

Improving Access to Palliative Medications in Australia

Changes to Access for Home Medications

For many years, some essential medications in palliative care have not been available on the Schedule of the Pharmaceutical Benefits Scheme (PBS). This has caused some people nearing the end of their lives to be faced with a difficult choice. Should they be admitted to hospital where they can get some of the medications they need free of charge or should they stay at home and pay for the medications themselves?

Some may choose to stay at home even though they cannot afford to pay, but many of these people will experience a reduced quality of life, because they will lack the medications needed to control their symptoms.

Recent changes to the Pharmaceutical Benefits Scheme (PBS) go a long way towards resolving this latter problem. There are now 96 items in the Palliative Care Section of PBS. A number of the medicines listed are available in a variety of forms or routes of administration to make it much easier for patients to receive the care they need in the place of their choosing.

The Palliative Care Medicines Working Group

These changes are the result of the National Palliative Care Strategy. The aims of the strategy are to increase awareness and understanding of palliative care, to increase the quality and effectiveness of palliative care, and to foster partnerships in care.

The Australian Government established a working group to address the issue of accessing palliative care medicine in the community. This group comprises representatives from the following key health care professions: medicine, nursing, pharmacy, peak industry bodies representing palliative care, the pharmaceutical industry, the National

Prescribing Service and the various relevant areas within the Department of Health and Ageing responsible for the registration and administration of medicines. Together this group identified medicines not covered by the PBS and planned how they could be listed. This turned out to be quite complex.

The Process of Medication Listing

Figure 1 shows the process of listing a new medication on the PBS. It is essential that the evidence for safety, reliability and effectiveness of the medicine is rigorously evaluated; this is the responsibility of the Therapeutic Goods Administration.

After the Therapeutic Goods Administration has approved the medicine, pharmaceutical manufacturers can apply to the Pharmaceutical Benefits Advisory Committee for listings on the PBS. This committee reviews the application and determines whether there is a place on the schedule for the medicine. If it is not approved for listing negotiations with the company over pricing occurs. If a consensus is reached, then the medicine is listed. This process is complex and expensive and, therefore, will not occur without the manufacturer choosing to initiate it.

How were the Medications Chosen?

In 2001, a Delphi process conducted by the Joint Therapeutic Committee of ANZSPM and the Clinical Oncological Society of Australia determined the most commonly used medications in palliative medicine (ref, Good 2006). The working group reviewed the medications that were on this list but were not PBS listed and chose those they felt were the most important.

Those chosen medications requiring minor amendments to get them listed were the first to be approved for the new section, followed by medications requiring small additions to the existing evidence base. The ones yet to

be listed are those that require completely new evidence.

The Australian Government has provided active support to assist in the collection of such evidence, with recent seed funding provided to support the establishment of the Palliative Care Clinical Studies Collaborative. This collaborative research network will support multi-site clinical drug trials across Australia. Flinders University, under the direction of Professor David Currow, is the lead organisation for this network.

Why do the Medications Listed require Authority Listing?

This work has resulted in the PBS scheme containing a list based on palliative care; making it is the first time the PBS has had a list based on a clinical grouping. It was imperative to determine how the scheme was used. Having the medications placed on authority meant the prescriptions are coded differently to the same medications in other parts of the schedule, so palliative care use could be monitored. Moreover, the government needed to know that the medications so listed would be used for the prescribed conditions and not diverted off to non-palliative patients. There was also a desire to ensure that medications were being prescribed appropriately, so the PBAC decided to require consultation between the prescribing clinician and a palliative care service in order to prescribe extended supplies of the medications.

What Drugs are on the List?

As depicted in Table 1, the listed drugs are common drugs. They are now available for indication that the PBS did not previously cover. For example, NSAIDs are normally allowed only for arthritis pain. But for people receiving palliative care, they are now also available for pain with an inflammatory component.

These drugs are not restricted to people with cancer, but are for all people with “an active, progressive, far advanced disease for whom the prognosis is limited and the focus of care is quality of life.” This means that the medications are available to people with the following: advanced organ failure, such as heart or renal disease; neurodegenerative conditions, like motor neurone disease; or fatal genetic conditions.

How to use the Palliative Care Section of the PBS Schedule

For the purpose of prescribing under the Palliative Care Section of the PBS Schedule, a patient receiving

palliative care is defined as: A patient with an active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.

All palliative care listings are “Authority Required”. All prescribers can request an initial authority to provide a maximum of 4 months therapy for palliative care patients. Where a subsequent authority is requested for continuing treatment, the provision of repeats is subject to confirmation by the prescriber that a palliative care physician or palliative care service has been consulted regarding the care of the patient. This could mean a phone call to a palliative care physician or service. The patient does not need to be seen by the service.

Authority approvals can be obtained through phoning 1800 888333 (General benefits) and 1800 552580 (Repatriation Benefits).

Narcotics and the PBS

The new Palliative Care section is not the only change in prescribing relative to palliative care. Narcotics are now also much easier to prescribe by GPs. Previously, long-term narcotics were only available to patients who were suffering a terminal malignancy or had chronic pain and only if the medication had been initiated by a specialist in a hospital or outpatient setting. This restricted the use of long-term opioids in people with non-malignant pain.

The problem with such a restriction is that any condition that causes severe pain can actually change the anatomy of the central nervous system and make the pain worse. A constant stream of pain messages delivered to the spinal cord leads to the enhancement of pain pathways from the affected body part, easing the passage of such noxious signals to the brain. The longer the spinal cord is exposed to this sort of pain insult, the more such preferential pathways develop and the harder it is to bring the pain under control. Early and adequate treatment of significant pain is essential to prevent this pain pathway development, regardless of the cause of the pain.

The PBS has recognized these new findings and made it easier for any medical practitioner to prescribe long-term analgesia. Any practitioner can prescribe regular analgesia for up to 12 months through the authority scheme. These patients can get indefinite opioid analgesia after this time, provided that they are reviewed by one other doctor (not necessarily a specialist), who agrees that ongoing pain relief is warranted.

Under state law, patients commencing long-term narcotics have to be notified to the Drugs of Dependency Unit. Authority Scripts can be prescribed for 1 month at a time over the phone, or for up to 3 months at a time by posting the script to the PBAC. It is wise to commence regular laxatives at the same time as starting long term analgesia.

Changes to the Schedule of Pharmaceutical Benefits Yellow Book

After December 2006 the Schedule of Pharmaceutical Benefits will be updated on a monthly basis and available online at www.pbs.gov.au

Unfortunately after the December 2006 edition is distributed the well-known PBS Yellow Book will no longer be available free to prescribers. This is creating new challenges to the Palliative Care Medicines Working Group as the online version of the PBS book will not have the instantly recognized mauve section, so unless medical practitioners are aware of the palliative care section, or look up a drug on the list by name, they may not know the medicine is available for palliative care patients. The Palliative Care Medicines Working Group is looking at ways to highlight the palliative care section in this new electronic environment.

For more information about the PBS online project, and to subscribe to updates go to the project's website at www.health.gov.au/pharmbiz.

Misconceptions

These changes have not been universally accepted. Feedback from individuals and some doctors' groups show dissatisfaction with the need to prescribe through the authority system. There is also discontent among practitioners who want to see their favourite drug on the list. The answer to both of these objections lies in understanding the rules under which governments operate.

It is essential to understand that the PBAC had to be able to track drugs used for palliative care purposes, and the authority system is the only way to achieve that.

With respect to the choice of drug, the drugs considered were identified through an inclusive process, and put to the committee. Much of the committee's work from that point on must remain confidential, as it is the prerogative of the manufacture to elect whether to take a given drug forward or not. Without an industry sponsor, the listing process won't even start. This step is a commercial or public good

decision made by the manufacturer, a decision over which the committee has no control. Hence a doctor's favourite drug may have been considered, but the committee cannot disclose what drugs have been considered.

Getting the message out

A communication subgroup of the Palliative Care Medicines Working Group had been charged with the responsibility of getting the message about this initiative to health professionals and consumers. This group has adopted a Train the Trainer model and established a national network of health professionals trained to keep their non-specialist colleagues aware of the existence of the palliative care pages and encourage them to make maximal use of them.

Feedback is always welcomed by the author of this article, Dr Geoff Mitchell. He encourages those with comments on this process or article to email him at g.mitchell@uq.edu.au.

Reference

Good P, Cavenagh J, Currow D, Woods D, Tuffin P, Ravenscroft P. What are the essential medications in palliative care? *Aust Family Physician* 2006;4:261-4.

Table 1: Medicine groups available on the PBS from 1/08/06

Stomatological preparations

Benzydamine Hydrochloride, Carmellose Sodium

Belladonna alkaloids

Hyoscine Butylbromide

Anti-Emetics and anti-nauseants

Promethazine Hydrochloride

Anti-inflammatory agents

Diclofenac sodium, Indomethacin, Sulindac, Ibuprofen, Naproxen

Analgesics – opioids

Morphine Sulfate – short acting tabs

Analgesics – non-opioids

Paracetamol suppositories and long-acting tablets

Anti-epileptics

Clonazepam

Psychoactive medications

Diazepam, Oxazepam, Nitrazepam, Temazepam

CPCRE ACTIVITY REPORT

Developing and Promoting the use of Evidence-Based Resources

Practice Guidelines

The Management of Syringe Drivers Guidelines Summary Card has been distributed to major palliative care facilities in Queensland. A copy of the summary card and complete guidelines booklet can be found on the CPCRE Website.

The on-line education package to support dissemination of the Guidelines has been launched. Please check the CPCRE Calendar and Website for Syringe Driver workshops scheduled for this year.

Paediatric Loss and Grief Information Resources

The newly published information booklet on Paediatric Bereavement has been disseminated to key stakeholders. A copy can be found on the CPCRE Website.

Palliative Approach in Residential Aged Care Implementation Workshops

CPCRE participated in a series of 10 skills-building workshops for RACFs in Queensland coordinated by the Australian Institute for Care Development. These workshops follow on from the success of the 45 workshops delivered throughout Queensland to facilitate implementation of the *Guidelines for A Palliative Approach in Residential Aged Care*.

Promoting access to high quality palliative care education

Palliative Care Curriculum for Undergraduates (PCC4U)

(A joint initiative between Queensland University of Technology, CPCRE, Flinders University and Charles Darwin University; funding from the Department of Health and Ageing through the National Palliative Care Program). A National Workshop to profile palliative care undergraduate education was held on 7th June 2006 at QUT. The workshop included presentations on the outcomes of work undertaken by 10 course providers across medical, nursing and allied health disciplines who had been involved in a project to integrate palliative care in undergraduate health education.

PEPA (Program of Experience in the Palliative Approach): (Funded by the Department of Health and Ageing through the National Palliative Care Program)

A total of 175 clinical placements have been facilitated in Queensland as part of the PEPA program. An additional 10 placements are available for the period from July 2006–Dec 2006.

National Coordination Activities

A comprehensive national evaluation of the program has been completed, involving survey and interviews with participants, employers, host site personnel, mentors and program managers. The recommendations in this report are currently being reviewed by the Department of Health and Ageing, with a view to planning for a revised program from 2007.

GP Education Program

Five projects that are part of the 2006 Program are nearing completion. These projects address issues including: knowledge and skill through specialist lead seminars and workshops; strengthening partnerships between GPs and specialist services; improving accessibility to educational resources via an online program with a mentoring component and a video demonstrating insertion of a subcutaneous catheter; and building networks of local GPs interested in developing palliative care services in their district.

Applications for 2006-07 Program close in Mid August. Please review the CPCRE website for further information.

CARESOURCES and the Queensland Palliative Care Education Calendar

The 2006 Education Calendar is available from CPCRE. CARESOURCES, the Queensland Palliative Care Education Directory can be accessed on www.cpcre.com.

Allied Health Education

Further workshops are planned in the second half of 2006. Please check the CPCRE Calendar and Website for further information.

Paediatric Grief, Loss and Bereavement Education

The booklet entitled *When a Child Dies: A Guide to Working with Bereaved Parents after the Death of a Child* prepared by Liz Crowe, BSW, has been distributed to key stakeholders. A copy of the book can be found on the CPCRE Website.

Karuna-RBWH-CPCRE Specialist Palliative Care Nursing Education Program

Karuna Hospice Services in collaboration with RBWH and CPCRE is offering a structured education program to four nurses to develop skills in palliative care nursing.