



# VIETNAM VETERANS ASSOCIATION of AUSTRALIA

## (QUEENSLAND BRANCH)

*"Honour the dead, but fight like hell for the living"*

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1. The Vietnam Veterans Association of Australia Queensland Branch Inc (VVAA Qld) would like to thank the Minister for Veterans Affairs, Mr. Alan Griffin. MP, for finally announcing a review into the situation of the gap that has arisen between the Co-payment for pharmaceuticals and the pharmaceutical allowance (PhA). The VVAA Qld would like to have it placed on record that we fully endorse and support the submission by the VVAA but would like to take the opportunity of placing our position on the table by putting in a submission also. The VVAA Qld believes that our submission will only reinforce the submission from VVAA.

### Review into removing the gap between copayment and pharmaceuticals

2. In 1991 the government introduced a system whereby veterans needing pharmaceuticals would not be out of pocket. When this system was first introduced the Co-payment and PhA was the same \$2.50 with a safety net. In 1998 this changed with the Co-payment being indexed up to the nearest ten cents and the PhA indexed down to the nearest ten cents thereby ensuring that the Copayment and PhA would never be the same. At the moment the Co-payment is \$5.40 and the PhA is \$3.00 and the Safety Net has been increased from 52 scripts to current level of 60 scripts. Veterans are out of pocket and this amount is increasing each year. The increase initially was very small, 50 cents per script but now it stands at \$2.40 per script and will increase over the next 6 years to about \$4.00 per script providing the government does not increase the safety net again

### Relative value of Pharmaceutical Allowance against the Copayment

3. The relative value of the PhA against the Co-payment rate, together with the threshold level of the Safety Net, are the key drivers of Veterans' out of pocket expenses for pharmaceuticals. Table 1 below is a representation of the key policy changes since 1991 and the effect of these in terms of out of pocket cost for pharmaceuticals.

**Table 1 – Key PBS/RPBS policy changes affecting copayment, allowance and safety net**

|   | Year | Veteran (max) Out of Pocket amount | Safety Net Threshold (SNT) scripts per year |
|---|------|------------------------------------|---|
| Introduction of the pharmaceutical copayment & the Pharmaceutical Allowance | 1991 | \$0                                | SNT set at 52                               |
|   | 1992 | \$0                                |   |
|   | 1993 | \$0                                |   |
|   | 1994 | \$0                                |   |
|   | 1995 | \$0                                |   |
|   | 1996 | \$0                                |   |
| Copayment indexation method changes   | 1997 | \$0                                |   |
|   | 1998 | \$26                               |   |
|   | 1999 | \$26                               |   |
|   | 2000 | \$26                               |   |
|   | 2001 | \$31                               |   |
|   | 2002 | \$36                               |   |
|   | 2003 | \$42                               |   |
|   | 2004 | \$47                               |   |
| Copayment and Safety Net realignment  | 2005 | \$88                               |   |
|   | 2006 | \$103                              | SNT to 54                                   |
| Review in Election Commitment   | 2007 | \$124                              | SNT to 56                                   |
|   | 2008 | \$139                              | SNT to 58                                   |

|                  |      |       |           |
|------------------|------|-------|-----------|
| Review commences | 2009 | \$162 | SNT to 60 |
|                  | 2010 | \$168 |           |

4. As identified above, the initial annual amount of the PA fully offset the Pharmaceutical Co-payments up to the Safety Net threshold. The Co-payment was indexed to reflect movements in the Consumer Price Index (CPI), and so the PhA was indexed using the same methodology to maintain relativities between the two.

5. The 1997 Budget included a measure that changed the indexation method for the Co-payment (to round up the CPI calculated increase to the next 10 cents). The effect of the measure was to almost guarantee an annual increase to the Co-payment, while the PhA indexation method remained unchanged, requiring a higher CPI rate to enable an increase to the PhA.

6. In 2005, as a consequence of the 2002-03 Budget, there was a one off increase to the Co-payment of around 20 per cent. Also arising from the same Budget were prospective increases to the Safety Net Threshold, increasing by two scripts per year from 2006 to 2009. The implications of these changes over time, while initially small, became obvious in 2005 when the maximum out of pocket expenses for Veterans increased by 87 per cent compared to the previous year.

7. Assuming that there is no change to current policy settings and an annual CPI increase of 3 percent, Veterans will be exposed to out of pocket costs of up to \$250 annually by the year 2016 – refer Table 2. The PhA will cover around 40 per cent of the maximum Co-payment amount in this scenario.

**Table 2 – Initial, current and projected settings of the PhA, Co-payment and Safety Net threshold – Single or Couple**

| Year | PA per annum | Pharm. Copayment | Safety Net Threshold | Veteran max. Copayments per annum | Veteran max. out of pocket amount per annum |
|------|--------------|------------------|----------------------|-----------------------------------|---|
| 1991 | \$130        | \$2.50           | 52                   | \$130                             | 0   |
| 2010 | \$156        | \$5.40           | 60                   | \$324                             | \$168                                       |
| 2016 | \$171        | \$7.00           | 60                   | \$420                             | \$249                                       |

**Increases in Co-payment result in decrease in dispensing volumes due to cost.**

8. Comparisons were made of dispensing over two periods. Those periods were before and after increase in the PBS Co-payment. Those from January 2000 to December 2004 were compared with those from January 2005 to September 2007.

9. Following the January 2005 increase, significant decrease in dispensing volumes were observed in 12 of the 17 medicine categories, namely anti- epileptics, anti-Parkinson's treatments, combination asthma medicines, eye-drops, glaucoma treatments, HmgCoA reductase inhibitors, insulin, muscle relaxants, non-aspirin antiplatelets, osteoporosis treatments, proton-pump inhibitors (PPIs) and thyroxine.

10. **Conclusions:** The study findings suggest that recent increases in Australian PBS copayments have had a significant effect on dispensing of prescription medicines. The results suggest large increase in co-payments impact on patients' ability to afford essential medicines.

11. The statistics cited above translate to the fact that those medicines, prescribed to patients for preventative or prophylactic purposes, such as for heart disease, cholesterol and diabetes control and gout are those foregone, whereas medicines considered to be immediately essential such as for pain relief or sleep are those that show no significant decrease in dispensing. Prof Andy Gilbert, convener of the MATES programme, agrees with this information

*Ref: The impact of co-payment increases on dispensing of government- subsidised medicines in Australia, Hynd et al\*, pharmacoepidemiology and drug safety 2008; 17: 1091-1099*

*This study was conducted by \*Anna Hynd BA (Hons), PhD1, 2\*, z, Elizabeth E. Roughead PhD3x, David B. Preen BSc (Hons), PhD1\_, John Glover BEc, BA4\_, Max Bulsara MSc1, 5k and James Semmens BSc, MSc, Dip Ed, PhD5#*

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12. It is obvious from the results of this report that there is a distinct relationship between the increasing copayment and the ever widening gap between the copayment and the PhA. Although this is not a Veteran specific study it is obviously detrimental to Veterans' health and has the potential of increasing health costs to DVA. If there was no Co-payment, or the PhA and Co-payment were the same, then this problem could be either eradicated or reduced considerably within the Veteran community

13. DVA have put forward two options which are:

**Option 1: Reimbursement for those with Qualifying Service and receiving Disability Pension**

Under this proposal, all veterans with QS and any percentage of DP would receive reimbursement for out of pocket pharmaceutical costs.

While this option would target those veterans whose service history and conditions are closely aligned with the Government's commitment, it does not distinguish pharmaceutical usage, which is related to war caused disabilities, compared to usage for other health issues. It therefore extends additional assistance beyond the scope of the Government's commitment. However, it would be reasonably simple to administer and for recipients to understand.

**Our Comment**

*This option is great if you have qualifying service but it does not cover all the other DVA card holders such as those who are now covered under the VEA with Defence Service as per Labour's decision in Dec 1972. Our suggestion here would be to grant this option to all card holders who are covered by the VEA regardless of whether they have qualifying service but obviously with White Card holders it would relate to accepted conditions only. We have disability pensioners who are on above general rate but do not have qualifying service. Their disabilities may not be war caused but they are defence caused which are covered under the VEA which was bought in by a Labour Government in 1972*

**Option 2: Reimbursement for those with Qualifying Service and receiving Disability Pension, adjusted by DP rate**

An alternative option would be to consider an approach which adjusts the level of reimbursement, in a manner which includes a proxy adjustment for pharmaceutical usage which is not related to war caused disabilities. One possible such proxy could be, for those veterans with QS and in receipt of DP, to use the DP rate as a determinant of the amount of reimbursement.

Under this option DP Veterans with QS would receive reimbursement for out of pocket pharmaceutical costs with the level of additional payment related to their level of disability. As such, those in this group on a DP of 100%, EDA, Intermediate, Blind, TPI and TTI could receive the full reimbursement while those on less than 100% DP could receive a pro rata reimbursement according to their rate of DP. For example under this approach, in 2010, a 50% DP veteran who had incurred the maximum possible out of pocket cost of \$168 would be reimbursed \$84.

**Our Comment**

*This option is excellent for those on 100% of the general rate and those on above general rate but is discriminatory against those who are only on a percentage of the general rate as they would not be getting the full reimbursement for their required pharmaceuticals. Regardless of rate of pension no disability pensioners should be out of pocket and should be reimbursed accordingly.*

**The VVAA Policy in relation to Pharmaceuticals is:**

14. DVA concession card holders to be deemed to have reached the Pharmaceutical Benefits Safety Net threshold at the commencement of each calendar year.

Where an RPBS item is priced above the lowest priced brand or product in a therapeutic group of medicines the concession card holder must receive reimbursement from DVA where:

- (i) The illness or injury is an accepted disability; and
- (ii) The treating physician affirms in writing that the higher priced item is the only appropriate item for that treatment

**VVAA Qld Branch Preferred Option**

15. The VVAA Qld Branch preferred option is that all DVA card holders entitled to the PhA be deemed to have reached the Pharmaceutical Benefits Safety Net threshold at the commencement of each calendar year.

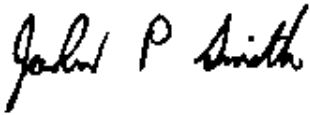
16. Where a RPBS item is priced above the lowest priced brand or product in a therapeutic group of medicines the DVA card holder entitled to PhA must receive reimbursement from DVA where:

- (i) the illness or injury is an accepted disability; and
- (ii) the treating physician affirms in writing that the higher priced item is the only appropriate item for that treatment,

17. Our second option would be that the Copayment and the PhA be the same amount each as it was for the first seven years of its operation and they remain equal in the future

18. The VVAA Qld Branch Inc fully endorses the submission by the VVAA and also their policy and it has our full support. However we take this opportunity to submit our own in conjunction. We believe that both submissions are in tandem and that there should be no conflict. We take this opportunity to thank you for conducting this review and inviting comments from those interested parties. We eagerly await the outcome.

Yours faithfully



Signed Electronically

John P Smith, OAM, JP (Qual)

President

Vietnam Veterans Association of Australia

Queensland Branch Inc.