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National Health Amendment (Pharmaceutical Benefits - Budget Measures) Bill 2002

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No. 170 2001–02

National Health Amendment (Pharmaceutical Benefits - Budget Measures) Bill 2002

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Contents

Purpose 1

Background 1

Main Provisions 2

Concluding Comments 3

Endnotes. 4

National Health Amendment (Pharmaceutical Benefits - Budget Measures) Bill 2002

Date Introduced: 6 June 2002

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Items 1-24 of Schedule 1 commence on 1 August 2002, items 25-28 of Schedule 1 commence on 1 January 2003, and the remainder commences on Royal Assent.

Purpose

The purpose of the National Health Amendment (Pharmaceutical Benefits – Budget Measures) Bill 2002 ('the Bill') is to introduce a 2002-03 Health and Aging Portfolio Budget measure (Outcome 2) that specifies an increase in the patient co-payments for the purchase of drugs subsidised under the Pharmaceutical Benefits Scheme (PBS). The Budget measure proposes that the co-payment amounts rise by 28 per cent from $22.40 to $28.60 for general patients and from $3.60 to $4.60 for concessionary patients (to be effective from 1 August 2002). It is also proposed that the concessional patient safety net threshold will increase from $187.20 to $239.20, and the general patient safety net threshold will increase from $686.40 to $874.90 (both changes to be effective from 1 January 2003).

Background

Basis of policy commitment

The PBS is currently the fastest growing area of health expenditure in Australia. In the 2001-2002 financial year PBS expenditure is estimated to cost $4.837 billion, 13.6 per cent more than it did in the previous year. In the last decade it has experienced an estimated average annual expenditure growth rate of around 14 per cent. According to the fiscal projections of the *Intergenerational Report 2002-03*, government expenditure on the PBS will increase five-fold by 2041-42 (as a percentage of GDP).

The stated mission of the PBS is to make affordable to all Australians the medications they need, but at a responsible cost to the community. The currently growing cost to the community of the PBS is placing pressure on the scheme's future capacity to make available to Australians newly developed expensive medicines. The sustainability of the PBS is consequently an important issue.

Between 1991-92 and 2001-02, the government contribution to the overall annual PBS expenditure has increased at an average annual rate of 13.5 per cent. Patient co-payments have had a slightly lower rate of increase in that period – 12.4 per cent. In 1991-92, the patient contribution to annual PBS costs was around 20 per cent, and has been steadily declining to around 15 per cent in 2000-01. At the level of patient co-payments proposed in this Budget measure, the estimated total annual contribution to PBS costs from patients will be restored to approximately 20 per cent.[1]

The response of the ALP/Australian Democrat/Greens

There has been opposition to the proposed co-payment rise from the ALP, and the Australian Democrats. The Australian Democrats have argued that the co-payment increases will shift costs to the States through increased hospital and emergency room visits.[2] Senator Stott-Despoja has urged the government to consider alternative measures, such as increased application of price-volume agreements (where prices paid to manufacturers vary depending on the sale of drugs), as well as further reforms to prescribing practices which contribute to high PBS cost increases.[3] The ALP has similarly argued that increasing co-payments places an unfair burden on those least able to afford it, and has endorsed a range of cost-effectiveness measures for the PBS.[4] The Greens are also opposed to the rise in co-payments.[5]

Main Provisions

Items 1-15, 17 and 18 of **Schedule 1** make amendments, and consequential amendments, to the *National Health Act 1953*, which give effect to the stated increase in co-payments. These changes are detailed in the *Explanatory Memorandum* to the Bill.

Item 16 of **Schedule 1** specifically preserves the concessional beneficiary safety net threshold - and amount equal to 52 times the concessional patient co-payment - at its current level ($187.20) for the remainder of the 2002 calendar year. From 1 January 2003, this threshold will rise to $230.20.

Items 19-24 of **Schedule 1** amend or refer to section 99G of the *National Health Act* 1953, and make provision for the future indexation of the increased patient co-payments

and safety net thresholds. These changes are detailed in the *Explanatory Memorandum* to the Bill, which also notes:

> [The increases in co-payments and safety net thresholds] will take the place of indexation changes that would otherwise occur with effect from 1 January 2003. Indexation of patient co-payments and safety net thresholds will resume with effect from 1 January 2004.

Items 25-27 of **Schedule 1** increase the general patient safety net threshold from $686.40 to $874.90. There is no specific savings provision akin to that provided in item 16 of Schedule 1 (in relation to the concessional beneficiary safety net), but the stated commencement date of these items (see **clause 2** of the Bill) means this change will not come into effect until 1 January 2003.

Concluding Comments

The proposed increases in co-payment levels will reduce the proportion of the annual costs of the PBS that the Commonwealth will have to pay. It is questionable, however, whether this will have the stated long-term impact of enhancing the sustainability of the PBS. It can be argued that such an increase may negatively affect the operation of the PBS.[6]

The increasing costs of the PBS have partly been attributed to aspects of its operation which are not cost-effective. The PBS is designed to make available medicines that will have cost-savings effects on the use of other health-care and related resources (such as further GP visits, extended hospitalisation, productivity, etc). A cost-effective PBS, even when it is costing more in and of itself, will still be *reducing* expenditure in other areas.

The problematic PBS growth drivers will be those that detract from the PBS' capacity to deliver the greatest level of health-related cost-benefits. One key problematic growth driver is the rising prescription of expensive newly developed medicines outside of their PBS cost-effectiveness guidelines. A number of factors contribute to this prescribing, including primarily a lack of clear, accurate and timely information about cost-effective uses of these drugs, and misleading information and promotional incentives from manufacturers. Although there are other 2002-03 Budget measures that do address some of these factors, it is not clear that raising co-payments in any way contributes to the enhanced cost-effectiveness of the PBS. Moreover, any additional payment patients are asked to make will be partly wasted if it is paying for a less than completely cost-effective system.

There is some evidence that raising patient co-payments can act as a disincentive for patients to purchase prescribed medicines, and thus as a disincentive for them to adequately address their medical needs. This introduces the risk that further subsequent costs may be introduced into the health-care system, perhaps through those patients seeking further GP visits, or through hospitalisation due to their conditions being

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improperly addressed. Recent NATSEM modelling (on 1996–97 data) observed that a flat 25 per cent rise in co-payments would place a burden on the lowest income earners among general patients (making expenditure on pharmaceuticals a high average of 8.6 per cent of disposable income).[7] There is also overseas evidence that increases in co-payments can result in patients not filling their prescriptions.[8]

Apart from these concerns about the potential impacts of co-payment rises, there are also questions surrounding the rationale for why the rises should be of the specified amount. Although the proposed rise will bring the proportional patient contribution to the total annual PBS costs into line with what it was in 1991-92, it is not clear why that particular proportioning is especially important. Nor is it clear that any proportionality or balance in government-patient contributions has ever been, historically, a relevant policy consideration. The rationale for setting the general patient safety-net threshold at approximately 30 times the general co-payment amount is similarly unclear.

Endnotes

1 Second Reading Speech, National Health Amendment (Pharmaceutical Benefits-Budget Measures) Bill 2002.

2 M. Lees, "PBS Cuts: Another Cost Shift to the States" *Press Release* Wednesday May 15, 2002.

3 N. Stott-Despoja "Government Urged to Drop DSP and PBS Charges" *Press Release,* 9 June 2002; N. Stott-Despoja, "Costello's Quick Fix is no Benefit to Ailing System", The Australian, 7 June 2002.

4 S. Crean, "Reform of the Pharmaceutical Benefits Scheme", *Press Release* June 16, 2002.

5 B. Brown, "Greens to oppose super cuts for the rich in the Senate" *Press Release*, May 17, 2002.

6 See further M. Rickard, The Pharmaceutical Benefits Scheme – Options for Cost Control, *Current Issues Brief*, no 12, 2001-02, Department of the Parliamentary Library, 28 May 2002, http://www.aph.gov.au/library/pubs/CIB/2001-02/02cib12.htm.

7 A. Walker, 'Distributional Impact of Higher Patient Contributions to Australia's Pharmaceutical Benefits Scheme', Australian Health Review, vol. 23, no. 4, 2000, pp.32–46.

8 Two recent reports note the negative impact of increased co-payments on usage. S. Jacobzone, Pharmaceutical Policies in OECD Countries: Reconciling Social and Industrial Goals. Labour Market and Social Policy Occasional Papers, no. 40, OECD Section 2.1.1, 2000; Senate Standing Committee on Social Affairs, Science and Technology, Interim Report on the State of the Health Care System in Canada, vol. 2, January 2002, pp. 33–34.

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