

The PBS community awareness campaign: how helpful is blaming patients?

Evan Doran and David A Henry

The current "Pharmaceutical Benefits Scheme (PBS) community awareness campaign" explicitly links the difficulties facing the PBS to patient behaviour and "waste". The campaign suggests that patients are taking advantage of affordable access to prescription medicines, and emphasises that patient responsibility is "the prescription for a healthy PBS". By neglecting to inform the public that the pressures facing the PBS also include doctors' prescribing habits and intensive pharmaceutical industry marketing, the campaign has missed an opportunity to initiate a balanced and constructive debate about the future viability of the PBS. (MJA 2003; 179: 544-545)

IT HAS BECOME SOMETHING of an axiom that increasing cost is endangering the Pharmaceutical Benefits Scheme (PBS), and that something must be done about it. Typically, policy responses have been to target the prescription end-user — the patient. Successive governments have increased patients' out-of-pocket charges as a means of containing drug costs. The present federal Government, thwarted thus far by the Senate in its attempt to increase the patient co-payment, is trying an alternative — appealing to patients' moral sensibilities rather than their hip-pocket nerve.

The current "PBS community awareness campaign",¹ an initiative of the National Strategy for Quality Use of Medicines (QUM)² has been launched at a reputed cost of \$27 million through a nationwide advertising strategy.³ The objective of informing the Australian public about the operation, strengths and costs of the PBS is laudable. However, the tone of the campaign is morally charged, with the suggestion that many Australian patients are not acting responsibly in their use of prescription medicines. The two main mediums of the campaign — a series of television advertisements and an information booklet — emphasise an association between patient behaviour, "waste", and the increasing financial pressure on the PBS, a pressure which imperils the future viability of the scheme. It appears that patient responsibility is "the prescription for a healthy PBS".

As part of the National Medicines Policy, the strategy for QUM is underpinned by a set of principles, the first of which is "the primacy of consumers". The strategy claims to recognise "the wisdom of consumers" and states "consumer involvement in all aspects of the Strategy is critical".² Far from incorporating the wisdom of patients, the present campaign appears to selectively choose more extreme examples of misuse of medicines to establish a moral position and

place the responsibility for increasing prescription demand on patients.

The campaign booklet states "some people like to get a prescription every time they visit a doctor". This statement implies that patients drive the demand for prescriptions and that the low cost of prescription medicines promotes wasteful behaviour. The campaign repeatedly advises patients to take note of the full cost of the prescription that is borne by the Scheme (this is now highlighted on prescription labels). With such information, patients can "use the PBS responsibly" and minimise "waste". Patients are also exhorted to consider their need for repeat prescriptions, but are not advised of the dangers of stopping treatment for some serious disorders (eg, diabetes and heart failure).

The National Medicines Policy document raises the concern that "easy access can work against the quality use of medicines", offering the common anecdote of patients' stocking up unnecessarily on prescription medicines "... because they are available free or at low cost". While patients probably do initiate a certain amount of unnecessary prescription demand, the relationship of this to the cost of a prescription is not clear in the available evidence.⁴ Further, there is no substantial evidence to show that such behaviour is common enough to be a major contributor to rising drug expenditure. The emphasis on patient responsibility reveals a conviction that prescription subsidy through the PBS results in significant "moral hazard". In other words, low out-of-pocket cost generates unnecessary prescription demand or "waste".

Arguments for the operation of a "moral hazard" rest not on direct observations of patient behaviour, but on studies of aggregate prescribing data.⁵ Rather than drawing on the wisdom of patients, fluctuations in use of prescription medicines after changes to out-of-pocket costs are used to make inferences about patients' motivations. Differences in rates of use of "essential" therapies compared with "discretionary" therapies are taken as proxies for "necessary" and "unnecessary" patient behaviours.⁶ However, prescribing data cannot show whether the changes in pharmaceutical use reflect appropriate or inappropriate patient responses to increased cost; nor can they reveal the motives of patients who have received prescriptions. Increased demand when drugs are affordable does not itself mean that patients are using medicines unnecessarily.⁷

 MJA Rapid Online Publication: 20 October, 2003

Department of Clinical Pharmacology, University of Newcastle, Newcastle, NSW.

Evan Doran, PhD, Researcher; David A Henry, FRACP, Professor.
Reprints will not be available from the authors. Correspondence: Professor David A Henry, Department of Clinical Pharmacology, University of Newcastle, Level 5, Clinical Sciences Building, Mater Misericordiae Hospital, Newcastle, NSW 2298. mddah@mail.newcastle.edu.au

The increasing cost of the PBS does, however, mean that Australians are being given more prescriptions, often for newer or novel therapies. Australians, like the citizens of other developed nations, live in a society where prescription medicines are central to the provision of healthcare and increasingly prominent in how we prevent and manage illness. The pharmaceutical industry devotes considerable expense and effort to promoting drugs directly to doctors and less directly to patients.⁸ Australian doctors' preferences for prescribing newly released medicines, often neglecting older cheaper alternatives, have long been noted.⁹⁻¹³ Patients may sometimes ask their doctor to prescribe the latest available drug for their condition; however, there is no evidence to indicate that low cost is a prime motivator in this demand.

The diminishing numbers of general practitioners willing to "bulk-bill" their patients means that seeing a doctor requires an increasing out-of-pocket expense for many patients.¹⁴ Most Australian patients do not undertake the cost and inconvenience of consulting a doctor lightly. It is unlikely that many visit their doctor to unnecessarily access affordable medicines. Even with affordable access, the underuse of prescription medicines is a commonly acknowledged problem. While some patients may "like to get a medicine every time they visit the doctor" (quote from the Strategy), other patients don't seek a medicine when it is necessary, do not always accept a necessary prescription, nor do they always adhere to their prescribed therapy. Despite the PBS providing affordable access, medicine costs can still present a barrier for some Australian medicine users, particularly the chronically ill and those on lower incomes but not eligible for government concessions.¹⁵

While the strategy has parallel initiatives aimed at enhancing QUM among health professionals and the pharmaceutical industry, the notion of pharmaceutical "waste" is not a prominent feature of these. In contrast to the message about "waste" that is communicated to consumers, health professionals and industry staff who visit the PBS Web home-page receive a brief outline of the PBS drug-listing process. The strategy and its current awareness campaign give the impression that whatever waste exists is largely driven by consumers taking advantage of affordable access. Related phenomena such as prescription "drift" (the tendency to prescribe newer more expensive medicines for common conditions) and "leakage" (prescribing to a broader population than was intended in the subsidy decision) and aggressive industry marketing are left out of the public gaze.^{13,16} This restricts the community's awareness about the PBS, the pressures it faces and its future viability. An opportunity has been missed to provide the public with a comprehensive and balanced view of the problems facing the PBS.

The Strategy, as presented to the public, has selectively focused on the role of affordable access in creating "waste" and in contributing to the pressure on the PBS. Because of the complexities of prescription drug use in the community,

this will have little impact on quality use of medicines overall. Further, this focus potentially alienates patients from information on the other important factors contributing to increasing PBS expenditure, such as intensive promotion by pharmaceutical companies and doctors neglecting to prescribe older, cheaper therapies. Accepting that most prescription use is necessary begs the question of what proportion of medicine use is unnecessary and what factors combine to generate such use. These questions are still to be coherently answered, and what current knowledge exists is insufficient to justify elevating "moral hazard" to a primary cause of difficulties facing the PBS. A more balanced approach to informing the community about these problems would be to acknowledge the role of patients, health professionals and the pharmaceutical industry in creating demand, and to initiate an informed debate on how to sustain the PBS.

Competing interests

None identified.

References

1. Australian Government Department of Health and Ageing. PBS community awareness campaign. Available at: www.health.gov.au/pbs/general/campaign.htm (accessed Oct 2003).
2. Australian Government Department of Health and Ageing. The National Strategy for Quality Use of Medicines. Canberra, ADHA, 2002. Available at: www.nmp.health.gov.au/quality.htm (accessed Oct 2003).
3. Parliamentary debates. Australian House of Representatives. 40th Parliament, 1st Session—6th Period. Official Hansard, No. 14, 2003: 20527. Available at: www.aph.gov.au/hansard/reps/dailys/dr180903.pdf (accessed Oct 2003).
4. Davey P, Lees M, Aristides M. Report on the Australian System of Pharmaceutical Financing and Delivery. Vol 1: Efficiency and equity implications of public versus private funding of pharmaceuticals. Chatswood, NSW: Medical Technology Assessment Group, Nov 1999.
5. Gerdtham U-G, Johannesson M. The impact of user charges on the consumption of drugs. *Pharmacoeconomics* 1996; 9: 478-483.
6. McManus P, Donnelly N, Henry DA, et al. Prescription drug utilization following patient co-payment changes in Australia. *Pharmacoepidemiol Drug Saf* 1996; 5: 385-392.
7. Stuart B, Grana J. Ability to pay and the decision to medicate. *Med Care* 1998; 36: 202-211.
8. Moynihan R, Heath I, Henry D. Selling sickness: the pharmaceutical industry and disease mongering. *BMJ* 2002; 324: 886-891.
9. Richardson J. The effects of consumer co-payments in medical care. National Health Strategy Unit, June 1991. (National Health Strategy Background Paper No. 5.) Available at: www.health.gov.au/archive/nhs/documents/nhs6.pdf (accessed Oct 2003).
10. Kerr SJ, Mant A, Horn FE, et al. Lessons from early large-scale adoption of celecoxib and rofecoxib by general practitioners. *Med J Aust* 2003; 179: 403-407.
11. Dowden JS. Coax, COX and cola [editorial]. *Med J Aust* 2003; 179: 397-398.
12. Hill SR, Henry DA, Smith AJ. Rising prescription drug costs: whose responsibility? [editorial] *Med J Aust* 1997; 167: 6-7.
13. Rickard M. The Pharmaceutical Benefits Scheme: options for cost control. Canberra: Parliament of Australia, Department of the Parliamentary Library, 2002. (Current Issues Brief No. 12, 2001-02.)
14. Young AF, Dobson AJ. The decline in bulk-billing and increase in out-of-pocket costs for general practice consultations in rural areas of Australia, 1995-2001. *Med J Aust* 2003; 178: 122-126.
15. Consumers' Health Forum. Costs of chronic illness and Quality Use of Medicine. Lyons, ACT: Consumers' Health Forum of Australia Inc, 1997.
16. Nelkin D. An uneasy relationship: the tensions between medicine and the media. *Lancet* 1996; 347: 1600-1603.

(Received 18 Sep 2003, accepted 10 Oct 2003)

□