to the PBS in November 1990, resulted in a reduction in the level of utilisation of both discretionary and essential medicines. However the magnitude of this reduction (proportionally) was greater for discretionary than for essential medications. An unintended consequence of

these copayments was the large anticipatory increase in utilisation which occurred in the month before the copayments came into effect.

Given statistical limitations relating to the limited number of pre-intervention points available prior to the PBS copayments, an ITS evaluation was also undertaken using the much longer RPBS database to assess the effect of subsequent copayment introduced to the RPBS in January 1992. This confirmed the findings from PBS copayment evaluation and was better able to estimate the magnitude of changes in underlying trend associated with the copayments. The reduction in the level of utilisation of discretionary medications was greater than that for essential medicines. Further, while discretionary medication utilisation continued to decline after the copayments were introduced, there was an attenuation of this decline for essential medicines.”

Donnelly, Neil J. "The Use of Interrupted Time Series Analysis to Evaluate the Impact of Pharmaceutical Benefits Scheme Policies on Drug Utilisation in Australia." University of New South Wales, 2005. P109

These academic analyses confirm that the conclusion we reached, that price increases would be likely to increase the number of unfilled prescriptions, is a reasonable one.

Drug price analysis

As we pointed out in our submission, our comparison of England and Australia's pricing was done for drugs that are the highest cost to government and which are also available in the UK's Category M schedule, in addition to several that recently went through price disclosure. Where prices for these drugs were lower in Australia, they were included in our comparison. The drugs in our analysis account for over one fifth of PBS volume.

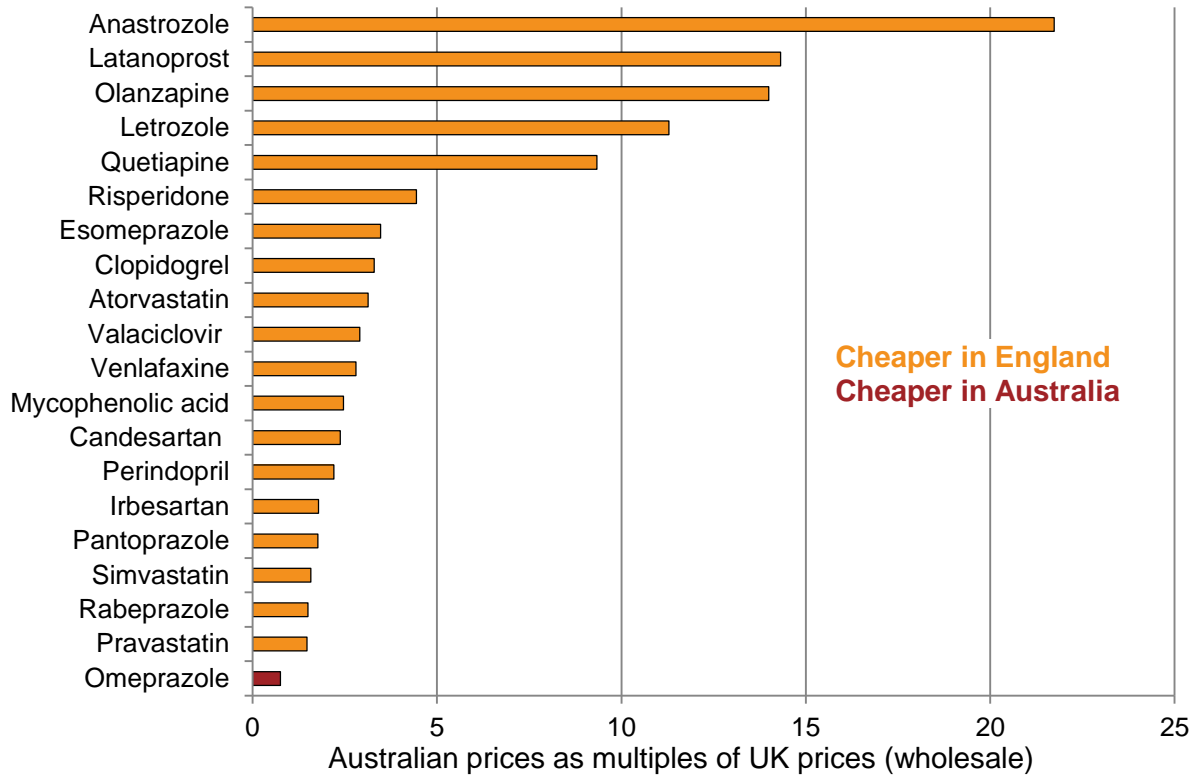
Our drug price comparison was criticised in Departmental evidence to the hearings. In contrast to our approach, four specific drugs were mentioned by the Department: docetaxel, paclitaxel, rosuvastatin and atorvastatin. The Department said they were commonly prescribed drugs with prices that are significantly lower than those in England. No basis for their selection was given. Presumably it was because these drugs were reported to have cheaper prices in Australia.

In fact, for one of the drugs mentioned (atorvastatin), the Australian price is currently almost six times the English price. Contrary to their characterisation as commonly used, docetaxel and paclitaxel account for a very small fraction of PBS services (the topic of the hearing). According to online PBS item reports, in 2013-14 there were around 30,000 and 50,000 services for these drugs, respectively. That compares to around eight and nine million for the two statins they are mentioned alongside.

It would be remarkable if Australia's policy was so bad that we never got a better deal than other countries on any drug. Finding a handful of drugs with better prices does not provide evidence that our pricing/negotiating strategy is best practice.

Our analysis has also been criticised because we compared prices at June 2014 in the two countries. It has been suggested we should have compared the English prices now with Australian prices in October. Although this is not as methodologically rigorous, we have undertaken that comparison and the results are below. On that basis our savings estimates decline from \$580 million a year to \$415 million. That assumes no reduction in prices in England. Even then, Australia's prices are still on average six times those of England for these drugs (down from seven times). As before, only one of the drugs is cheaper in Australia.

Figure 1: A comparison of future Australian (October) and current UK wholesale drug prices



Source: Grattan Institute

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22 August 2014