

Cost shifting and the quality use of medicines

Is it time for National Medicines Policy 2.0?

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Australia's National Medicines Policy states that Australians should have timely access to medicines the consumer and the country can afford, medicines that are appropriate for them and their health problem, and that medicines should be used in a manner that maximises the benefits and minimises possible harmful effects.¹ A challenge for the Policy is that the cost of access to medicines differs between public hospitals and the community. This has implications for continuity of care and the shifting of costs in the health system. The problem is accentuated in some states by the incomplete implementation of the Medicare reforms around medicines funding and access to medicines subsidised by the Pharmaceutical Benefits Scheme (PBS) in public hospitals. These reforms (implemented in Victoria, South Australia, Queensland, Western Australia, the Northern Territory and Tasmania) provide patients with PBS-subsidised access to one month's supply of medicines on discharge from public hospitals supporting the continuity of care. In states where the reforms have not been implemented, patients on discharge are provided with a limited supply of their medicines, sometimes only a few days, requiring them to visit their GP and pharmacy to access medicines on the PBS.

Public hospital pharmacies are required to purchase pharmaceuticals in accordance with the supply

contracts for their state. This does provide an opportunity for public hospitals to negotiate prices which may be cheaper than the PBS price. These contracts can influence what brands of medicines are available on hospital formularies and the quality use of medicines in the public system. This situation may also provide an opportunity for hospitals to profit when they can purchase a medicine, which they supply on the PBS at discharge, at a price lower than the remuneration the hospital receives from the PBS.

For example, a patient in a public hospital with neuropathic pain may be offered gabapentin. This is an off-patent medicine and there are a number of alternative brands on the Australian market. This competition enables negotiations to achieve the best price for supplying public hospitals. When discharged from hospital into the community the same patient cannot obtain the drug at a subsidised price because gabapentin is not listed for neuropathic pain on the PBS. Pregabalin is a therapeutically equivalent drug for neuropathic pain which is listed on the PBS, however there is only one brand on the Australian market and it costs more than gabapentin. Another problem is that in states and territories which have access to PBS-subsidised medicines, public hospitals are likely to stock pregabalin, rather than gabapentin, as the cost will be borne by the Federal Government. Although this benefits the hospitals' drug budgets the overall cost to the health system is increased.

A second example would be a patient taking a fixed-dose combination of an antihypertensive drug who is admitted to a public hospital. The hospital may not stock all of the available fixed-dose combination products and is likely to supply alternative brands of the individual medicines included in the combination product while the person is in hospital. On discharge from hospital the patient is likely to receive a prescription for the individual medicines (incurring two dispensing fees) with the added risk of confusion (and double dosing) about whether they should recommence the combination product.

These scenarios have important implications for cost shifting in the health system and the continuity of care for the patient. Added to the complexity of the health system is the risk of confusion when switching between different brands of medicine when

From the Editor



The quality use of medicines requires that drugs are used safely and judiciously. Ahamed Zawab and John Carmody discuss how this can be achieved when prescribing sodium valproate, while Rebecca Adams and Robert Bird advise on the quality use of blood products.

Sometimes it is better not to prescribe a drug. This is often the case in childhood coughs, say Danielle Wurzel, Julie Marchant and Anne Chang.

Similar principles apply to the use of nutritional supplements. Anne Schneyder says that the first step in managing elderly people at risk of malnutrition is eating real food.

The quality use of medicines also requires an awareness of drug interactions. Andrew Finch and Peter Pillans explain the role of P-glycoprotein in some interactions.

patients are discharged from hospital. The cheapest brand in the hospital may not be the cheapest in the community pharmacy. Interestingly, pharmaceutical companies may employ a 'loss leader' approach by providing their medicines to public hospitals at a discount price to ensure they are included on the formulary, knowing that many medicines commenced in hospital are continued after discharge. This will mean that a patient will then obtain that medicine through the PBS, once they return home from hospital, increasing the uptake of that medicine in the community.

Cost shifting in the health system and funding 'workarounds' seem to be the norm for healthcare professionals. They have to do their very best to ensure their patients have sustainable and affordable access to medicines especially when moving between settings of care. Cost shifting is not a new issue, but it is a continuing challenge. The Society of Hospital Pharmacists of Australia prepared a possible solution in a position paper more than a decade ago. It said:

A single national system for medicines funding would foster integration with many other government programs on medicines use and allow the benefits of hospital work to flow to the community sector and vice versa.²

The National Medicines Policy was originally developed almost two decades ago at a time when the Australian health system and medicines issues were substantially less complex. The NPS MedicineWise national census on medicines use in 2012 highlighted the increasing complexity of medicines-related issues in the health system, including the high prevalence of medicines use and polypharmacy in older Australians.³ Invariably this complexity has created gaps and tensions in the

health system, including barriers to achieving the quality use of medicines. These structural issues highlight the need to revisit and refocus the National Medicines Policy in the context of the present health environment and likely future challenges related to medicines and health.

Revisiting the National Medicines Policy in the context of medicines use and access must retain the commitment to a partnership approach. This has been the hallmark of the policy, ensuring the health of Australians is at its core and engaging with all partners in the sector (health professionals, regulators, consumers and industry), including the layers of government that fund access to medicines.

In summary, while we continue to have a disjointed health system with partially implemented funding reforms we will continue to have problems with timely access to affordable medicines and conflict, confusion and discontinuity for consumers. There is now a need to reframe Australia's National Medicines Policy and its implementation to ensure we remove barriers to achieving the quality use of medicines. <

Andrew McLachlan is an investigator on the PRECISE clinical trial which has received in kind research support (provision of pregabalin and placebo) from Pfizer. He has also received funding from GSK to support a research student scholarship. Professor McLachlan is the chair of a Drug and Therapeutics Committee at a public hospital and a member of a number of Australian government committees related to medicines regulation and antidoping. He is the former chair of the National Medicines Policy Committee.

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