ERM presentation
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Compared with citizens in most other developed countries, Australians enjoy widespread access to pharmaceuticals at relatively low prices. This is largely due to the PBS, which over the past 60 years has resulted in substantial health, social and economic gains to the Australian community.

However, the pressure on Australia's pharmaceutical budget is growing. New and expensive drugs are coming onto the market all the time. Consumers are becoming better informed about their conditions and demanding the latest in pharmacological treatments.

This has created a need to look closely at how we allocate our precious pharmaceutical resources to deliver maximum gains to the community. While those of us in the health sector will continue to argue for increases in the overall funding for health and pharmaceuticals, the reality is that there will always need to be some form of rationing. No matter how much we increase the PBS budget, we will never be able to satisfy all demand for medicines.

It is the responsibility of the Govt to decide how much health resource is to be available to the citizens of Australia

ADGP believes that it is the role of clinicians – primarily general practitioners -to ensure that the health resource available is managed to ensure the maximum health outcome improvement is achieved for Australian citizens.

This management is best driven by clinicians and consumers and consumer interests, rather than the interests of the pharmaceutical industry or the often short-term and politically-driven interests of bureaucrats trying to save dollars.

As the pressure on the PBS grows, it is becoming more imperative than ever to find new and creative ways of getting the best possible value from our PBS dollars.

There is no doubt that governments are looking for ways to curtail the PBS budget that is rising by about 10% yearly.

In the recent Federal Budget we saw the thresholds for the PBS safety-net increase – this is almost certainly not the end of the Government's attempts to manage the PBS budget but rather is a sign of more cuts to come.

Divisions are concerned to ensure that GPs are involved in how our pharmaceutical resources are managed.

We don't want indiscriminate cuts being made by faceless bureaucrats in Canberra who do not know the reality of delivering health care on the ground.

We want the focus to be on quality and on patient outcomes. Not on arbitrary budgets and indiscriminate cost-cutting.

We all know that there are areas of medical practice in which there is over-prescribing or where expensive medications are used when more cost-effective alternatives would work as well or better.

We also know that there is significant under-use of medications in some areas and that there are many people who currently don't take medications that should be.

Both these issues need to be addressed to effectively increase QUM in the community and achieve the best possible outcomes from our limited pharmaceutical resources.

One of the ways that Divisions have been exploring to improve the quality and efficiency of prescribing in general practice is an evolving concept called Effective Resource Management, or ERM.

We expect ERM to be about delivering better health outcomes through the smarter use of health resources.

It is based upon the principle that through working together, GPs can find effective local solutions to local problems.

ERM essentially involves local Divisions identifying areas in their own Division where they feel prescribing could be improved, and implementing quality use of medicines programs to address these areas.

It is a very simple idea. Divisions obtain data on the prescribing patterns of their GPs (those who agree) and identify where these may differ from current best practice guidelines. This may involve both under-prescribing and over-prescribing. They may also look at areas in which non-pharmacological treatments, such as physiotherapy, counselling or dietary advice, can be a more effective option than taking a medication.

Education sessions are then delivered by appropriately qualified non-partisan professionals to improve prescribing within that Division to bring it in line with current best practice. This may involve providing GPs with the option of offering their patients the choice of a non-pharmacological treatment. For example, they may be able to offer their patients a course of physiotherapy instead of an anti-inflammatory medication – a course of counselling rather than an anti-depressant.

Let me emphasise at this stage, that involvement by GPs in this process would be entirely voluntary and the decisions they make in the consultation remains between the doctor and their patient, as it should be. The benefits of involvement for patients however are clear – they receive higher quality care and the option of alternative treatments, where these are likely, on the evidence, to provide the same or better outcomes.

The broader community benefits are also clear, better health outcomes and a more efficient use of precious health resources.

Of course, initiatives such as this take time and resources to implement and Divisions have many other competing priorities. Current Divisions' funding does not allow much flexibility in the way that Divisions use their resources and so to support Divisions to undertake this additional work, incentives would need to be provided.

There are a number of ways in which this could be done. Divisions and ADGP have explored one possible option but we are interested in hearing any other suggestions from other stakeholders such as you.
Clearly, the way in which these activities are supported needs to fairly distribute the risks and the potential benefits.

Currently, the risk of the PBS blowing out rests solely with the Government – and indirectly the tax payer.

The problem with this is that the way the Government often tries to minimise this risk is by implementing crude cost cutting measures that are not in the best interests of patients.

One of the options we have suggested to address this is that Divisions could help the Govt manage the risk of the growth in cost of pharmaceutical prescribing.

We would be prepared to do this, because we believe that Divisions are in a better position than governments to improve the use of pharmaceuticals in line with best practice.

This would mean that if Divisions successfully improve quality prescribing, and as a result of this the rate of growth in PBS expenditure decreases, some of the savings could flow back to Divisions to support their work in improving primary care in their region.
I think this would be a much better outcome for consumers, doctors and the community than if the money saved simply goes back into the Treasurer's coffers.

Of course, there are a number of issues that would need to be addressed before Divisions would be prepared to take on some of these risks.

Divisions are by their nature and the relationship they have already developed with their members, very well placed to work with their GPs to improve quality prescribing. They do however have little control over some other factors influencing the cost of the PBS. For example, GPs have no influence over drug company activities, the PBS listing process or new developments in pharmaceuticals.

Divisions would need to be assured that any risk they take on appropriately reflects the level of influence they can have over quality prescribing within their communities.

As I've already said, we are interested in looking at all the potential options for supporting Divisions to implement QUM activities and are keen to involve other health and medical groups in developing innovative ways to improve the use of our limited pharmaceutical resources.
I believe that this ERM concept could be a promising option for improving the use of pharmaceutical resources to deliver high quality outcomes for consumers.

It is a more sophisticated approach to managing pharmaceutical budgets than simply cutting benefits or restricting the listing of medications, without regard to quality health care.

It supports the development of locally-based strategies to improving quality prescribing, rather than a one-size-fits-all approach that we know, will not meet the differing needs of diverse Australian communities.
Most importantly, it will directly engage GPs on a totally voluntary basis, in strategies to improve QUM and result in improved prescribing among the largest group of prescribers, achieving better health outcomes and delivering more choice to Australian consumers.