Response to BMMS Implementation Taskforce
July 2001

Better Medication Management System (BMMS) Bill 2001 (exposure draft)

As the peak body for the 31 Victorian divisions of general practice, GPDV circulated a paper outlining some of the issues arising from the proposed BMMS that are relevant to general practice and the divisions. This submission to the BMMS Implementation Taskforce has been developed from that paper in light of comments received from Victorian divisions of general practice.

The lack of access to accurate information on consumers' medicines can result in adverse outcomes including unnecessary hospitalisation. The BMMS seeks to address this problem, so that consumers, pharmacists and doctors all have access to accurate information about the consumer's medicines.

GPDV supports this goal, which is particularly relevant to divisions of general practice, many of which conduct programs related to improved communication between GPs and other health providers (including pharmacists) and to improving the quality use of medicines in general practice. The BMMS proposal is an extremely ambitious one and GPDV believes there is a range of issues which need to be addressed before the system is likely to be acceptable to the majority of GPs.

IM/IT infrastructure

A sound information management/information technology (IM/IT) infrastructure is crucial to the success of the BMMS project. The proposal is based on the premise that GPs have adequate IT and the knowledge to use it effectively. The fact that the Department of Health & Aged Care is currently in the process of withdrawing IMIT funds to the divisions is a serious threat to the BMMS. These funds will enable general practice as a whole to take up IM/IT, rather than the few with a passionate interest. There is evidence that divisions have increased IM/IT capacity in practices and there is still room for improvement. Public key technology is a step beyond the capacity of most GPs at the moment and yet the BMMS is likely to rely on PKI. The IM/IT work of divisions must be continued and built on if the BMMS is to involve general practice as a whole. The BMMS Implementation Taskforce is in a position to raise this matter with the GP Branch to ensure that specific resources are provided to allow the continued development of IM/IT in general practice.

Incomplete medication records

The fact that medication records are likely to be incomplete, because of the opt-in nature of the system, is likely to make it more difficult to get GPs involved. Some divisions of general practice have suggested that a better approach would be to concentrate on piloting aspects of the system, so that it will be possible to have a fuller implementation with universal coverage. The involvement of hospitals would encourage GP participation, as GPs feel strongly about the lack of shared information as consumers move between the acute and community sectors.

Implementation in practice

The amount of consultation time that would need to be devoted to the BMMS record could be a barrier to GP involvement. Similarly, gaining patient consent may be difficult to implement in practice, given the complex layers of consent in the proposal. Consent to participation in a scheme such as this may need to be multi-faceted, i.e. consumers should be exposed to written material, have the opportunity to discuss it in person (with GP, pharmacist or perhaps practice nurse) and have access to telephone support in making their decision. They should also be reassured that non-participation will not affect their right to PBS subsidies (now or in the future).

These and many other practice-level issues could be partly addressed through appointing division staff who work in practice support activities to the appropriate BMMS working groups. These people are very well-informed about the day-to-day practice issues across a wide variety of practice structures in their local area. (Several representatives from divisions have already expressed interest.)

Devoting specific resources to divisions to assist with practice level implementation would also help to address these barriers. The Evaluation of the General Practice Immunisation Incentives Program (conducted in 2000) showed that the division support component was essential to the success of the program. This component was implemented alongside outcome-based and service-based incentive payments to GPs and practices. The divisions of general practice helped to educate practice staff and GPs to enable them to increase their immunisation rates (addressing cold chain procedures, recall and reminder systems, data issues, notifications of immunisation to the national database, interpretation of data from the Health Insurance Commission etc.) A similar support program would be necessary to bring about the very significant change in general practice advocated by the BMMS proposal.

Errors in records

Many GPs are likely to be concerned about the possibility of harsh penalties for errors that may occur in the new system. Some may not see the section of the legislation relating to criminal offences as problematic, as doctors should be able to obtain necessary patient consent etc. However, this section of the legislation may need to be amended to allow other practice staff to download the record (e.g. practice nurse) using the GP – or practice – authentication mechanism. As the Implementation Taskforce would be aware from the AMA submission, many doctors may be unlikely to opt in to the BMMS system unless they are reassured about the possibility of very serious penalties.

A related GP concern will be about who may be held responsible for any mistakes or errors (made unknowingly) in the record.

Practice level registration

Advice from the divisions who responded to GPDV's policy issues paper on the BMMS, and from individual board members, suggests that registration to participate in the BMMS would be more appropriate at a practice level, rather than the individual GP level. As one GP pointed out,

> When consumers attend a practice there is implied consent for the medical record to be shared by all of the GPs (this is not discussed as far as I am aware, but invariably happens when the patient sees another of the GPs). In fact this is an important component of continuity of care and why most patients attend the same practice, even if not the same GP.

Encouraging practices (rather than individual GPs) to participate would be consistent with the continuity of care that is at the heart of the BMMS proposal.

Additionally, some divisions have suggested that a practice nurse should be able to download the BMMS data on behalf of the GP, to enhance the smooth running of the practice, and to encourage GPs to use the system, as it may take up less of their time within the consultation. Obtaining practice level consent (for all medically qualified individuals) may address the patient consent issues.

GP incentives

In order to promote GP participation in the BMMS, it will be important to develop some detail about the incentives for GPs, which were mentioned by taskforce members at the briefing meeting in June. Real GP incentives will be required to encourage GP involvement, given the additional time that will be taken up in the consultation for obtaining patient consent, explaining the scheme, and downloading and updating the BMMS record, as well as making whatever practice changes are necessary to participate (e.g. PKI).

Additionally, there will need to be significant resources to divisions to assist with support and education. Although important, the individual GP-level and practice-level incentives alone are not enough to ensure a successful program. (See above points on *IM/IT infrastructure* and *Implementation in practice.*)

Representation of GPs

The draft bill states that there will be two representatives on the 8-member BMMS Board who are 'medical practitioner nominees' (appointed by the Minister) but does not distinguish between different types of medical practitioner. Given the central place of general practice in the intended roll-out of the BMMS, GPDV suggests that there should be specific general practice representation on relevant committees, and on the board. Divisions of general practice (through ADGP, the Australian Divisions of General Practice) would be the most appropriate organisations to provide representation, given their key role in implementation of government-funded initiatives at the practice level.

Identified data

Responses from divisions to GPDV's policy issues paper have agreed that identified prescriber data should be available for QUM programs.

The current Quality Use of Medicines proposals under consideration (which will return any savings from improved prescribing to general practice) and the current NPS Prescribing Practice Reviews are both adversely affected by the incomplete nature of the PBS information that is returned to GPs.

The Practice Reviews provide information only on those items claimed through the PBS but some items are not claimed. The PBS has data on prescriptions for:

- concession card holders (who pay less than the co-payment amount, so the remainder is claimed by the pharmacist, from the PBS)
- Items above the co-payment for patients without a concession card (as pharmacists claim the portion above the co-payment from the PBS).

This means that "those prescriptions for PBS items which cost less than the patient co-payment are not available from pharmacy claims data. This is a recognised deficiency in the data and explains the disparity between … [a] known practice and the profile as provided for some drugs."[1] The QUM proposal uses the same data, with the same problem that not all of a GP's prescribing is included when calculating baselines or measuring change in prescribing.

At some future time, if there is wide patient participation in the scheme, the BMMS might provide an opportunity to redress the deficiency in the data used for this sort of education, review and feedback which provides an opportunity for GPs to enhance their own prescribing without taking any sort of punitive approach. This will not be possible if legislation prohibits using identified prescriber data for any purpose. We suggest that further consultation with the National Prescribing Service and any other relevant sections of the Department of Health & Aged Care would be wise, before passing legislation that will prevent BMMS prescribing information from being used to improve quality prescribing patterns.

If the prohibition were removed, policies would need to be in place to ensure that the HIC will not use the data in a punitive way, in order for prescribers to have confidence in the system, and to protect data from breaches of confidentiality. The legislation might specify that identified data may be used for the sole purpose of prescriber feedback, where the participating prescriber has agreed to this.

Other issues raised by Victorian divisions

Some responses to GPDV's issues paper raised some additional issues:

- Strong objections to the possibility of tendering out the management of the BMMS were raised, for reasons of privacy and security.
- All those qualified to dispense (including complementary therapists) should be included in the BMMS for it to be successful. Trialling all aspects before introducing a universal system (including hospitals) with mandatory participation for all health providers was also suggested.
- It is unclear whether alternative therapies are to be included on the BMMS (and they should be, to ensure a full medication record).

Conclusion

GPDV believes that the goal of the BMMS is worthwhile and relevant to divisions of general practice, but that a substantial amount of work still needs to be done before the BMMS is likely to be taken up by general practice as a whole.

Key points to be addressed in the proposal are:

- the need for greatly improved IM/IT infrastructure in practices and, in order to achieve this, the need for IM/IT funding to divisions which have demonstrated substantial improvements in the area over the last 3 years.
- the need to overcome the potential barrier to GP participation that will be brought about by incomplete medication records. Some suggestions from divisions include: more thorough pilots prior to full introduction; introducing the system into general practices and hospitals simultaneously; simplifying the layers and /or procedures for gaining consent;

[1] NPS web site, section on *Understanding the Data in the Practice Prescribing Review* at http://www.nps.org.au/

and ensuring that information to GPs makes it clear that the BMMS record is likely to be incomplete, but that it will nevertheless be a fuller record than those currently existing.

- the need to minimise the amount of time that will be spent on the BMMS during a general practice consultation.
- the need to review the penalties that may be incurred by prescribers particularly in relation to a failure to gain adequate consent.
- the need for resources to divisions to enable full implementation of the BMMS at the practice level.
- registration should be at practice rather than individual GP level to enable the sharing of records and continuity of care.
- given the voluntary nature of the system, substantial GP incentives will be needed, to offset establishment of the system and ongoing costs. Consumer incentives should be considered also: if consumers are to opt-in, they will need convincing information about what the BMMS can offer them.
- identified prescriber data should be available for QUM purposes, with the consent of the individual prescriber (and with protection against breaches of confidentiality built in).
- general practice, specifically, should be represented on the BMMS board.
- the inclusion of general practice representatives on working groups to help develop detailed practice-level issue will help achieve a workable scheme. Division practice-support staff would be an ideal source of such advice, as they will have a wider working knowledge of practices than a single practitioner or practice staff member.

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