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The price must be right to put obesity drug on the PBS

Medicines It is vital that the gatekeepers of the scheme hold the line on the cost benefits of blockbuster drugs.

Nick Coatsworth

Whether to fully subsidise the new-generation weight loss drugs such as Mounjaro and Ozempic for obese Australians without diabetes represents one of the most challenging decisions in years for the Pharmaceutical Benefits Advisory Committee (PBAC).

The drugs are known collectively as GLP-1 agonists, and no other class of medications has gained such a foothold in the private market before being funded under the Pharmaceutical Benefits Scheme (PBS). Nor has there been such publicity and, indeed, controversy over how a medication should be used to treat a complex and often socially determined medical issue.

A staggering four in five older Australians are overweight or obese. One in every 15 adults aged 45-54 is classified as "morbidly obese". This is an epidemic responsible for the vast majority of lifestyle-related medical conditions. It is estimated that by 2032, obesity could cost the Australian budget a staggering $87.7 billion.

At the same time, obesity, like so many lifestyle conditions, reflects the wider social determinants of health. There is a substantial gradient of obesity according to socio-economic status and place of residence. The corollary is that those in most need of these drugs cannot afford them on the private market.

Global pharma giant Eli Lilly has signalled that it will lodge a submission to have its drug Mounjaro listed on the PBS in mid-2026. Burden of disease, affordability and access, and the UK's decision to publicly fund these drugs, will put significant external pressure on the PBAC to approve the submission.

However, it is essential that the relatively unknown group of medical and scientific professionals who make up the PBAC hold the line on their key metric: the cost-benefit analysis of widespread and government-subsidised use of GLP-1 agonists.

PBAC holds a vital gatekeeper role for Australian patients and the taxpayer base more broadly. It considers the safety, efficacy and, most importantly, the cost-benefit of new pharmaceuticals before making a recommendation to the health minister about whether a medicine should attract a PBS subsidy.

Author Johann Hari in his book *Magic Pill* cautioned against these drugs being seen as a panacea in the absence of long-term data. PHOTO: JOHN DAVIS

As a clinician, I admit patients on Ozempic and Mounjaro with gastrointestinal side effects relatively frequently.

Once those medications are on the PBS, they represent a new and permanent liability for the taxpayer until downward pressure is placed on prices when patents expire and generics enter the market. A PBAC that loosens its commitment to driving down cost and forcing global pharma giants to justify their pricing would be a nightmare for Finance and Treasury.

PBAC and its parent, the Therapeutic Goods Administration (TGA), have been accused of excessive waiting times for novel medicines to get PBS approval, with an average of 466 days from submission to approval. But most of this time is spent in pricing negotiations, for which pharma giants also bear responsibility if they enter negotiations at excessively high prices.

If the pricing set by Eli Lilly for the use of Mounjaro in type 2 diabetes is any marker, the company is unlikely to do the Australian taxpayer any favours with its initial pricing bid. A protracted negotiation is likely to be accompanied by political pressure to broaden the use of Mounjaro.

This may work in favour of PBAC, with competitor drug semaglutide (Ozempic) set to come off patent in the coming years, potentially forcing a compromise position on pricing.

Meanwhile, PBAC and the TGA may take the listing of GLP-1 agonists as an opportunity for a new approach to the approval of blockbuster drugs in Australia. The funding of post-marketing studies once drugs enter the PBS is an under-used means of assessing drug effectiveness and answering important cost-benefit questions and side-effect issues raised by the public.

Cutting through the hype to recognise that all drugs have undesirable side effects is crucial.

While the drug company-funded studies suggest a rate of gastrointestinal side effects causing treatment cessation at 4 per cent to 7 per cent, those studies may underestimate or fail to identify side effects that emerge in the "post-marketing" phase.

As a clinician, I admit patients on Ozempic and Mounjaro with gastrointestinal side effects relatively frequently. Author Johann Hari, in his book *Magic Pill*, cautioned against these drugs being seen as a panacea in the absence of long-term data, reflecting among other things on the relapse potential once the medication ceases.

With this in mind, the TGA should insist on Eli Lilly making a funding contribution to independent post-marketing analysis of Mounjaro if it is approved for obesity on the PBS. Such an approach could provide the leverage both sides need to reach quick agreement and offer much needed financial support to Australian researchers.

Finally, the debate over PBS approval of Mounjaro must not overshadow the critical elements of Australia's 2022-2032 National Obesity Strategy: creating equity, addressing wider determinants of health and empowering personal responsibility. Although everybody agrees on the need to engage in preventive health at a whole of community level, few articulate just how far upstream we need to go to make that a reality.

Australia's obesity crisis isn't about a magic pill. It's about how we encourage, fund and support Australians across all policy areas of government to live within a healthy weight.

Now that's a challenge worth taking on in 2025.

Nick Coatsworth is the Nine Network medical expert. He is a paid adviser on quality and safety for weight loss drugs to the telehealth company Eucalyptus.

Mediscare 'he said, she said' insults voters' intelligence

Politics A Labor-Coalition clash over bulk-billing is not only foolish, but masks the fact that much more must be done to keep our healthcare system fit for purpose.

Terry Barnes

Since the demise of the Abbott government's $7 mandatory GP co-payment, a 2014 budget measure, Medicare bulk-billing for general practitioner services has become more of an untouchable sacred cow than ever. It has become as preserved in political aspic as the sclerotic, chaotic and inefficient National Health Service has long been in Britain, and it will be no surprise if, in 2032, the Brisbane Olympics opening ceremony features a homage to bulk-billed Medicare, just as London 2012 starred the dancing beds of the NHS.

This hasn't stopped the Albanese government resorting to another "mediscare" to denounce its Coalition opponents. After Bill Shorten's highly successful mediscare 1.0 in 2016 – conjured from a modest administrative proposal to reorganise the Medicare back office – almost defeated then-prime minister Malcolm Turnbull and set the clock ticking on Turnbull's leadership, Labor has returned to the well again and again to frame itself as the defender of Medicare against conservative Visigoths seeking to destroy it.

It's therefore unsurprising, with Anthony Albanese's government languishing in the polls, and exploiting the fact Opposition Leader Peter Dutton was health minister in 2014, that mediscare is again being trotted out by Labor, and lavish public spending on Medicare is being foreshadowed as the centrepiece of Albanese's re-election pitch.

Before Christmas, Treasurer Jim Chalmers started the mediscare ball rolling. Addressing Coalition criticism of spending blowouts in the mid-year economic and fiscal outlook, Chalmers said: "When Peter Dutton was the health minister he came after Medicare. He tried to introduce a GP tax, he tried to attack the universality of Medicare, and we know he's a risk to Medicare because we know his record as health minister."

Both major parties are lazily reducing the debate on healthcare priorities and reform to the lowest common denominator of bulk-billing.

Federal health minister Mark Butler joined the fray, saying Labor had rescued bulk billing after its "free fall" under the Coalition. He cites the success of Labor's increased incentives to GPs to bulk-bill under-16s and concession cardholders while remaining silent on Australian Institute of Health and Welfare data showing that bulk-billing rates for Australians aged between 16 and 64 are falling, and patient out-of-pocket costs for GP services have increased. Butler hints at yet more public money being thrown at Medicare to increase bulk-billing and expand Labor's taxpayer-funded urgent care centre network that cuts the lunch of private general practices.

After Chalmers' first mediscare lunge, the Liberal Party parried with a video of opposition health spokeswoman Anne Ruston decrying Labor's hyperbole. Ruston highlighted billions of dollars in year-on-year Medicare funding increases under the previous Coalition government. "This led to record high bulk-billing rates," she boasted, stating that, under the Coalition, headline bulk billing reached 86 per cent, while under Labor it has fallen to 78 per cent. Ruston also made sure to mention that, under Labor, "Australians are paying more out-of-pocket costs than ever before".

As for policy proposals to improve Medicare, make primary and acute service more affordable to consumers, and keep an increasingly rickety healthcare system on the road as the Boomer generation threatens to swamp it, ideas from Ruston come there none.

Indeed, for almost three years, the Coalition has sharply criticised Labor, but months out from a federal election has as yet offered no comprehensive policy solutions other than restoring former minister Greg Hunt's 20-per-patient Medicare-funded psychologist consultations. No wonder Chalmers, Butler and Labor think yet another mediscare will work: the Coalition has given a blank sheet to work on.

From a policy perspective, what's most disappointing about this "he said, she said" Medicare politicking is its confirmation that both major parties are lazily reducing the debate on healthcare priorities and reform to the lowest common denominator of bulk-billing. Universal bulk-billing is no Nirvana: it's middle-class welfare. Working people in normally good health, who can afford to pay $50 or so on top of their Medicare rebates a few times a year – at most – to see a GP, are brainwashed to think any out-of-pocket cost is immoral. Moderate out-of-pocket costs for those who can afford them are unpopular but are necessary and instrumental to keeping Australian general practices the accessible and affordable world-class healthcare services that they are.

A Labor-Coalition electoral clash over which party is better for bulk-billing is not only foolish but masks the fact that so much more needs to be done to keep our sprawling healthcare system fit for purpose. From improving the viability of primary care to prioritising prevention and early intervention, getting more value for massive public hospital funding investments, and renovating private health insurance and the private health choice, there are so many more pressing needs for reform than entrenching the "free stuff" political mentality behind bulk-billed Medicare.

As this election year starts, the bulk-billing obsession of both sides insults the intelligence of Australian voters.

Terry Barnes is a Liberal Party member and policy consultant who formerly advised federal and Victorian Liberal ministers.

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