

Are prescription copayments compromising patient care?

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In 2011, around 240 million prescriptions were dispensed on the Australian Pharmaceutical Benefits Scheme (PBS) at a cost of \$8.3 billion to the government and a further \$2 billion in patient copayments to the pharmacies. The copayment is the price paid by a patient for a prescription.¹ It has evolved over the years and now seems to lack a purpose other than offsetting the cost to government.

In 2013, patient copayments are \$36.10 for each prescription or \$5.90 if the patient has a concession status. These charges are reduced once a family's expenses in one year reach a safety net threshold. Currently, these thresholds are \$1390.60 for general and \$354 for concessional patients. The copayments and safety net thresholds are adjusted for inflation every January.

Most general practitioners and community pharmacists are well aware that some patients have difficulty paying for their prescriptions. While copayment increases may reduce what the government pays for medications, they also have

unintended effects on patients and elsewhere, for example on the hospital system.

Increases in copayments primarily affect vulnerable populations such as those on low incomes and patients with chronic medical conditions taking multiple medications. To deal with increased costs, patients often reduce or stop taking their medicines and this can have potentially serious health consequences.² This failure to take medicines can also lead to increased visits to the doctor and hospitalisations.³

There is a relationship between patient cost sharing, medication adherence and clinical and economic outcomes. Increasing the patient's share of medication costs is associated with a decrease in adherence, which in turn is associated with poorer health outcomes.⁴ Tiered prescription copayments (similar to brand price premiums and therapeutic group premiums) shift use from 'nonpreferred' to the lower cost 'preferred' medications.⁵

Some have argued that greater cost sharing does not undermine overall patient health because patients facing rising costs will reduce their consumption of perceived non-essential medications more than their consumption of essential drugs.⁶ However, 'preventive' drugs are different, because not all patients understand the long-term benefits of taking medicines for conditions such as hypertension and hypercholesterolaemia. In this case, underutilisation may be the problem and 'too much' cost sharing could lead to a loss of clinical benefit.⁶ For example, in the USA when copayments were increased from \$6 to \$10 there was a 6% increase in non-adherence and a 9% reduction in full adherence in patients with type 2 diabetes.⁷

According to the Australian Bureau of Statistics, 9% of adults will delay or not collect their prescriptions.⁸ In addition, both non-adherence and poor persistence with long-term treatment are well documented in Australia.⁹ One of the major reasons (but not the only reason) for patients failing to collect their medicines is the relatively large out-of-pocket costs of the prescriptions. These costs can become prohibitive if patients are taking multiple drugs.

Evidence is emerging that more patients are failing to collect their prescriptions. Industry data on prescribing of a third-line 'add-on' antihypertensive drug showed that towards the end of 2011, the

From the Editor



The first issue of 2013 could be controversial. The papers on calcium, chemotherapy, convulsive therapy, competency and copayments are certainly thought-provoking and could change practice.

Calcium supplements are widely promoted and prescribed for bone health. While some patients may benefit, Mark Bolland, Andrew Grey and Ian Reid believe that widespread use of calcium is no longer appropriate as the supplements can increase the risk of cardiovascular events.

The use of oral cytotoxic drugs is increasing. Although patients can now be treated at home, there are risks and Christine Carrington advises how to minimise the potential harm.

There is also increasing use of biological medicines in the community. Sateesh Shankaranarayana, Claire Barrett and Paul Kubler review the safety of leflunomide.

Concerns about the safety of lithium have limited its use, but Gin Malhi, Michelle Tanious, Danielle Bargh, Pritha Das and Michael Berk say it is well tolerated if prescribed wisely. Although it is not heavily promoted, lithium is an effective treatment for bipolar disorder.

Some patients with depression will require electroconvulsive therapy. Colleen Loo tells us that the new technique of ultrabrief pulse stimulation could reduce the cognitive adverse effects of this treatment.

Safe treatment requires health professionals to be competent in what they do. Elaine Lum, Charles Mitchell and Ian Coombes consider how to assess the competencies of Australian prescribers.

proportion of prescriptions dispensed on the PBS had declined relative to the number of prescriptions written by general practitioners.

Compared to 2010 the percentage change in concessional prescriptions was consistent with a reduced rate of dispensing from about August 2011. The change in concessional dispensing was also apparent with other antihypertensives. This suggests that concessional copayments may have been too high and fewer patients reached the safety net threshold. (Patients had to pay an extra \$12 to reach the concessional safety net in 2011).

Even though the PBS has reduced the price of many commonly prescribed medicines, the cost to concessional patients did not change, because their copayment remains the same. In contrast, general

patients derived significant savings from the lower prices, but only if their drugs were priced under the general copayment.

The current fixed copayment system has been around for more than 25 years and with all the PBS reforms taking place, it may be time to take a closer look at patient copayments. The current approach to PBS savings is that the government takes most of the cost savings, but increases copayments and safety net thresholds each year in line with inflation. Increasing copayments reduces medication adherence and ultimately may compromise the care of some patients. ◀

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Letters to the Editor

Error in compounding imiquimod 0.1% cream for molluscum

Editor, – Imiquimod 5% cream (Aldara) is available in single use 250 mg sachets for genital warts and basal cell carcinoma. For some years, doctors have been prescribing imiquimod 'off-label' for the treatment of molluscum contagiosum in children. Because of the cost (\$150–200 for 12 sachets) it is usually prescribed as compounded imiquimod 0.1% cream. To make this, one sachet of imiquimod 5% cream can be diluted 50-fold to 12.5 g of 0.1% cream.

I have seen four children who had been prescribed imiquimod 0.1% which was compounded incorrectly by three separate pharmacies. Each pharmacist had incorrectly assumed that the label '250 mg' on the packaging refers to the quantity of the active ingredient – imiquimod – in the sachet. In fact, it refers to the quantity of 5% cream.

As each dispensed jar of cream is labelled 'imiquimod 0.1%', clinicians need a high index of

suspicion to detect this error. They will need to confirm with the patient how much cream was given and what it cost. For example, if a patient received a 250 g jar of '0.1% cream' for \$49.95 (as in one of my cases), it is clear an error has been made as this would otherwise contain several hundred dollars worth of imiquimod.

Some months after it began being routinely used for molluscum treatment in Melbourne, imiquimod 0.1% was described to me as 'working well' and 'effective' in many children. To my knowledge, all those children had received their compounded cream from one pharmacy and the dilution was incorrect. As such they had only received imiquimod 0.005%, a 1 in 1000 dilution of the commercially available product. It is unlikely that this was effective and illustrates the difficulty of assessing treatments for molluscum. Molluscum lesions often flare (and hence present to the doctor) shortly before complete resolution so that clearing



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