Dear Senate

I am writing in my capacity as a specialist with a clinical and academic interest in Osteoporosis Management to comment on the proposal by the PBAC to create new therapeutic groups. My understanding is that initially this will apply to bisphosphonates and it is possible that this may be rolled out to involve other therapeutic groups as well.

I have a number of concerns to raise with regard to the potential adverse impact on patient treatment, especially older patients. Treatment choice is made by a clinician based on patient and clinician preference and is usually guided by cost, risk – benefit, convenience and special qualities of a particular agent in terms of evidence of benefit in a particular subgroup of patients or patients with comorbidities and potential interactions with other medications and diseases. The group of patients that we deal with are generally a frailer, older group with multifactorial problems, multiple medical issues and comorbidities and polypharmacy. Reducing choice of treatment in patients with a high risk profile is fraught with risk.

My concerns relate to removal of the choice of the clinician and patient to make a judgement on the most appropriate agent for their particular disease profile. Not withstanding the pharmacological differences of these agents, geriatricians would prefer to select agents based on good available evidence, efficacy and tolerability in older patient groups.

Current treatment selection for osteoporosis therapy is based on patient profile and factors that influence choice in terms of dosage, frequency and modality of delivery. Currently not all therapeutic groups are available across the range of dosages, frequency and modality of delivery. Allowing interchangeability may impact adversely on this choice which is made for specific indications. For example, the choice of less frequent dosing, e.g. monthly over weekly, is based on the premise that the compliance, cost and convenience may be improved. Removing this option may adversely affect patient outcomes through reduced compliance, convenience and costs of formal or informal carers, I.e. less frequent dosing may be preferred for patients who require supervision.

Secondly not all agents are available with complimentary calcium and vitamin D which is supplied by some but not all pharmaceutical brands. Furthermore these supplements are provided with combinations of calcium and or vitamin D and dosages and combinations may vary. With the lack of standardisation across each of these pharmaceutical agents and their co-supply of calcium and vitamin D combinations, there is a potential for confusion resulting in either diminished benefit or increased risk of incorrect combinations.

Similar arguments may apply to other therapeutic groups should the PBS choose to extend this to other therapeutic groups. I am aware that specialist societies that I am affiliated with including Australian New Zealand Society of Geriatric Medicine, Australian Rheumatology Association and Australian and New Zealand Bone and Mineral Society (ANZBMS) have made submissions relating to this and I agree with the statements made by them and support their concerns relating to this.

To summarise, my view which is in keeping with the view of most experts in this area, this new proposal is likely to disadvantage all patient groups but even more so the older patient groups and may lead to poorer compliance and adverse outcomes including fracture and toxicity. We would be happy to meet the PBAC to further outline our concerns.

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