CHAPTER 3

EXEMPTION FROM PAYMENT OF THERAPEUTIC GROUP PREMIUMS

3.1 As outlined in Chapter 1, drugs in a therapeutic group may be subject to a charge in addition to the co-payment amount, known as a 'therapeutic group premium'.[1] This additional fee is paid by the consumer and only applies to a medicine where the manufacturer does not accept the Pharmaceutical Benefits Scheme (PBS) price under the therapeutic group pricing policy.[2]

3.2 At present, there are 523 brands of medicines in therapeutic groups. Of those, six have a therapeutic group premium applied ranging in value from $2 to $4.35.[3]

3.3 When prescribing a medicine subject to a therapeutic group premium, a doctor may apply for a patient to be exempt from paying the premium on the basis that it would be 'clinically inappropriate for a patient to be prescribed a different medicine in the therapeutic group in order to avoid a therapeutic group premium'.[4] In this circumstance, the Commonwealth Government pays the patient premium where the prescriber has obtained an authority from Medicare Australia, based on one of the following specified criteria:

- the patient suffers from adverse effects when taking all of the drugs in the group that have no therapeutic group patient premium;
- the patient experiences drug interaction issues when taking all of the drugs in the group that have no therapeutic group patient premium;
- it is expected that the patient would experience drug interaction issues if they took any of the drugs in the group that have no therapeutic group patient premium; or
- transferring the patient to a drug in the therapeutic group that has no therapeutic group premium would cause patient confusion resulting in problems with compliance.[5]

3.4 During the course of the inquiry, a number of doctors suggested to the committee that oral bisphosphonates were not interchangeable at a patient level on the basis of:

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1 Department of Health and Ageing (DoHA), *Submission 27*, p. 15.

2 DoHA, *Submission 27*, p. 15.

3 Mr David Learmonth, Deputy Secretary, DoHA, *Committee Hansard*, 7 May 2010, p. 93.

4 DoHA, *Submission 27*, p. 16.

5 DoHA, *Submission 27*, p. 16.

> …clinically significant differences in these agents in terms of their speed of onset and persistence of effect at offset. There are areas where there are distinctly different levels of evidence on efficacy, e.g. corticosteroid osteoporosis treatment, between the different agents. Moreover there are differences that may relate to compliance as to whether they can be administered weekly, monthly or annually.[6]

3.5 As a result of these clinical differences between the oral bisphosphonates, doctors in the field were concerned that the creation of a therapeutic group for the bisphosphonates might result in 'patients suffering financial or therapeutic penalty'.[7]

3.6 It became apparent to the committee that some of these doctors were unaware that they were able to request on exemption on behalf of their patients, so as to avoid any financial or therapeutic disadvantage. Dr Gabor Major stated he 'certainly was not aware…that we can ring up and request a special dispensation for the patient'.[8] Professor Stephen Oakley and Dr Charles Inderjeeth were equally unaware of the exemptions.[9]

3.7 The department advised that a two-year education campaign was carried out, commencing in 1997-98, to inform prescribers of the introduction and implications of the therapeutic group policy:

> The education campaign included:
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> - Direct mailings to prescribers of PBS medicines;
> - A telephone help line service;
> - A health professionals and consumer groups information kit;
> - Consumer leaflets for distribution by medical practices and pharmacies;
> - Articles in the Health Insurance Commission (now Medicare Australia) Forum and other professional and consumer group newsletters; and
> - An insert in the Schedule of Pharmaceutical Benefits, which at the time, was distributed free-of charge to doctors at each update.[10]

3.8 The committee is concerned that doctors responsible for prescribing medicines in therapeutic groups may be unaware that they are able to seek an exemption from a therapeutic group premium on behalf of their patients. The

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6 Professor John Eisman AO, *Submission 6*, p. 1. See also Associate Professor Stephen Oakley, *Committee Hansard*, 7 May 2010, p. 67 & Dr Gabor Major, *Committee Hansard*, 7 May 2010, p. 70.

7 Professor John Eisman AO, *Submission 6*, p. 1. See also Associate Professor Geoff Littlejohn, *Submission 7*, p. 1 & Dr David Kandiah, *Submission 5*, p. 1.

8 Dr Gabor Major AC, *Committee Hansard*, 7 May 2010, p. 71.

9 Associate Professor Stephen Oakley & Dr Charles Inderjeeth, Member, Australian and New Zealand Society for Geriatric Medicine, *Committee Hansard*, 7 May 2010, pp 71 & 72.

10 DoHA, *Answers to questions on notice*, 7 May 2010 (received 15 June 2010).

exemptions are intended to protect patients from additional costs, in cases where medicines in a therapeutic group are not interchangeable at the individual patient level. However, the exemptions cannot achieve this if those responsible for prescribing medicines that attract a therapeutic group premium are unaware of the exemptions.

3.9 The committee acknowledges the work undertaken by the department to educate prescribers at the time the therapeutic group policy was first introduced during 1997-98. The committee believes, however, that regular and ongoing education and information is required to ensure prescribers are aware of the exemptions from payment of a brand premium and the process for seeking those exemptions on behalf of a patient via a Medicare authority.

Recommendation 3

3.10 The committee recommends that the Department of Health and Ageing provide regular and ongoing education and information to prescribers to ensure they are aware of the exemptions from payment of a brand premium and the process for seeking those exemptions on behalf of a patient.