

RECESSION AND DEPRESSION

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Introduction

The current economic crisis is increasing the level of financial stress confronting Australians, at a time when out-of-pocket health care costs are high. The heaviest burden will fall on those with the poorest health and the greatest need, people with chronic illnesses, including those with mental illness.

Despite the universal cover offered by Medicare, free public hospital care and the significant subsidization of prescription medicines by the Pharmaceutical Benefits Scheme (PBS), sick Australians face some of the highest co-payment costs within the Organisation for Economic Co-operation and Development (OECD) countries (1), and have out-of-pocket costs close to those faced by Americans (2). An international study released by the Commonwealth Fund (3) shows that in 2008, 36 percent of chronically ill Australians said that they had failed to fill a prescription or skipped medication doses, did not visit a doctor when they had a medical problem or did not get recommended tests, treatment or follow-up because of cost.

A recent Australian survey conducted by the Menzies Centre for Health Policy and The Nous Group reinforces these reports. This survey, conducted in July and August last year, found a direct correlation between reported levels of financial stress and missed medical tests and treatment, failure to collect a prescription and skipping doses of medication, and going without needed dental care. These Australians were 50 percent more likely to report their health as fair or poor compared to those whose families were not under financial stress, only half as likely to have private health cover (reported levels at 28 percent compared to 60 percent) and 78 percent said they found it difficult to access non hospital based medical services out of hours, at weekends and holidays (4).

A current study looking at what pharmacists do when they become aware that patients are non-compliant with their prescription medication regime has highlighted that chronically ill patients often struggle to afford to fill all their prescriptions and make choices about which medicines they must go without, at least for a certain period of time (5).

PBS co-payment and safety net threshold increases

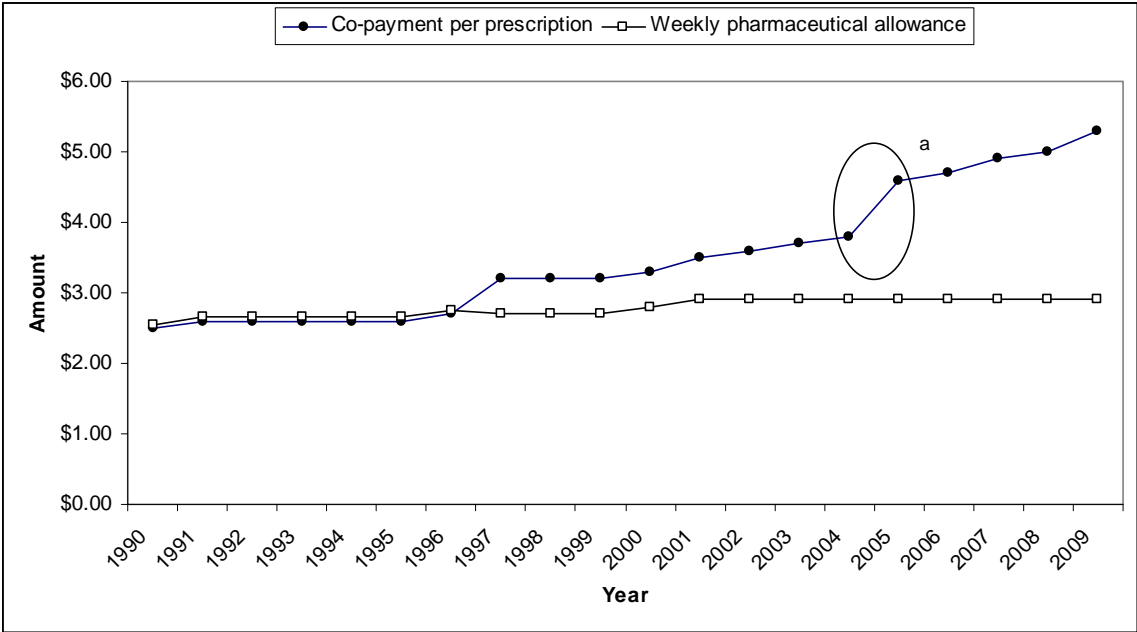
The 1 January 2009 increase in PBS co-payments and safety net thresholds passed almost unremarked, but for many these increases (see Figure 1) will be an additional health cost they can ill afford. Since 2006, the safety-net thresholds have increased by the equivalent cost of two prescriptions a year, meaning that fewer patients are eligible for fully-subsidised medicines as the year progresses. People with concession cards must now pay \$318.00 (the

cost of 60 prescriptions) before they qualify for the PBS safety net. In 2004, the PBS safety net threshold for concession card holders was \$197.60 (equivalent to the cost of 52 prescriptions).

The fact that concession card holders pay only \$5.30 for each prescription may seem a small impost, but many of these people are chronically ill and need multiple medications (6). They also have substantial other health costs – for medical care, equipment and aides, care and transport (7).

Once again, as for the past 12 years, the annual increase in PBS co-payments is not matched by an increase in the Pharmaceutical Allowance paid to pensioners (Figure 1 and Table 1).

Figure 1: Historical co-payment amounts for concessional beneficiaries and weekly pharmaceutical allowance provided to pensioners.



a: January 2005 24% co-payment increase

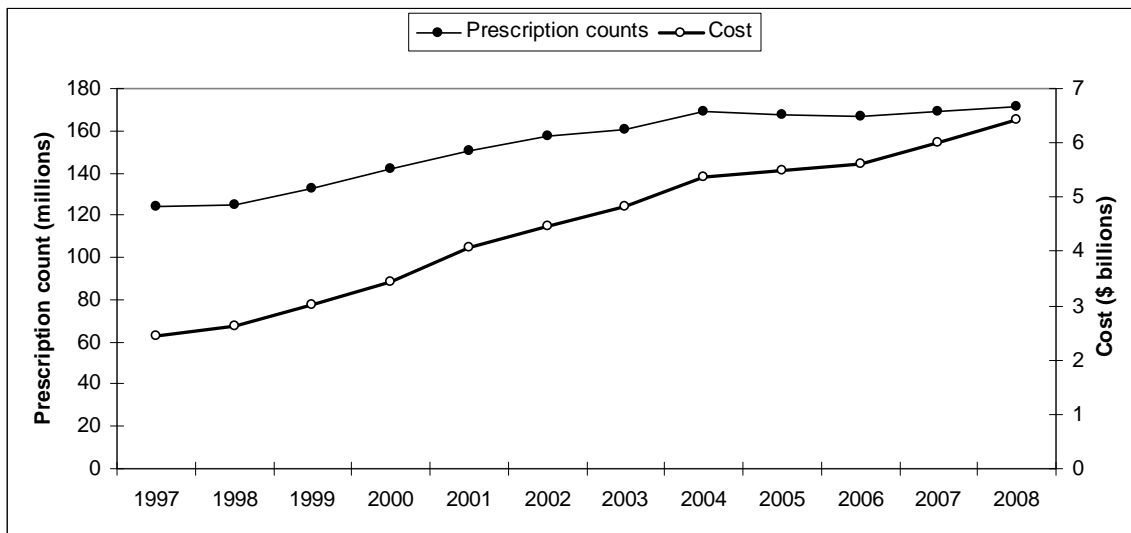
Table 1: Historical co-payment amounts and safety net thresholds for concessional beneficiaries.

Year	Co-payment amount	Safety-net threshold	Equivalent cost of safety net
1990	\$2.50	\$130.00	52 prescriptions
1991	\$2.60	\$130.00	50 prescriptions
1992	\$2.60	\$135.20	52 prescriptions
1993	\$2.60	\$135.20	52 prescriptions
1994	\$2.60	\$135.20	52 prescriptions
1995	\$2.60	\$135.20	52 prescriptions
1996	\$2.70	\$140.40	52 prescriptions
1997	\$3.20	\$166.40	52 prescriptions
1998	\$3.20	\$166.40	52 prescriptions
1999	\$3.20	\$166.40	52 prescriptions
2000	\$3.30	\$171.60	52 prescriptions
2001	\$3.50	\$182.00	52 prescriptions
2002	\$3.60	\$187.20	52 prescriptions
2003	\$3.70	\$192.40	52 prescriptions
2004	\$3.80	\$197.60	52 prescriptions
2005	\$4.60	\$239.20	52 prescriptions
2006	\$4.70	\$253.80	54 prescriptions
2007	\$4.90	\$274.40	56 prescriptions
2008	\$5.00	\$290.00	58 prescriptions
2009	\$5.30	\$318.00	60 prescriptions

The impact of PBS co-payments on prescription numbers

Previous studies by the authors and their co-workers (8,9) have shown that when the PBS co-payments rose sharply, by 24% in January 2005, there were substantial falls in dispensings of prescription medicines (Figures 2, 3).

Figure 2: PBS prescription and costs to government before and after the 2005 24% co-payment increase.

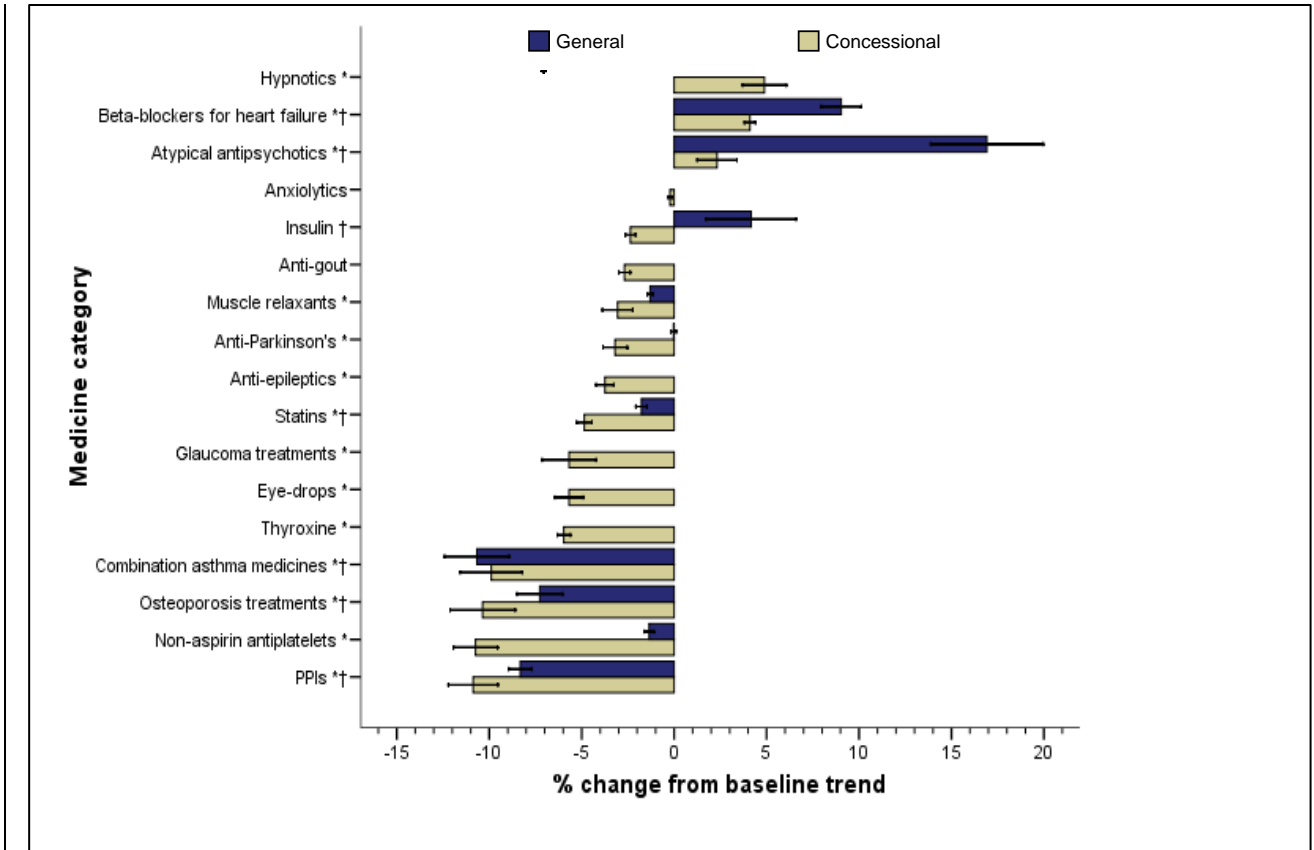


In the calendar years (CYs) up until 2005, the average growth rate for prescriptions dispensed in Australia was 5.25%. There were fewer prescriptions dispensed in CY 2005, 2006, 2007 than in CY 2004, and only in CY 2008 have prescriptions numbers started to rise again (by 1.1% over the previous year). If prescription growth rates had continued at 5.25%, then 26.4 million additional prescriptions would have been dispensed in CY2008 than was actually the case (171.2 million). While a temporary drop in prescription numbers following the introduction of the co-payment increase was expected, the long-lasting nature of this drop was not.

There are a number of confounding factors impacting on these figures, however, including many medicines falling off data capture with each rise in co-payments. Work from Hynd et al (9) examined categories of medicines that were not affected by changes in data capture, as all medicines remained above the co-payment thresholds for the period being studied. The study found that the impact of the 24% increase in co-payments was not distributed equally across all therapeutic categories of medicines, and fell heaviest on concession card holders (Figure 3).

While it is possible that some patients reduced ‘unnecessary’ use of these medicines, previous evidence suggests that co-payment increases often result in decreases in both ‘essential’ and ‘non-essential’ medicines (10, 11). The most likely explanation for the decreases seen across many categories of essential medicines is that patients were struggling to afford their needed medications (Figure 3).

Figure 3: Percentage change (95% CIs) in dispensings after the January 2005 increase in patient co-payments to concessional and general beneficiaries compared with the baseline trend. (9)



*Indicates significant percentage change in dispensings to concessional beneficiaries, $p < 0.001$.

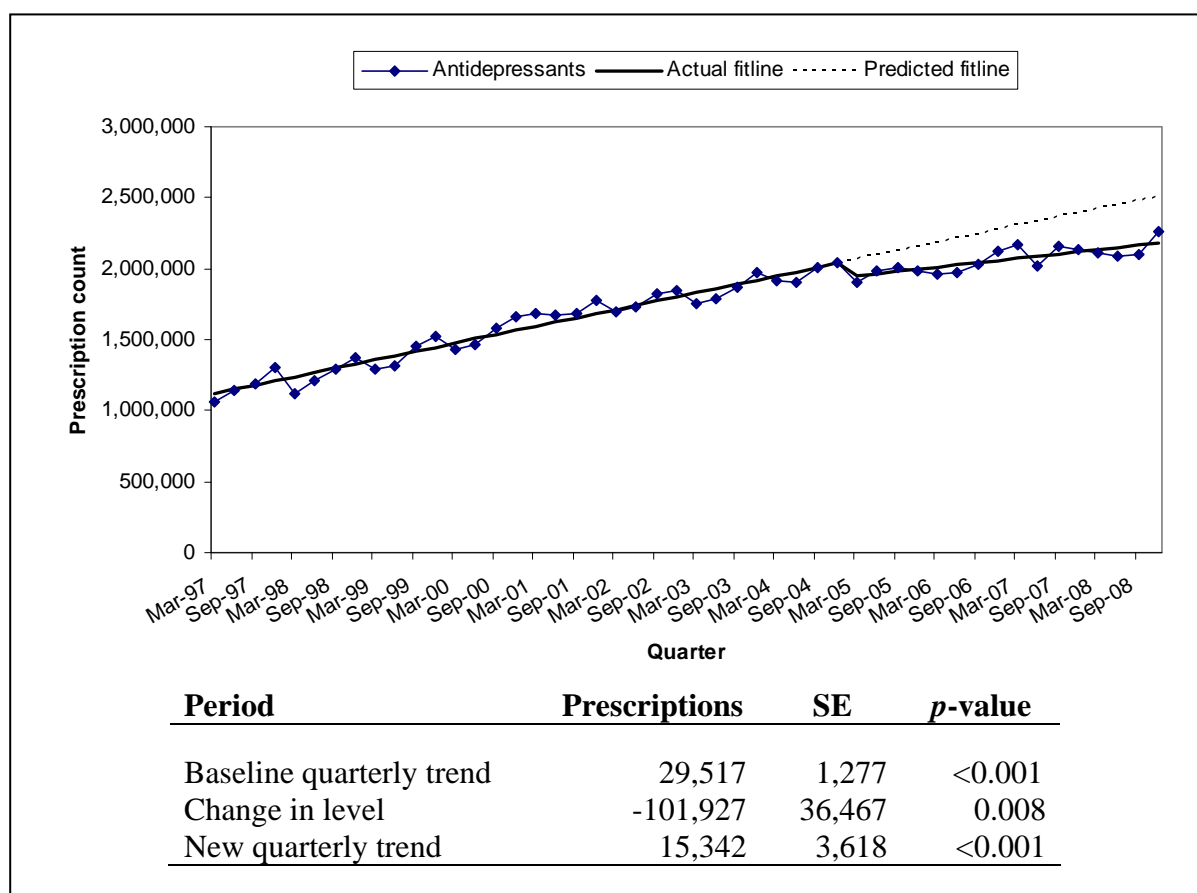
†Indicates significant percentage change in dispensings to general beneficiaries, $p < 0.001$.

The impact of PBS co-payments on PBS medications for depression

We were interested in the impact of PBS co-payment increases on medicines used to treat depression, which is now Australia's most debilitating illness (12). Recent current events such as the global economic crisis are likely to contribute to this disease burden, at least in the short term. We were also interested to see if the Medicare Better Access to Mental Health Services program, introduced in November 2006, had resulted in a change in the prescribing levels of these medications.

We analysed the number of PBS prescriptions for medicines used to treat depression which were dispensed to concession card holders, in each quarter between January 1997 to December 2008 (Figure 4) (13).

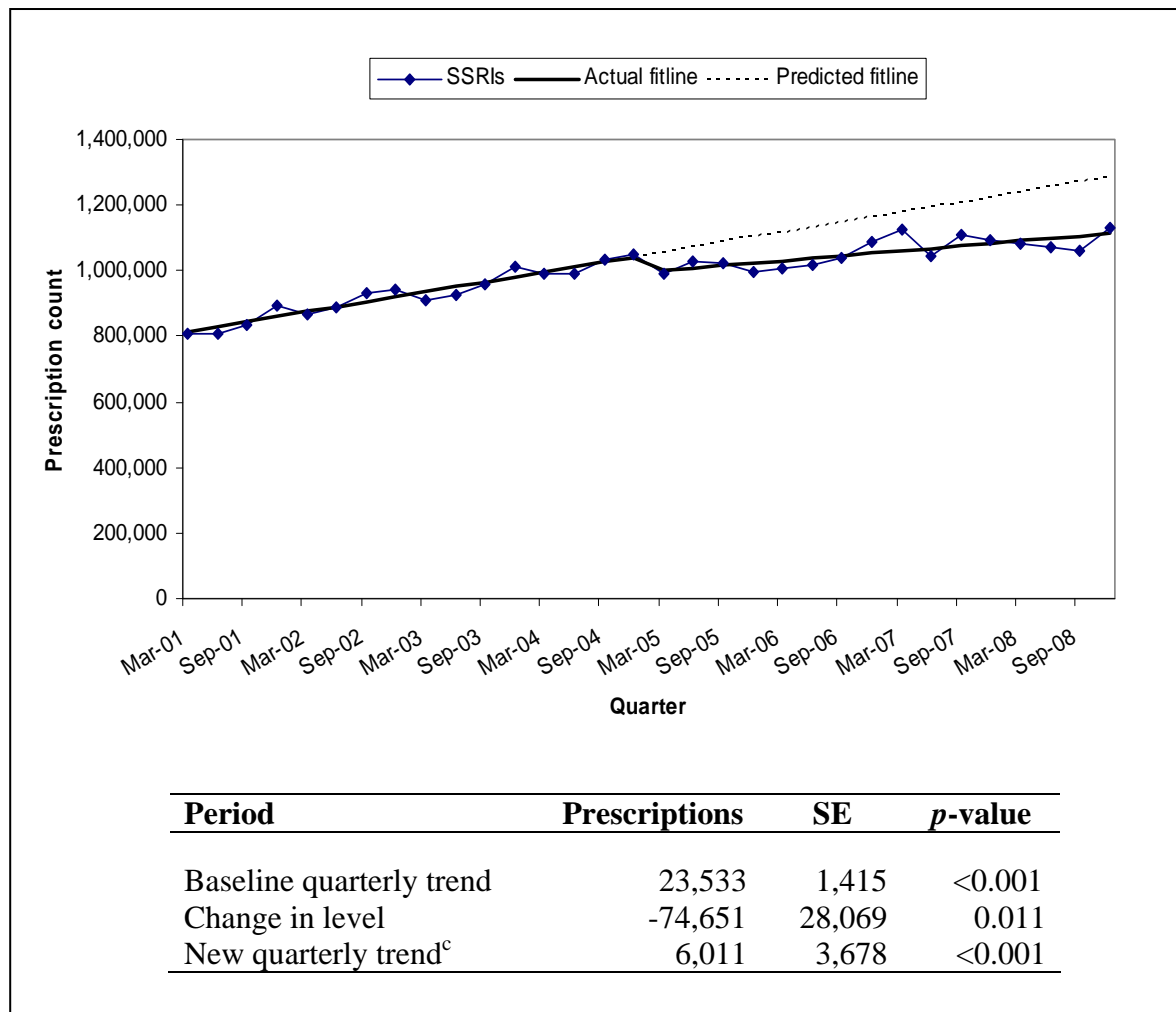
Figure 4: Aggregated script volume of all antidepressant medicines dispensed to concessional beneficiaries in Australia before and after the 24% rise in co-payments (by date of processing).



Prior to January 2005, an additional 29,514 antidepressant prescriptions were being dispensed to concessional beneficiaries each quarter, on average (Figure 4). After the January 2005 increase in co-payments, there was an immediate drop of approximately 100,000 prescriptions, and only 15,342 additional prescriptions were dispensed each quarter, on average, after this point in time. The actual number of prescriptions dispensed to concession card holders at the end of December 2008 was 2,264,096. The value that would have been expected in December 2008, had the 2005 24% co-payment rise not occurred, is 2,509,562. The actual dispensing trend after January 2005 is an average of 9.6% lower than would have been expected, had the co-payment rise not occurred (this is a significant fall $P < 0.001$).

Antidepressants can be categorised into four groups: 1) tricyclics, 2) monoamine oxidase (MAO) inhibitors, 3) selective serotonin reuptake inhibitors (SSRIs), and 4) 'other' antidepressants. We looked specifically at the SSRI category as these medications are the most commonly prescribed of the antidepressants (13) and are recommended because of their efficacy and tolerability (14) (Figure 5).

Figure 5: Aggregated script volume of all SSRIs dispensed to concessional beneficiaries in Australia before and after the 24% rise in co-payments (by date of processing).



Prior to January 2005, an additional 23,533 SSRI prescriptions were being dispensed to concessional beneficiaries each quarter, on average (Figure 5). After the January 2005 increase in co-payments, there was an immediate drop of approximately 74,000 prescriptions, and only 6,011 additional prescriptions were dispensed each quarter, on average, after this point in time. For SSRIs, the actual count of prescriptions dispensed at the end of December 2008 was 1,131,378. The number of prescriptions that would have been expected in December 2008, had the January 2005 co-payment rise not occurred, is 1,283,494. The actual trend after January 2005 is an average of 9.5% lower than would have been expected, had the co-payment rise not occurred (this is a significant fall $P < 0.001$). (i.e. 62% of the fall in antidepressant medications is due to a fall in prescriptions filled for SSRIs)

Discussion

The clear evidence from our data is that there has been a decline in the rate of PBS prescriptions filled for antidepressant medications, and that this decline is coincident with a large increase in co-payments and the safety net thresholds. Moreover, the rate decline seen for these medicines from the first quarter of 2005 has remained constant through to the end of

December 2008. As a consequence, in the December 2008 quarter, there were 245,466 fewer antidepressant prescriptions dispensed than might have been expected.

The most significant issue here is whether there is a major discrepancy between the number of prescriptions that doctors are writing for their patients and the number of prescriptions that patients are filling and taking, and the impact of increasing co-payments and financial pressures on the number of prescriptions filled.

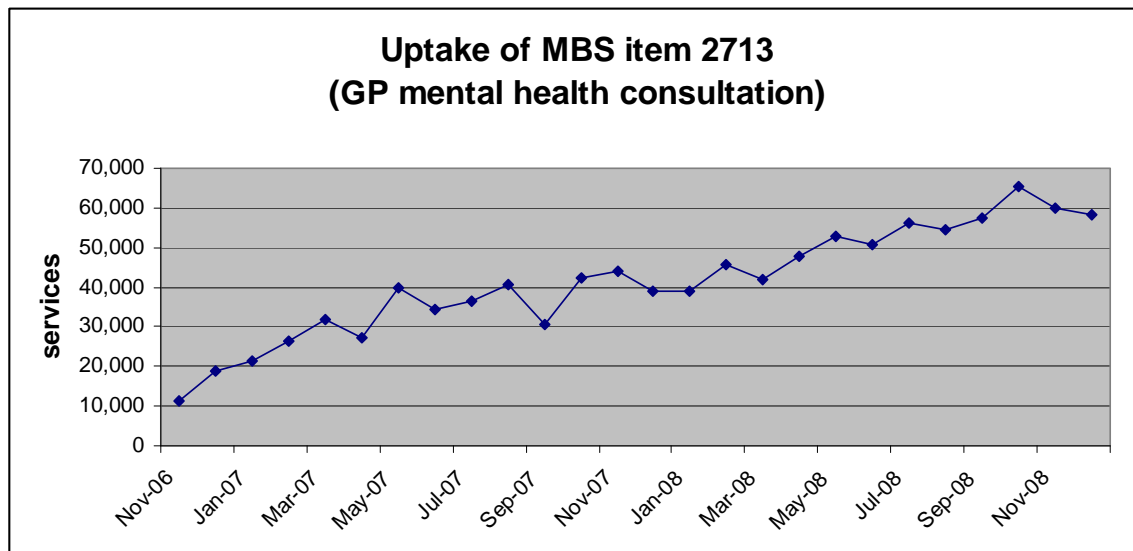
We are not able to definitively answer this question with the data available to us. While we acknowledge that there are a variety of confounding factors that come to bear on this issue, we do believe that current evidence gives rise to very real reasons for concern, especially in the current economic climate, that financial pressures are having an adverse impact on the ability of many Australians to comply with their medication regimes.

The most recently available BEACH data show that the prescribing rates by general practitioners (GPs) for psychoanalytic drugs (the majority of which are antidepressants) increased from 2.1 / 100 problems managed in 1998-98 to 2.4 / 100 problems managed in 2006-07 (15). This suggests that a significant (but unknown) number of prescriptions go unfilled.

There is no evidence to hand to suggest that this drop in prescription numbers is due to a greater focus on treatments for depression such as Cognitive Behavioural Therapy (CBT) that may diminish the need for medication.

The Medicare Better Access to Mental Health Services Program, introduced in November 2007, now provides reimbursement for mental health services delivered by psychologists, social workers and occupational therapists, but none of these health professionals has PBS prescribing rights. There has however been a rapid growth in the use of the relevant MBS items for GPs, such that by December 2008, there were 60,000 GP mental health specific consultations a month (Figure 6).

Figure 6. Increase in GP mental health consultations (MBS item 2713) in Australia between November 2006 and December 2008.



In 2006-07 the average rate of prescribed medications for GPs was 83.3 / 100 encounters (15). Assuming this prescribing level for mental health consultations (item 2713), would indicate an expected increase in prescriptions of 122,451/ quarter by December 2008.

Of course this increase in prescriptions is only seen if the increase in mental health consultations reflects new patients accessing care for their mental health problems. The recent ABS National Survey of Mental Health and Wellbeing highlighted that in 2007 there had been no increase in the number of people with a mental health problem receiving services (35%) over the number reported a decade earlier (38%) (16).

Both Prime Minister Kevin Rudd and US President Barack Obama have acknowledged that health care is as much an economic issue as it is an issue of social justice and equity. However it is clear from this data that, as the economic crisis deepens, there is a very real risk that those most dependent on the health care system will miss out on needed services.

That will mean reduced quality of life for them, diminished productivity for business, increasing pressure on the public hospital system and increased health costs for government budgets. Under such circumstances, there are no winners, only losers.

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