
Australian Government

Department of Veterans' Affairs

# Consultation Paper on the Review of War Caused Disabilities and Pharmaceutical Costs

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# Foreword

The Australian Government, with all Australians, recognises and values the contribution of those who have experienced active service in defence of our country.

As part of this, it acknowledges the long standing commitment of Governments to these veterans to meet the costs associated with treatment from their war caused or related conditions.

This is why, in the 2007 election, we committed to a review of the cost of pharmaceuticals for war caused disabilities. We recognised the concerns within the veteran community with growing out of pocket costs for essential medicines to treat these conditions.

This Report sets out, for consultation with the ex-service community, the issues raised by the Review undertaken within the Department of Veterans' Affairs.

In summary, the Review has found that a solution which directly links pharmaceutical usage to war caused disabilities in line with our election commitment is not viable. This is because of a range of complex policy and practical issues.

Recognising this, the Review has canvassed approaches which accord with the specific intent of the Government's election commitment.

I encourage those in the ex-service community to consider and, should they wish, comment on the work of the Review.

The Honourable Alan Griffin MP
Minister for Veterans' Affairs
Minister for Defence Personnel

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# Consultation Paper on the Review of War Caused Disabilities and Pharmaceutical Costs

# Introduction

This Consultation Paper for the Review of War Caused Disabilities and Pharmaceutical Costs (the Paper) is a key step towards delivering the Government's election commitment.

It sets out for consultation with the veteran community:

1. the context of the Review including the Government's election commitment;
2. the processes undertaken by the Department of Veterans' Affairs (DVA) to date; and
3. the key findings of this work.

In preparing this Consultation Paper, the Review team in DVA has considered the specific practical and policy issues in identifying pharmaceutical usage related to war caused disabilities.

# Government Commitment

As part of Labor's Plan for Veterans' Affairs, the Government acknowledged the clear view in the ex-service community that pharmaceuticals required for war caused disabilities should be at no cost to the veteran. In doing so the Government committed:

"...to review this matter in the first term of Government and to establishing, in consultation with the ex-service community, a fair solution that relieves the burden on veterans of the cost of medication to treat their war caused disabilities." [1]

This commitment recognised that over recent years there had been growing concern within the veteran community regarding the widening gap between the DVA Pharmaceutical Allowance (PA) and the cost of the concessional pharmaceutical copayment (from hereon referred to as the 'copayment') paid by veterans for each prescribed medication available under the Repatriation Pharmaceutical Benefits Scheme (RPBS).

# Scope of Review

In line with the Government's election commitment, the focus of analysis has been to examine pharmaceutical usage, subsidy arrangements and out of pocket costs for those conditions which were war caused or linked to war caused disabilities. The target population was therefore those veterans who have disabilities resulting from participation in war-time conflicts.[2]

1. Labor's Plan for Veterans' Affairs – Election 2007 Policy Document, pp12
2. Although the analysis focused primarily on veterans covered by the Veterans' Entitlements Act1986 (VEA), the Review noted that there is also a number of former Australian Defence Force members eligible under the Military Rehabilitation and Compensation Act 2004 (MRCA) who have access to the RPBS and have war caused disabilities.

# Background

## The Copayment – why introduced

It has been a policy of all Australian Governments since 1991 that all patients make a contribution through a copayment towards the cost of all subsidised items under the RPBS and the Pharmaceutical Benefits Scheme (PBS). Reasons for the introduction of the copayment were:

- to share the financial burden of the cost of medicines, particularly given the increasing use of new expensive medicines;
- to ensure the sustainability of the PBS; and
- to promote the quality use of medicine.

A copayment can encourage the prescriber and veteran to consider more carefully the need for a particular pharmaceutical. It can discourage hoarding and stockpiling of medication and related misuse or overuse, including inappropriate self medication.

The concessional copayment paid by veterans, introduced at $2.50 per script in 1991, has risen to $5.40 in 2010.

## The Safety Net

The Safety Net for the PBS/RPBS is based on single or family use of prescriptions and for concessional beneficiaries provides for free pharmaceuticals after the threshold is reached. The threshold, originally introduced at 52 scripts per year in 1991, was progressively increased between 2006 and 2009 and stands at 60 scripts in 2010.

## The Pharmaceutical Allowance

The PA has been paid fortnightly since 1991 when it was introduced as a counter to the initial copayment of $2.50. To be eligible for the PA, a beneficiary had to be in receipt of a service pension, widows or orphans pension, an income support supplement or be a Treatment Card holder.

When introduced, the PA was set at a rate (and similarly indexed) to offset the copayment, in that it initially covered the maximum number of copayments to the point where the Safety Net threshold was reached and pharmaceuticals became free of charge for concessional beneficiaries.

As a result of the 2009-10 Secure and Sustainable Pension Reforms – the Harmer Review – the PA, Telephone Allowance, Goods and Service Tax supplement and Utilities Allowance were rolled into a single Pension Supplement paid fortnightly with the Service Pension or Age Pension. From September 2009, a Veterans Supplement was also introduced to recompense those veterans in receipt of a Disability Pension with no Income Support payments. The PA component of the Pension and Veterans Supplement is currently $3 per week (for a single veteran or couple combined) or $156 per annum.

For the purpose of this paper the PA, although now subsumed into these Supplements, will continue to be referred to in this document.

# Relative value of Pharmaceutical Allowance against the Copayment

The relative value of the PA against the copayment rate, together with the threshold level of the Safety Net, are the key drivers of veterans' out of pocket expenses for pharmaceuticals. Table 1 below is a representation of the key policy changes since 1991 and the effect of these in terms of out of pocket costs for pharmaceuticals.

**Table 1 – Key PBS/RPBS policy changes affecting copayment, allowance and safety net**

| | Year | Veteran (max) Out of Pocket amount | Safety Net Threshold (SNT) scripts per year |
|---|---|---|---|
| Introduction of the pharmaceutical copayment & the Pharmaceutical Allowance | 1991 | $0 | SNT set at 52 |
| | 1992 | $0 | |
| | 1993 | $0 | |
| | 1994 | $0 | |
| | 1995 | $0 | |
| | 1996 | $0 | |
| Copayment indexation method changes | 1997 | $0 | |
| | 1998 | $26 | |
| | 1999 | $26 | |
| | 2000 | $26 | |
| | 2001 | $31 | |
| | 2002 | $36 | |
| | 2003 | $42 | |
| | 2004 | $47 | |
| Copayment and Safety Net realignment | 2005 | $88 | |
| | 2006 | $103 | SNT to 54 |
| Review in Election Commitment | 2007 | $124 | SNT to 56 |
| | 2008 | $139 | SNT to 58 |
| Review commences | 2009 | $162 | SNT to 60 |
| | 2010 | $168 | |

As identified above, the initial annual amount of the PA fully offset the pharmaceutical copayments up to the Safety Net threshold. The copayment was indexed to reflect movements in the Consumer Price Index (CPI), and so the PA was indexed using the same methodology to maintain relativities between the two.

The 1997 Budget included a measure that changed the indexation method for the copayment (to round up the CPI calculated increase to the next 10 cents). The effect of the measure was to almost guarantee an annual increase to the copayment, while the PA indexation method remained unchanged, requiring a higher CPI rate to enable an increase to the PA.

In 2005, as a consequence of the 2002-03 Budget, there was a one off increase to the copayment of around 20 per cent. Also arising from the same Budget were prospective increases to the Safety Net Threshold, increasing by two scripts per year from 2006 to 2009.

The implications of these changes over time, while initially small, became obvious in 2005 when the maximum out of pocket expenses for veterans increased by 87 per cent compared to the previous year.

Assuming that there is no change to current policy settings and an annual CPI increase of 3 per cent, veterans will be exposed to out of pocket costs of up to $250 annually by the year 2016 – refer Table 2. The PA will cover around 40 per cent of the maximum copayment amount in this scenario.

**Table 2 – Initial, current and projected settings of the PA, copayment and Safety Net threshold – Single or Couple**

| Year | PA per annum | Pharm. Copayment | Safety Net Threshold | Veteran max. Copayments per annum | Veteran max. out of pocket amount per annum |
|---|---|---|---|---|---|
| 1991 | $130 | $2.50 | 52 | $130 | 0 |
| 2010 | $156 | $5.40 | 60 | $324 | $168 |
| 2016 | $171 | $7.00 | 60 | $420 | $249 |

# Linking Pharmaceutical usage to War Caused Disabilities

The Government's election commitment was to examine the costs of pharmaceuticals required to treat war caused disabilities. Within DVA, arrangements for the recognition of war caused or service related disabilities are well established for determining eligibility for compensation.

## Accepted Disability assessment

Accepted Disabilities (ADs) are established following the determination of claims for disability pension (DP). Injuries and diseases are accepted on the basis of whether they meet one of the factors listed in a Statements of Principle (SoPs) issued by the Repatriation Medical Authority (RMA). The SoPs detail all the possible factors that must be met for an injury or disease to be accepted as war or service-caused. Injuries and diseases that are part of the claim are recorded on DVA systems as disabilities, and marked as 'Accepted' if the claim is successful. Once accepted the disabilities are assessed to determine a rate of Disability Pension (DP).

## Policy and practical issues

To extend the recognition of ADs to the arrangements which would apply for prescribing, dispensing and subsidising pharmaceutical usage for all veterans with ADs raises a number of significant policy and practical issues.

For the prescribing doctor, this would require:

- specific knowledge of the veteran's AD as recognised in DVA systems (rather than the knowledge of the veteran's condition as the treating doctor);
- ability to link the pharmaceutical need to an AD or not; and
- prescribing arrangements which can distinguish whether the prescription is AD related or not.

For the dispensing pharmacist, this would require:

- dispensing arrangements which recognise the prescription as AD related or not.

For DVA and Medicare Australia, this would require:

- data and processing systems which could support doctors and pharmacists with this additional decision making and associated administrative arrangements.

## DVA data quality for accepted disabilities

As indicated above, an arrangement which relied on identifying pharmaceuticals linked to an AD would require the prescribing doctor to have specific knowledge of the veteran's AD as recognised in DVA systems.

DVA's recording of ADs was not undertaken with this purpose in mind. These records date from the time of the determination of the veteran's original compensation claim, with many from the 1940s to 1960s which were subsequently manually entered into information systems in the 1970s. As such they have significant limitations for this purpose.

Analysis of AD records on departmental databases indicated that all were recorded in 'free text' (i.e. non-standardised) and that there are 90,000 distinct values. The reasons for this are numerous and include the same medical condition being described in many ways, e.g. 'Nervous leg', 'night leg', 'jumpy leg' and 'twitchy leg'.

Additionally, many ADs are also coded according to the International Classification of Diseases (ICD) format. There are many inconsistencies between these codes and the text records which would require a lengthy and labour intensive project to correct. It is also not feasible to store information about ADs on DVA treatment cards.

There are several hundred thousand AD records on departmental data bases and in related paper records. A clean up/standardisation exercise would be a lengthy and labour intensive project, requiring both paper and electronic records to be reviewed. Even to address records post WW2 this could take in excess of 12 months and cost over a million dollars. The complexity of the task for earlier records would be even greater.

## Implications for Prescribing Doctors

Discussions with GP representatives have indicated that it is likely few know the recorded ADs of veterans with a Gold Card (i.e. the majority of veterans). The problems with the existing AD data records would have to be resolved to provide information to medical professionals when completing prescriptions. Even where the prescribing doctor had knowledge of the veteran's AD, the doctor may require judgement/examination simply to determine if a current condition is linked to the AD.

An example would be an AD of a 'gun shot wound to the thigh'. The veteran may require anti-inflammatory medication for arthritis of the knee or hip, either of which may be related to the original war injury. Full medical details of the original injury would be needed to determine if there was a connection. This is a challenge even for the compensation determination process. Such assessments are likely to require additional time and few GPs are likely to have the experience and expertise to make consistent judgements.

## Summary

A policy that would require recognition of the use of pharmaceuticals as related to ADs would be difficult to implement and operate. Not only are there issues with enabling the data quality to support the measure, but there would be a requirement for changes to forms, processes and systems.

Most importantly, the requirement to classify prescriptions would be an impost on prescribing doctors which potentially could result in a reluctance to treat Gold Card veterans. In some circumstances this would require exercising a judgment or decision which is unrelated to the clinical care of the recipient but more appropriate to the compensation system. This difficulty

would be more complex where a veteran was being treated for a range of conditions, and the direct link or lack of link to a war related condition would become increasingly uncertain.

This broad range of issues, both practical and policy, mean that directly subsidising costs for pharmaceuticals which are specifically related to war caused conditions is not a practical option. That is, a literal implementation of the policy intent of the Government's election commitment is not possible.

# Alternative Approaches

Despite this conclusion, the issue remains that some veterans with war caused disabilities are experiencing out of pocket costs for their pharmaceutical needs. The DVA commissioned Australia Institute of Health and Welfare (AIHW) Study "Health care usage and costs" (2002) focused on Gold Card veteran and war widow health care costs compared with the rest of the community. The AIHW study noted that health care costs for Gold Card veterans were higher than for the rest of the community of similar age, and found that this difference was entirely attributable to service related disability. Additional analysis conducted as part of the Review has confirmed that pharmaceutical usage is particularly high for veterans on some of the higher rates of disability pension.

Given the barriers to directly addressing the Government's commitment, the options for Government are either to do nothing or to consider approaches which, as close as is practicable, meet the specific intent of the commitment.

The Government's commitment clearly targets pharmaceuticals for treating war caused disabilities. The Review has identified two possible options which broadly meet this objective – although for different reasons neither precisely reflects the commitment to target just those pharmaceuticals required for war caused disabilities.

Both options are predicated on providing a single retrospective annual reimbursement to a targeted group of veterans (and eligible persons under the MRCA). This reimbursement would be calculated on the basis of the gap between prescription copayment costs covered by the PA, currently 28 scripts, and copayment costs for pharmaceuticals incurred before the safety net is reached, currently 60 scripts. Reimbursement would be based on individual usage and would apply on a calendar year basis, with payments to occur in the following year.

A starting point could be to target additional assistance to those veterans who have qualifying service (QS) . The current service definitions are peacetime, non-war-like service and war-like service, with only the latter being the equivalent of QS. QS is linked to the concept of having incurred danger from hostile forces and, as such, aligns with the Government's commitment to address pharmaceutical costs for war caused disabilities.

A further refinement would be to target those with both QS and DP, that is those who have war-like service and also have one or more accepted disabilities. DP can result from disabilities obtained during service that is QS but also as a result of peacetime service. As such, DP in isolation is not a true indicator of war-like service and a consequent need for pharmaceuticals for war caused conditions. Similarly QS may not have resulted in an AD and a related need for pharmaceuticals.

Targeting reimbursement to those veterans who have both QS and DP focuses on those who have both incurred danger through a period of war-like service and who also have an AD.

## Option 1: Reimbursement for those with Qualifying Service and receiving Disability Pension

Under this proposal, all veterans with QS and any percentage of DP would receive reimbursement for out of pocket pharmaceutical costs.

While this option would target those veterans whose service history and conditions are closely aligned with the Government's commitment, it does not distinguish pharmaceutical usage which is related to war caused disabilities, compared to usage for other health issues. It therefore extends additional assistance beyond the scope of the Government's commitment. However, it would be reasonably simple to administer and for recipients to understand.

## Option 2: Reimbursement for those with Qualifying Service and receiving Disability Pension, adjusted by DP rate

An alternative option would be to consider an approach which adjusts the level of reimbursement, in a manner which includes a proxy adjustment for pharmaceutical usage which is not related to war caused disabilities. One possible such proxy could be, for those veterans with QS and in receipt of DP, to use the DP rate as a determinant of the amount of reimbursement.

Under this option DP veterans with QS would receive reimbursement for out of pocket pharmaceutical costs with the level of additional payment related to their level of disability. As such, those in this group on a DP of 100%, EDA, Intermediate, Blind, TPI and TTI could receive the full reimbursement while those on less than 100% DP could receive a pro rata reimbursement according to their rate of DP. For example under this approach, in 2010, a 50% DP veteran who had incurred the maximum possible out of pocket cost of $168 would be reimbursed $84.

The use of DP rate to determine the reimbursement amount is an acknowledgement of the likelihood of higher pharmaceutical usage linked to war caused conditions for higher rate DP veterans. It recognises that not all pharmaceuticals are related to war caused disabilities. However, as a proxy for actual pharmaceutical costs that may relate to ADs, it does not take into account the actual costs of pharmaceuticals related to ADs for individual veterans. There will be instances where individuals with high pharmaceutical usage linked to their ADs receive less reimbursement than those whose AD related usage is lower and vice versa.

In summary, there is not an alternative approach which can exactly meet the Government's election commitment. The options identified above present different advantages and disadvantages. Importantly, both options actually go beyond the Government's commitment for many of the veterans affected. That is, a veteran who went to war will under the wider option (Option 1) be reimbursed for out of pocket expenses regardless of the clinical basis for the pharmaceuticals. Under the narrower option (Option 2) many will be compensated to a greater extent than they would be under a literal consideration of the commitment.

Comments on these possible alternatives are welcome. Other alternatives may also be put forward as part of this process. Arrangements for providing comments are set out below.

# How to Comment

The Department of Veterans' Affairs calls for submissions from interested individuals and organisations.

E-mail: pharmacycopayreview@dva.gov.au

Mail:
Pharmaceutical Costs Review
Department of Veterans' Affairs
GPO Box 9998
CANBERRA ACT 2601

**Closing Date: 18 June 2010**

## Accessibility

Submissions may be forwarded electronically in Word, RTF, PDF format, or forwarded handwritten or in typed hardcopy. In order to make submissions available as soon as possible, submissions will be published in their original format. Handwritten submissions will be scanned into PDF documents. The text of e-mail submissions will be reproduced in Word format.

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