Medical Software Industry of Australia Submission – Review of Pharmacy Remuneration and Regulation

September 23, 2016

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Medical Software Industry Association – Pharmacy Review Submission

1 Executive Summary - MSIA Profile
The Medical Software Industry Association (MSIA) represents interests of the medical software providers across the spectrum of health care with 100% representation of those providing pharmacy services. The MSIA is a valuable stakeholder in Australian healthcare, and is frequently invited to submit its responses and offer suggestions in regard to initiatives such as MyHealth Record, PBS Online, DHS Online PBS Authorities and the AMT to name just a few.

The MSIA has negotiated a range of important changes with government and other stakeholders having built a considerable profile with Commonwealth and jurisdictional Health Departments as the de-facto channel of communication between these organisations and the healthcare software providers. It is in this capacity that the following response is made.

1.1 Review of the July 2016 Pharmacy Remuneration and Regulation Discussion Paper
The MSIA is pleased to have the opportunity to table this submission.

Although the MSIA membership is significantly wider than that relating to pharmacy, this response relates principally to the MSIA membership subsection associated with the provision of software to s.90 community pharmacy and s.94 hospital pharmacy dispensing.

The MSIA believes that those companies which produce software for community pharmacy dispensing are totally represented in their MSIA membership.

Community Pharmacy Agreements (CPA) extend over five years, the last of which the 6CPA commenced its operation on 1 July 2015, when regulatory aspects of the previous 5CPA expired.

It is important to note that other sections of the MSIA membership are also associated with this review such as the prescribing software developers currently considering impacts of the proposed online application for PBS authorities supplied by DHS as an alternative to the current telephone application process.

2 References from the Pharmacy Remuneration and Regulation Discussion Paper
In order to highlight the issues, MSIA has focussed on those specific sections from your extensive Discussion Paper which directly affect the software industry.

The sections below in italics are direct extracts from your published review:

2.1 Regulatory Landscape
Is it appropriate that the Government continues to negotiate formal remuneration agreements with the Guild on behalf of, or to the exclusion of, other parties involved in the production, distribution and dispensing of medicines? If so, why? If not, why not, and which other parties should be involved? Is there currently an appropriate partnership with these other parties, including consumers?
2.2 Summary of 6CPA Impact

Over the last five years, the increase in PBS expenditure has slowed as changes to generic medicine prices under PBS Reform have increasingly reflected their market price (see Figure 1). This decreased the remuneration to pharmacy over the Fifth Community Pharmacy Agreement (5CPA) from ‘mark-ups’ as these were calculated as a percentage of the wholesale price.

With the 6CPA, however, a new flat fee called the administration, handling and infrastructure fee (AHI) was introduced.

2.2.1 Pharmacy Remuneration for Dispensing 5CPA vs 6CPA Arrangements

Actual Government expenditure on supply chain remuneration under the 5CPA averaged $2.7 billion per year of the agreement. Dispensing fees made up the majority of payments to pharmacy (51%), followed by pharmacy mark-ups (25%), the Premium Free Dispensing Incentive (PFDI) (7%), dangerous drug fee (1%) and other fees such as wastage fee, container fees, and electronic prescription fees accounting for less than 1% of remuneration.

In the 6CPA, the percentage based mark-up that applied to the majority of medicines has been replaced by a flat rate AHI. This is to counter the effects of PBS reform savings measures that have reduced the price of many PBS medicines and consequently eroded the value of mark-ups to pharmacy. The PFDI, which pays an additional fee to pharmacists in certain circumstances to support the uptake of generic medicines, has been retained but is applicable to a reduced number of drugs compared to the 5CPA.

3 MSIA Comments

Over the past decade, particularly following the successful introduction of PBS online from 2005 with the assistance of MSIA, the dispensing of medicines has become 100% dependent upon computer software to assist pharmacy not only with clinical decisions but for all aspects of PBS pricing and claiming and support of patient DHS and DVA entitlements.

Reference is made in paragraph 2.2 above to the Commonwealth savings as a result of critical changes to the 6CPA funding model for pharmacy. Without the co-operation of the software industry these initiatives and enhancements to the PBS would have been impossible.

However, they were imposed on the software industry, unfunded and with minimal consultation.

In fact, the pharmacy software industry through its MSIA representation became aware of the 6CPA changes within approximately one month of their legislated introduction.

The changes were announced via the release of the 6CPA Agreement with no opportunity for prior consultation by MSIA or vendors. The changes affected possibly the most complex part of the dispensing software systems, those being associated with PBS pricing, pharmacy reimbursement and the introduction of the new concept of a regulated discount to the patient co-payment.

4 Key points of the 6CPA dispensing software releases effective from 1 July 2015,

- The burden placed on DoH, DHS, PGA, the dispensing software developers and MSIA in leading to the release and implementation of these PBS changes by the due date was widely acknowledged as bordering on the impossible, with the acknowledgement that the normal
timeframe for prudent processes required for software releases could not be followed. This introduced a variety of risks some of which were related to patient safety.

- The National Health Amendment (Pharmaceutical Benefits) Bill 2015 only passed into legislation with days to spare before the 5CPA expired. Had the Bill not been passed, there would have been enormous disruption to the pharmacy providers and Australia’s pharmacy system. The Business Rules for the new 6CPA AHI Fees were not initially available in the detail required to implement the software programming enhancements. It took nearly three weeks from the release of the 6CPA for these rules to be clarified.

4.1 The 6CPA TIER-2 Pricing Anomaly

- As evidence of these issues, DHS announced its inability to fully comply with all aspects of the new legislation and advised that they would be unable to release the correct PBS Online TIER-2 pricing remuneration to pharmacy via PBS Online. This resulted in nearly twelve months of manual adjustments to pharmacy claiming over this period.

- The fact that the Commonwealth’s own PBS administration organisation was unable to fully implement the changes is testament to the complexity.

- This delayed implementation by DHS meant that additional reconciliation software was required to be developed to allow pharmacy clients to accurately reconcile their PBS Online claims.

5 Other 6CPA Programs

There were several parts of the 6CPA to be phased in, each of which required extensive software development and consultations with DHS.

- Discounting of the patient co-payment introduced 1 Jan 2016.

- Distribution Arrangements under the National Health Act 1953 - changes to the EFC chemotherapy program involving alternate payment models to the compounders were delayed until 1 Sep 2016 due to the lack of acceptance and complexity of the changes.

- Pharmaceutical Benefits Scheme Medication Charts for Public and Private Hospitals commencing from July 2016. Health Ministers agreed to amend state and territory legislation to allow the use of the standardised hospital medication chart for the supply and claiming of Pharmaceutical Benefits Scheme (PBS) medicines. The introduction of the new chart will reduce regulatory burden on prescribers, pharmacists and nurses, improve patient safety and save hospitals has been reported as an estimated $270 million over 10 years in reduced administration. The chart is scheduled to be available for use by jurisdictions from July 2016.

5.1 Vendor Workload Estimates

Our members reported that their overheads for the July 2015 implementation (not including reworks), equated to a several months of development, design and specifications with a similar or greater commitment for the unknown component relating to deployment and support.

Further feedback reported a similar effort was required to implement the changes for the 1 January 2016 co-payment discounting release.
Such a “distraction” from other planned work has resulted in a loss of opportunities by vendors being diverted from other scheduled developments.

6 Conclusion - MSIA Recommendation

It must be acknowledged that the dispensing software developers displayed remarkable goodwill in delivering their part of these programs.

It is unreasonable that software changes which were required to be implemented by the dispensing software industry were externally imposed with little consultation and an unrealistic time frame.

The software industry must be viewed as an integral part of the management process and included under embargo during the planning process. There must be adequate funding provided to this vital part of the health system in Australia to ensure that appropriate resources can then be applied to critical work required by pharmacy to ensure the best possible health outcomes for all Australians.

By ignoring this due process there is the real risk of a total disruption to the PBS, this being narrowly avoided with the 6CPA.

Yours Sincerely,

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