Pharmaceutical Benefits Scheme
Presentation to Australian Health Care Summit

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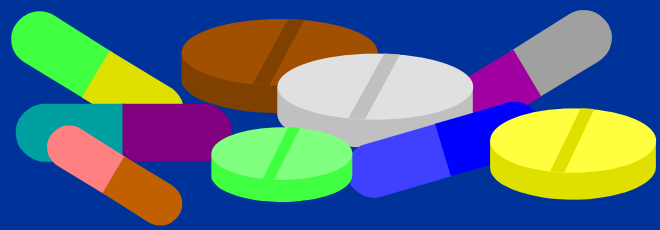


Background

PBS Development

- 1949: 139 “life-saving and disease preventing drugs”; estimated cost 2.5m pounds
- 1988: PBAC required by law to take cost-effectiveness into account, comparing the cost and effectiveness of therapy with that of alternatives
- 1993: sponsors required to provide economic analysis
- 2000: comprehensive & universal subsidy scheme
  - 594 different drugs; 2,448 products
  - 148 million scripts
  - Au$4.2 billion cost to government (2000/01)

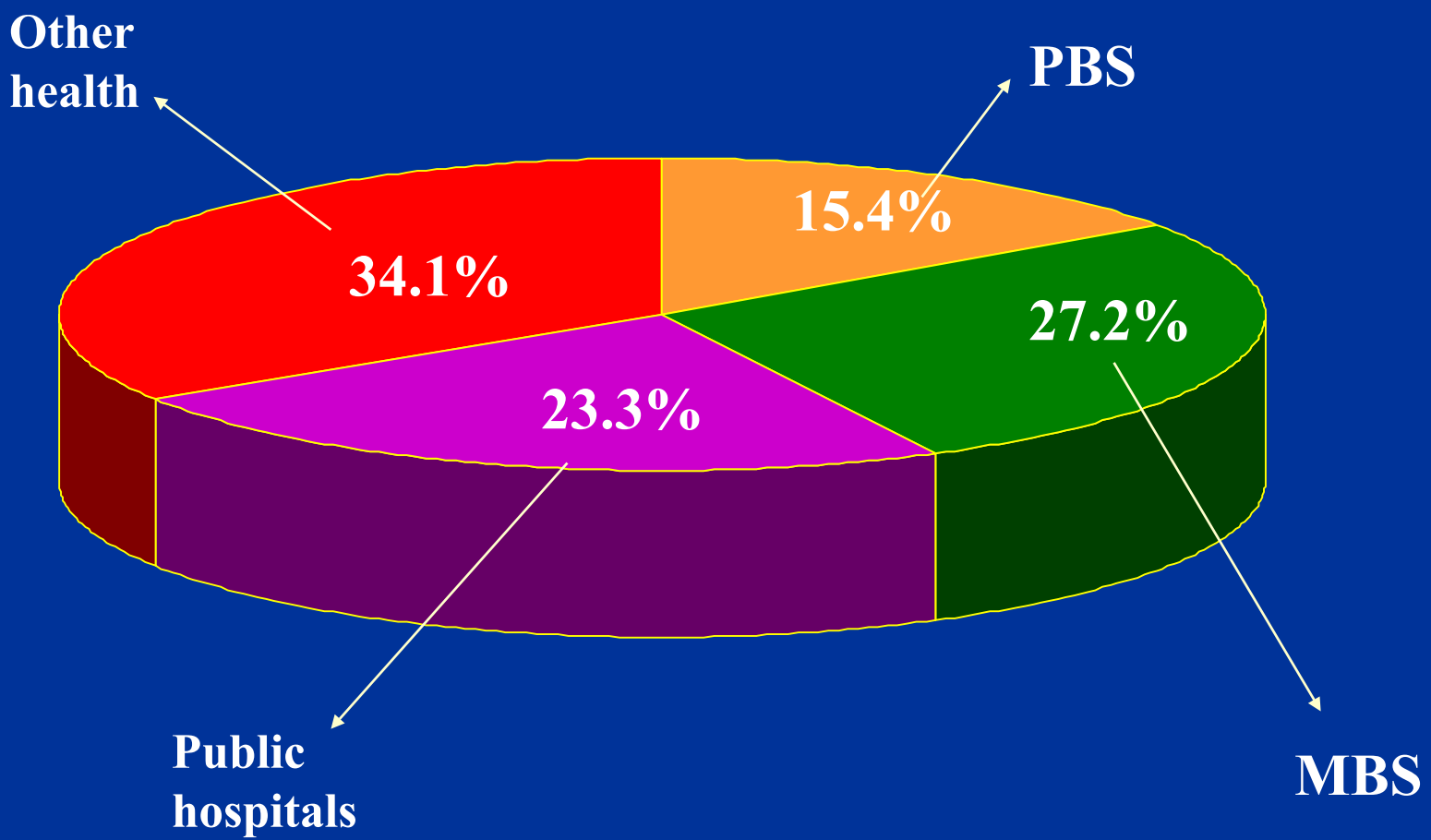
PBS listing process

- Pharmaceutical Benefits Advisory Committee
  - principle is the purchase of OUTCOMES, not products
  - comparative decision-making where alternatives exist
    - new product with same effect as an old product will be listed on cost-minimization basis (same cost)
    - higher price must be justified by greater effect
  - new therapeutic effect compared with placebo
  - cost-effectiveness varies between patient groups
    - projections often have high degree of uncertainty
    - role of restricted listings $\rightarrow$ maximize cost-effectiveness
  - reactive decision-making (most applications are sponsor-driven)

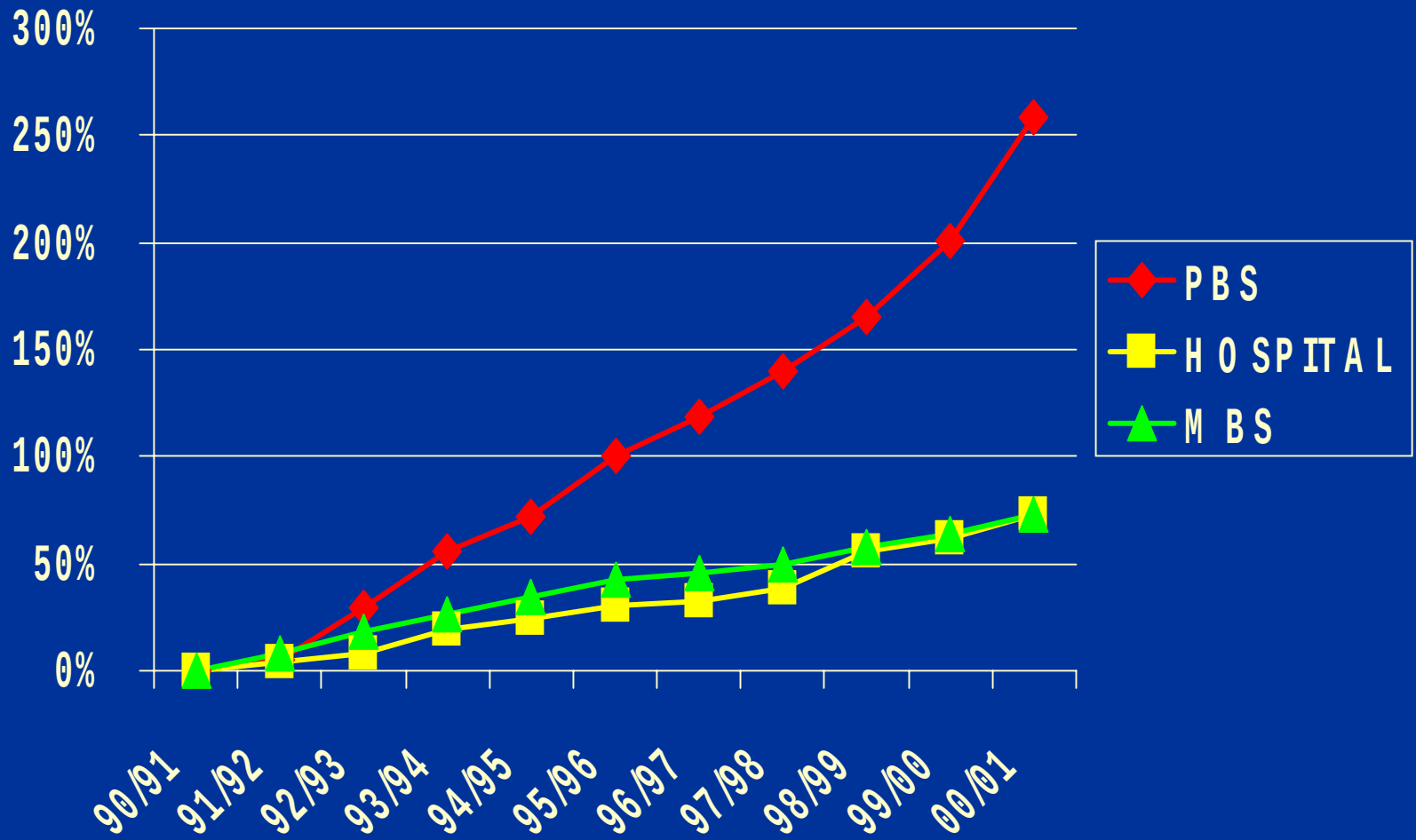
Current issues

- Sustainability (increasing costs)
- Commonwealth-State funding
- Co-payments
- US free trade agreement

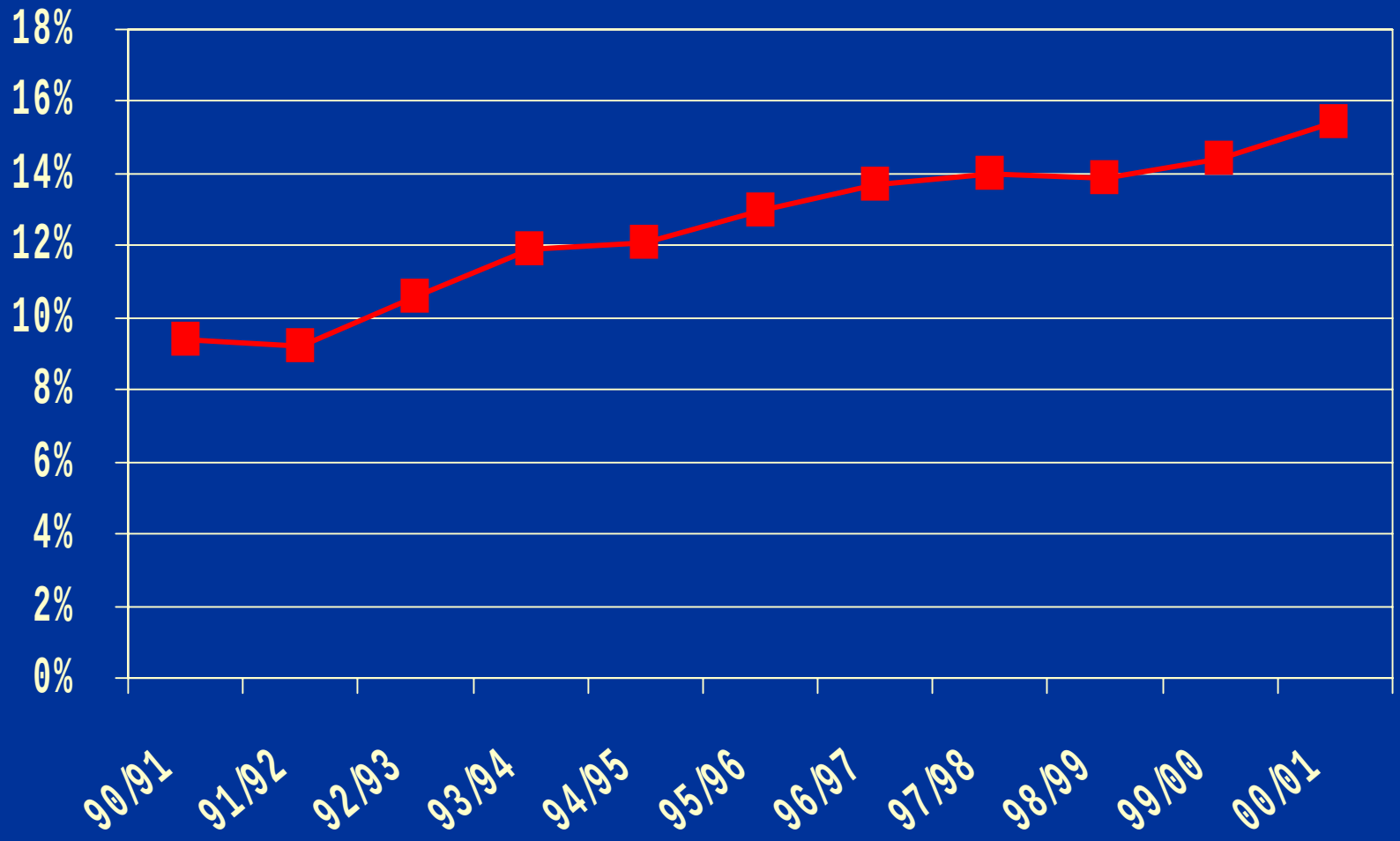
Commonwealth Health Expenditure ($27bn) 2000-2001



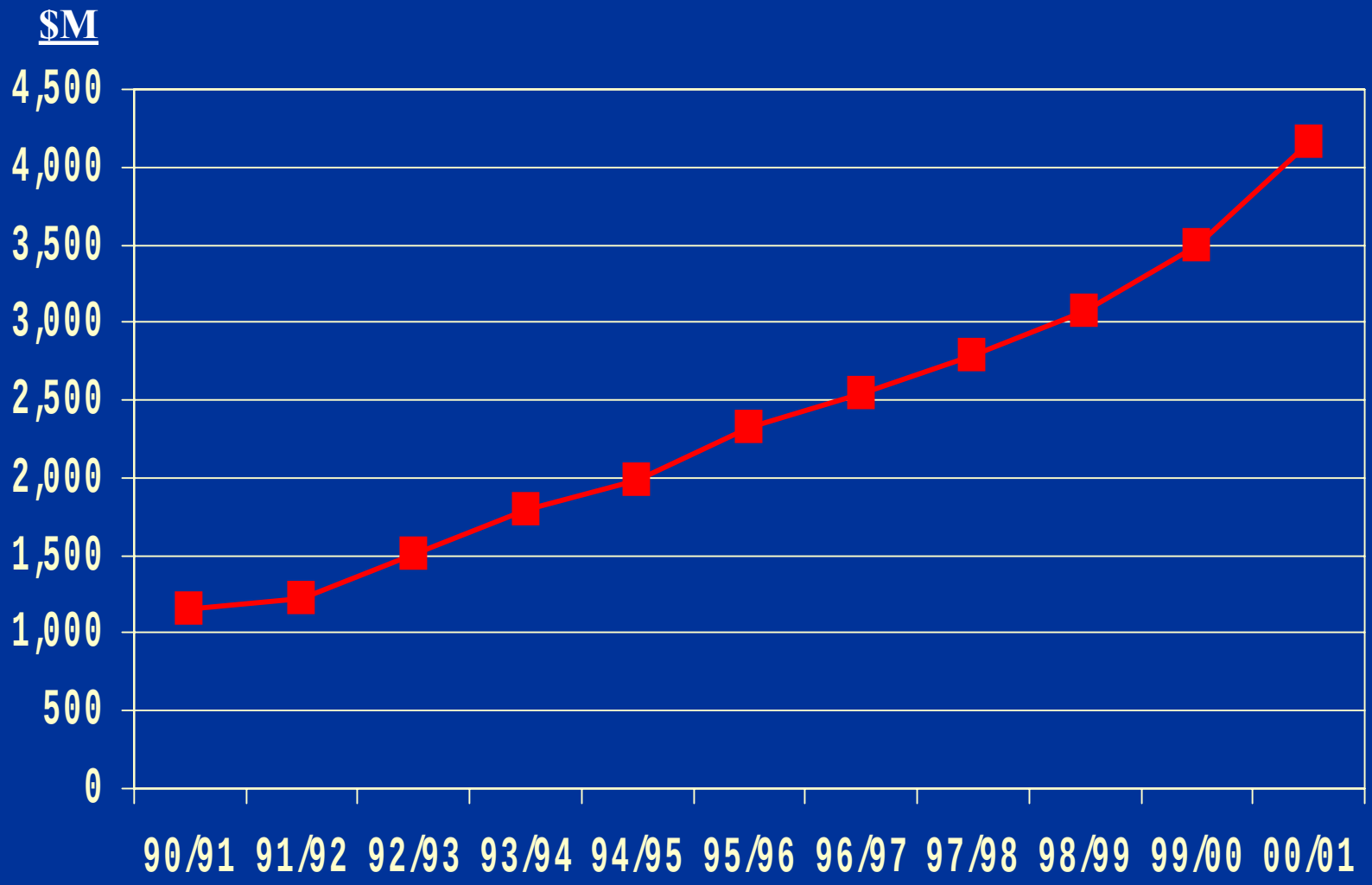
Cmwlth PBS, public hospital & MBS expenditure: % growth since 90/91



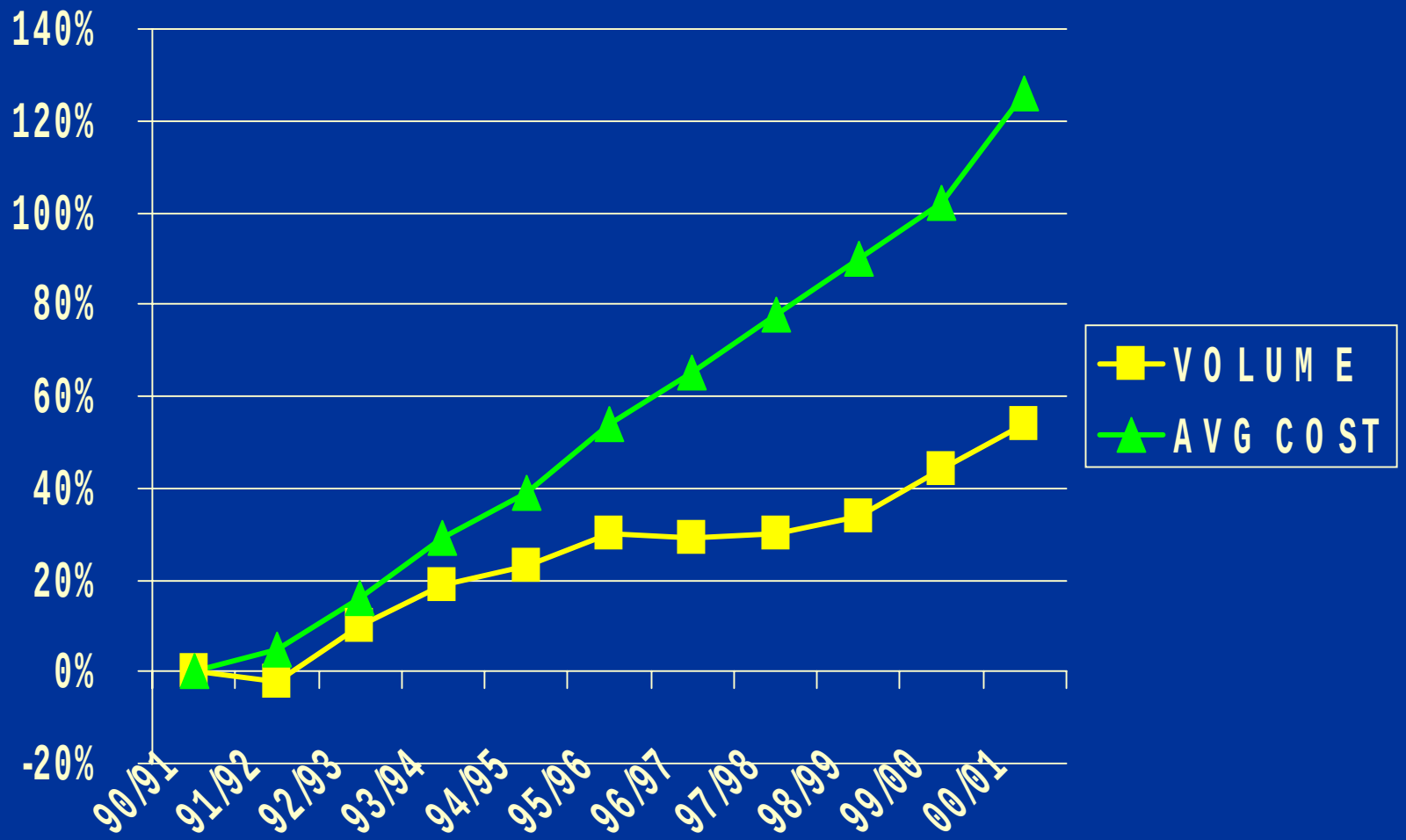
PBS as a % of Commonwealth Health Expenditure from 1990/91 to 2000/01



PBS Expenditure: the last 10 yrs



Script volumes and average govt cost/script: % growth



What drives PBS expenditure?

- increasing disease prevalence/detection
- new listings, esp high tech, high cost drugs (up to $40,000/yr/patient, and $M100's/year total cost to PBS)
- shift from old, cheap drugs to newer more expensive ones (not always with benefit)
- "leakage" from restricted cost-effective listings
  - sponsors promote all TGA-approved indications
- ageing and increased access to pharmaceutical concessions

Current issues

- Sustainability (increasing costs)
  - increased cost matched by increasing health benefits?
    - uncertain and very difficult to determine
  - need for public debate re:
    - is community prepared to pay increasing proportion of GDP on drugs?
    - prioritization (e.g. ED vs small prolongation of life in Ca vs improved quality of life in RA)
      - techniques for comparing across drug groups - $/QALY
  - high-tech, high cost drugs
    - some offer major health advances but at VERY high cost
    - some offer only incremental advances
    - risk-sharing by sponsors when future projections uncertain
      - but trend towards “global pricing” policies

Current issues

- Sustainability (increasing costs)
- Commonwealth-State funding
- Co-payments
- US free trade agreement

Commonwealth-State Funding

- SA Drug Usage Advisory Group (June 2003)
  - there should be a central Commonwealth funded process for all medicines deemed to be appropriate for public subsidy
  - financing arrangements for medicines should offer no need for cost-shifting between levels of government or other funders
  - the funding system should provide:
    - equity of access to those medicines deemed as essential and cost effective
    - uniformity of access in both private and public settings

Current issues

- Sustainability (increasing costs)
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Co-payments

- Progressive rise in co-payments
  - reduces number of drugs eligible for subsidy (i.e. only those more expensive than co-payment)
  - if rising at greater rate than CPI, eventually reduces effectiveness of system (affects equity of access)
  - most prescriptions are subsidized at concession rate; co-payment for non-concession holders is already limiting access for people on multiple drugs

Co-payments

- Differential co-payments
  - currently co-payments are identical for all drugs
  - ?differential co-payments
    - higher for some drugs (prioritization)
      - e.g. some European countries: "essential" drugs 100% subsidized, other drugs partially subsidized
      - has been suggested for ED drugs
    - lower for more cost-effective drugs (encouraging good prescribing)
      - e.g. 100% subsidy of more cost-effective antihypertensives
    - problems:
      - not in accordance with National Medicines Policy (equity of access), particularly if cost to patient of some drugs increases
      - basis for determining higher/lower costs to patient? (willingness, capacity, disease-based, cost-effectiveness?)

Current issues

- Sustainability (increasing costs)
- Commonwealth-State funding
- Co-payments
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US Free Trade Agreement

- Potential threat to cost-effectiveness principles on which PBS is currently based

Draft Recommendations

- Sustainability of PBS
  - Health outcomes research should be encouraged
    - methods for objectively measuring the outcomes achieved from use of new medicines
  - Public debate should be fostered regarding:
    - preparedness to pay increasing % GDP for drugs
    - prioritization of health outcomes
  - Increased use of “risk-sharing” approaches: lower prices “up-front” when future projections uncertain
    - price-volume arrangements, equating to variable prices for different indications (old and new drugs??)

Draft Recommendations (2)

- Commonwealth-State funding
  - there should be a central Commonwealth funded process for all medicines deemed to be appropriate for public subsidy
  - financing arrangements for medicines should offer no need for cost-shifting
  - the funding system should provide:
    - equity of access to essential & cost-effective medicines
    - uniformity of access in both private and public settings

Draft Recommendations (3)

- Co-payments
  - progressive increases in co-payments (above CPI) would threaten equity of access, reduce the effectiveness of the system, and should be avoided
  - differential co-payments could be considered as potential incentives for good use of medicines
    - higher for “non-essential” drugs (problems with equity of access)
    - lower for cost-effective drugs (promoting good prescribing)
- US Free Trade Agreement
  - impact on cost-effectiveness principles underlying PBS should be minimized