promoting excellence in medicines management

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Submission to:

National Commission of Audit

With a focus on the government funded Pharmaceutical Benefits Scheme and related pharmacist services, with regards to:

- **potential improvements to productivity, service quality and value for money and**
- **adoption of new technologies in service delivery and within government.**

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Background and introductory remarks

Contemporary health care demands that all health professionals act collaboratively to support consumers who have multiple chronic diseases, poor health literacy and often struggle to adhere to their treatment plan. Health care is increasingly focused on patient outcomes, patient safety, quality care and the efficient use of resources.

The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for over 3,000 pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia's health system. SHPA is the only professional pharmacy organisation with a strong base of members practising in public and private hospitals and other health service facilities.

SHPA is committed to facilitating the safe and effective use of medicines, which is the core business of pharmacists. **The use of medicines is a critical factor in the efficiency of the health system as a whole.**

The term 'responsible use of medicines' has been used to describe the system-wide approach that is required to ensure the activities, capabilities and existing resources of the health system are aligned to ensure consumers receive the right medicines at the right time, use them appropriately and benefit from them. That is, that medicines are:

- available and affordable
- used by the right consumer at the right time
- appropriately taken by the consumer and
- used with the support of structures that assist the prescribing, dispensing, administration and evaluation of medicines use in individual consumers and consumer populations

These concepts are reflected in objectives of Australia's *National Medicines Policy.*

The Australian government funds medicines through the Pharmaceutical Benefits Scheme (PBS) as most Australians could not afford the cost of most medicines without a subsidised system.

The Australian government also funds pharmacist and pharmacy services through the Community Pharmacy Agreements (CPA) which is essentially a **'public–private partnership'** negotiated through the organisation that represents community pharmacy owners the Pharmacy Guild of Australia.

Australia's PBS remains a highly effective mechanism for making medicines available and affordable. However the benefits associated with the use of medicines is compromised when a consumer does not take their medicines appropriately or at all (referred to as medication non-adherence) or when the consumer has a poor or insufficient understanding of health information which impacts on their ability to make effective decisions about their health care (health literacy). That is monies are wasted when subsidised medicines are not used appropriately.

With rising PBS expenditure and an increase in the number of Australians living with chronic illness and multiple chronic illnesses there has been a need to better support

consumers by improving medication adherence and health literacy i.e. ensuring value for money. This has been acknowledged in recent CPAs with the description and funding of professional pharmacy service programs. Consumers most at risk of medicine-related problems are targeted to reduce their overall health cost and they gain the greatest benefit from these services.

The Australian community expects a mix of public and private (not-for-profit and for-profit) primary care and hospital services; this is one of the reasons that providers in the public and private sectors are funded by public monies to provide medicines through the PBS.

Business rules regarding the PBS and pharmacist professional services are negotiated through the Department of Health. Reimbursements for medicines and pharmacist professional services are managed by the Department of Human Services.

Unlike other publicly funded professional services delivered by doctors, nurses and allied health professionals, professional pharmacy services are not reimbursed and managed through the Medicare Benefits Schedule. This results in differences in the approach to service delivery as well as inefficiencies in claims processing and accountability across funded health services.

There are four major aspects to the funding of medicines through the PBS and related pharmacist professional services that could be made more efficient:

- negotiation of the price that will be paid through the PBS (*which appears to be outside the terms of reference of this audit. However SHPA notes the potential for the Trans-Pacific Partnership Agreement to greatly impact on the price that will be paid by the Australian Government for medicines funded through the PBS.*)
- the wholesaling and distribution of medicines (*which is outside the terms of reference of this audit*)
- the supply of medicines and pharmacist professional services (*for the purpose of this audit: a focus on how service categories and payments are constructed*)
- claiming for reimbursement (*for the purpose of this audit: a focus on how claims and payments are made*)

This submission focuses on the last two issues.

SHPA believes that business rules written for the PBS in 1947 continue to drive how pharmacists provide services and how the Australian Government provides payments in 2013. Many claiming systems remain paper-based and most claiming processes do not have inbuilt prospective audit and outcome information.

The administrative burden for pharmacists and the Department of Human Services is onerous and the number of funding mechanisms and categories continue to expand.

The current plethora of funding mechanisms and rules for medicines cause confusion, increase the risks of medication error, diverts doctors and pharmacists away from direct patient care and increases the cost to the Australian Government of administering the payment / reimbursement systems.

Improving efficiency of the PBS model to improve the productivity of the Department of Human Services and pharmacists

SHPA would like to clearly state that we believe that the time has come to radically restructure how PBS medicines are categorised and reimbursed.

There have been multiple changes to the construct of the PBS over the last 60 years but most since the introduction of the Highly Specialised Drug program introduced in 1990.

Problems are created when new government policy is developed that further entrenches and promulgates the old problems. Superfluous and uneconomical activities have accumulated until a high proportion of what is done is non-value adding.

For consumers to access PBS-listed medicines the pharmacist must understand and consider a myriad of access and funding rules in addition to assessing the medication order for legal and clinical appropriateness.

The rules are different depending on where the consumer is (community, hospital outpatient, same-day hospital patient, hospital in the home, or overnight patient), if they are being treated for an acute or chronic condition, what type of facility is providing treatment (hospital, sub-acute or non-acute facility, Aboriginal Health Service), the ownership of the facility and the ownership of the pharmacy service supplying the medicine.

Payments that support the supply of medicines through the PBS are calculated on the basis of:

- Ownership and location of the pharmacy
- Under which section of the PBS the medicine is listed
- Which brand of the medicine is required
- If the medicine needs to be manufactured or prepared so that it is ready to administer to the consumer
- Eight authority categories:
  - Section 85 authority medicines (e.g. Anzatax injection)
  - Section 85 authority required for access to increased quantities of medicines listed as restricted benefits (e.g. Solu-Medrol injection where more than one dose is required)
  - Section 85 authority ‘streamlined’ (e.g. Gantin capsules)
  - ‘Efficient funding of chemotherapy medicines’ listed medicines available only through public hospitals (e.g. Fludara injection)
  - S100 highly specialised drugs (HSD) authority medicines, public hospitals (e.g. Mabthera injection)
  - S100 HSD authority medicines, private hospitals (e.g. Neoral liquid)
  - S100 HSD authority ‘streamlined’ medicines available only through public hospitals (e.g. Neupogen injection)

- S100 HSD Complex Authority Required medicines, public hospitals (CAR HSD) (e.g. Herceptin)
- Eligibility of prescribers to prescribe medicines supplied through the PBS
- Eligibility of the consumer to receive benefits through Medicare
- The required consumer's financial contribution including if the consumer is eligible for a concession card, if the consumer has met safety net arrangements
- Eligibility of the consumer to access medicines through the 'closing the gap' system

SHPA believes that to place pharmacy remuneration on a sustainable footing and streamline the reimbursement process there is a need to deconstruct and then reconstruct the suite of pharmacy remuneration categories to:

- simplify the number of payment categories
- increase the use of real-time electronic-based approval system (for medicines that require authorisation) at the point of prescribing. Data on the approval would flow through to the claim for re-imbursement by the pharmacy supplying the medicine
- identify services that have been reliant on the trading terms of some medicines and
- ensure the dollar values assigned are inter-related and adequately remunerate for the service provided.

SHPA would like to highlight that where pharmacy as a profession can deliver financial savings to the health system, or can demonstrate that it is 'doing more with less', the resultant gains should be used to improve access to services and not to pharmacists being further financially penalised.

Improving efficiency of the reimbursement system for pharmacist professional services to improve the productivity of the Department of Human Services and pharmacists

Medication safety is a consumer right and not an 'optional extra'.

Consumers with multiple chronic conditions requiring complex care and multiple medicines require additional pharmacist services to enable them to better manage their medicines and achieve their therapy goals. That is, access to clinical pharmacy or pharmacist professional services.

Consumers most at risk of medicine-related problems will gain the greatest benefit from these services. However collaborative and interdisciplinary care is often constrained by business rules that insist upon services being delivered through a physical building (i.e. community pharmacy, consumer's home) rather than through the consumer's medical home, or their choice of location if they are temporarily away from their usual home, or cannot attend their usual health service provider.

Access to these services is not equitable: consumers have different levels of access dependent upon their location, the ownership of the pharmacy service at the hospital they attend, if their Aboriginal Health Service or residential aged care facility has a service agreement with a specific community pharmacy, if they receive their medicines through a community pharmacy or pharmacy service in a public or private hospital and if the services are provided by their community pharmacy.

Pharmacist professional services are provided on the basis of program eligibility criteria and funded on a 'fee for supply' basis and some pharmacist services are provided on the basis of incentivised programs.

Unlike other government funded professional services delivered by doctors, nurses and allied health professionals the professional pharmacy service programs are not reimbursed and managed through the Medicare Benefits Schedule. This results in differences in the approach to service delivery (e.g. setting-specific medication review services rather than a comprehensive approach to achieve a stated therapy goal), claims processing and accountability.

There have been multiple remuneration / funding model changes to programs within the first two years of the current CPA (for example the Home Medicines Review program). The resulting 'agreements within the agreements' are not transparent and make business planning difficult for individual pharmacists, pharmacy managers and owners and the Department of Human Services.

SHPA believes that the current funding construct creates access-block, is bureaucratic, drives inefficiencies and increases the cost to government and providers.

There is a piecemeal approach to program development and funding systems which break down a pharmacist's professional service into multiple small activities and artificial borders that limit consumer access.

A stark example is the multiple programs that relate to one clinical pharmacy service: medication review. There are two programs based on where the consumer resides, two programs that provide a 'partial' medication review service. For the last decade several evaluations have been funded to investigate how medication reviews should be delivered after a consumer is discharged from a hospital.

That is 4-5 programs have been created so that discrete consumer groups have access to one type of professional pharmacy service. This should be contrasted to what is considered 'good practice' for services provided by all health professionals: the notion of providing medication review services through a care plan until a therapy goal is achieved, irrespective of where the consumer sees the pharmacist and how many occasions of service are required to achieve the therapy goal.

SHPA believes the approach of multiple programs is wasteful (as numerous investigations and consultations have been undertaken) and limits the potential community-wide health benefits of medication review services as consumers are eligible / ineligible based on where the live and the relationship they have with both their GP and usual community pharmacy.

SHPA believes that the current and future professional services provided by pharmacists should not be included in future CPAs. Similar to the model for professional services offered by other health professionals, they should be assessed through the MBS Medical Services Advisory Committee, attract funding for individual practitioners and be managed through usual MBS processes.

Moreover access to clinical pharmacy services should be based on clinical need and these services should not have a capped universal budget.

SHPA also believes the Research and Development program in future CPAs should be used to identify improvements in pharmacist professional services and undertake any required 'proof of concept' or pilot projects, and that the assessment of the service for funding with public monies should by undertaken by the MBS Medical Services Advisory Committee and managed through usual MBS processes. Ideally claims processes should include inbuilt prospective audit and outcome information.

We believe that this approach would remove conflict of interest concerns and assist with consistency of services across the continuum of care.

Improving efficiency of reimbursement systems to improve the productivity of the Department of Human Services and pharmacists

SHPA strongly supports the need for pharmacists to be accountable for the public monies they receive. However there has been inadequate acknowledgement of the inefficient and manual claims processes currently employed across all programs. Claims processes need to be reviewed to take advantage of electronic claiming mechanisms, improve efficiency, minimise payment delays and reduce the total cost to the Australian taxpayer.

Reimbursement for medicines supplied through the PBS

The administrative burden for pharmacists has been entrenched in business rules for reimbursement since the inception of the PBS. The reimbursement rules ignore the electronic transfer of information and require or presume a 'no script no drug' approach. This means that in hospitals the prescriber MUST write both a hospital medication chart and a PBS prescription for a medicine for payment to be claimed.

Consecutive governments have failed to capture the potential efficiency (for and within the Department of Human Services) and patient safety gains of claiming from medication charts in private and public hospitals.

The photo below shows **one week's worth** of prescriptions generated from inpatient medication charts through a Section 94 pharmacy at a private hospital.

All of the medicines have already been ordered on the patient's hospital medication chart and have already been supplied. **This paperwork shown is additional and required only for the pharmacy to make a claim for reimbursement.**

Each of these additional prescriptions must be:

- printed on approved PBS stationery obtained from authorised prescribers
- sorted, the relevant prescriber must be identified and the hardcopy prescription then must be sent to that prescriber
- signed by the prescriber
- sent back to the pharmacy and
- processed for claiming
- filed and stored separate from the patient's medical history for audit requirements

Frequently the pharmacy needs to reprint several hard copies of the prescription before it is signed by the prescriber.

It should be noted that in practice (to reduce delays in patient care in both public and private hospitals) a PBS prescription is frequently produced AFTER the medicine has actually been dispensed and received by the patient. The financial risk of supplying the medicine before a valid, claimable PBS prescription is completed is borne by the pharmacy / hospital. **The PBS claiming system drives unnecessary inefficient work practices in hospitals and within the Department of Human Services and impacts on patient care.**

The requirement for a hard copy PBS prescription in hospitals also leads to instances where **treatment is denied to the patient until a valid, claimable PBS prescription is received by the pharmacy**.

This issue has been acknowledged for over 20 years and was identified as part of the National Health Strategy (Macklin review) in 1992. In response a trial project, where reimbursement for PBS-listed medicines provided could be claimed through a bedside medication order (rather than a proscribed PBS prescription form), commenced in selected private hospitals in 1995. (This trial has informed the development of the *Supply and PBS claiming from medication charts in Residential Aged Care facilities* program in the 5CPA.)

Over the term of the current and previous CPAs SHPA has consistently highlighted the efficiency gains that could be realised through expanding the trial to 'business as usual' for all private hospitals (for PBS-listed medicines provided to inpatients and those leaving the hospital) and all eligible public hospitals (for PBS-listed medicines provided on discharge).

However after <u>18 years</u> the trial remains limited to a handful of selected private hospital pharmacy services.

Payment for pharmacist professional services

SHPA believes that the claims processes for CPA programs is archaic when compared to the processes used for other health professionals who also receive public monies when they supply services through the MBS and when compared to the electronic based system used by Australian private health insurers.

The recent introduction of a paper-based prior approval process for some HMR services highlights the inefficiency of the current manual claims system. Applications for prior

approval are not being considered / processed within a reasonable timeframe or within the time required for appropriate care. SHPA has provided the Department of Health and the Department of Human Services with multiple examples of how the claiming process is impacting on patient care.

One accredited pharmacist supplied the following anecdote:

> *The request was for a consumer from an Aboriginal Health Service who wished to see the pharmacist at the clinic. The initial request was made 18 April, the Department notified the pharmacist on 26 April that this request was rejected as an appointment date was not specified (as soon as possible from 18 April but before 9 May as requested by the GP was not sufficient).*
>
> *After several further requests for a decision without response from the Department, the pharmacist cancelled the appointment that had been made for 9 May.*
>
> *On 9 May the pharmacist received a reply from the Department apologising that the request was yet to be considered and that the pharmacist should advise them of the new appointment date if prior approval was granted. Approval was granted 22 May and the consumer received the service 27 May.*

In addition, claims for services provided in good faith can be rejected on the basis of a previous 5CPA listed service having been provided to the consumer without the knowledge of the service provider. It is assumed that community pharmacies would have information about the consumer's use of programs; however individual pharmacists making a claim for a professional service have no means of checking the consumer's eligibility for a service.

Claims processes for professional pharmacist services need to be reviewed to take advantage of electronic claiming processes at the point of service; this would improve efficiency and ensure consistency across all programs.

The current systems are cumbersome, lack transparency and accountability and do not have inbuilt prospective audit and outcome information.

SHPA understands that the cost of developing / updating electronic claims systems for CPA programs would be expected to be funded through the CPA rather than part of the wider MBS / Department of Human Services claiming system.

We believe that this expectation is limiting efficiencies in claims processing and reinforces the status quo as:

- the Pharmacy Guild of Australia has no incentive to change the system as the cost to change the system would reduce the budget of other programs within the CPA
- the Department of Health have allocated a budget to the CPA and assume that the Pharmacy Guild of Australia will drive innovation / allocate monies to changes that would improve the system
- the Department of Human Services act on directions from the Department of Health, they are not empowered to propose or implement changes.

Rethinking how public monies are used to provide medicines and pharmacist professional services

SHPA advocates a move from a pure retail business model for community pharmacy services towards a health delivery model.

We believe that simplifying the number of payments categories and moving to real-time electronic-based claiming systems, with inbuilt prospective audit and outcome information, have the potential to significantly improve government efficiency and reduce expenditure.

In our submission to the Australian National Audit Office (which is available upon request) a construct similar to that used for the National Diabetes Services Scheme was suggested. SHPA proposed a clear separation in the funding for the storage and supply of medicines (that currently cross-subsidise primary care services) and pharmacist services.

The model would seek to:

- remove the need for the Community Services Obligation (CSO) currently paid to manufacturers
- remove reliance on the trading terms of medicines supplied through the PBS to support primary care services provided through community pharmacies
- ensure pharmacies receive a fair remuneration payment for the dispensing of medicines
- ensure pharmacists receive a fair remuneration payment for providing professional services
- have eligible pharmacists reimbursed for professional services through the MBS just like the professional services delivered by doctors, nurses and allied health professionals
- ensure that pharmacist services would be available for all consumers irrespective of where they live, or the ownership of the pharmacy, or PBS authorisation category of the pharmacy from which they access their medicines. This would also allow consumer contributions of services fully funded by the consumer (where potentially any gap could be covered through the consumer's private health insurance).

SHPA believes that approach would address many of the issues highlighted in our submission to the National Audit Office and:

- improve the service offered to consumers
- reduce the overall administrative cost
- allow pharmacists to focus on providing professional services
- guarantee consumers continue to have access to the most frequently used primary care health professional by ensuring the long term sustainability of community pharmacy

Potential benefit for the Commonwealth:

- reduced bureaucracy
- remove need for CSO

- reduced claims complexity, one system for all authorised pharmacies (community pharmacies, private hospital pharmacies and eligible public hospitals)

Potential benefit to consumers:

- transparency regarding the cost of medicines
- improved service to consumers and improves equity of access across the system as a whole

Potential benefit to the community:

- reduced costs associated with bureaucracy
- improved access to primary care services including improved health literacy to better support improved health outcomes

Potential benefit to community pharmacy owners:

- reliance on the trading terms of medicines would be removed
- reduced bureaucracy and improved certainty
- reduced claims complexity.