SHPA's Response to the Review of the National Medicines Policy (NMP) Discussion Paper 2021

Introduction

The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for more than 5,200 pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia's health system, advocating for their pivotal role in improving the safety and quality of medicines use. SHPA members are progressive advocates for clinical excellence, committed to evidence-based practice and passionate about patient care. SHPA is committed to facilitating safe and effective use of medicines, which is the core business of pharmacists, especially in hospitals.

SHPA welcomes the review into the NMP as the medicines landscape has significantly changed in the last twenty years. In recent years, a majority of PBS expenditure and listings are for biologicals, high-cost and complex medicines used to treat cancers and autoimmune diseases, which are often initiated and supplied in hospital settings. This contrasts with when the NMP was introduced, where listings were dominated by medicines for lifestyle-related non-communicable diseases.

About hospital pharmacy

Hospital pharmacists account for just over 20% of the entire pharmacy workforce and are the fastest growing sector of the pharmacy workforce. It is in hospital where hospital pharmacists treat patients at their most unwell, often having a significant health event such as strokes, heart attacks and organ transplants. Patients are usually prescribed multiple new medicines in hospitals during their admission, many of which are taken for many months or years after discharge, relying on regular care by their community-based practitioners.

At the inception of the NMP twenty years ago, hospital pharmacy and the PBS were mutually exclusive, and hospital prescribers and pharmacists could not prescribe or dispense medicines to patients with PBS subsidy. In most recent 2019-20 data, hospital pharmacy accounted for 23% of all Pharmaceutical Benefit Scheme (PBS) expenditure, which included a majority of Section 100 Efficient Funding of Chemotherapy (EFC) and Highly Specialised Drugs Program (HSDP) expenditure. This is the result of Pharmaceutical Reform Agreements (PRAs) entered into by all Australian jurisdictions with the exception of New South Wales and Australian Capital Territory with the Commonwealth.

The PRAs enabled hospital prescribers and pharmacists to prescribe and dispense PBS subsidised medicines to hospital patients upon discharge from hospital, outpatients and patients receiving care from day-treatment services. They supported the transitions of care for patients discharging from hospital back into the community and allowed for patients to be supplied the standard PBS quantity of one-months' supply of discharge medicines. Previously, hospital patients received as little as three days' worth of discharge medicines, which placed pressure on them to see their primary healthcare provider very soon after discharge to continue receiving key medicines.

The inclusion of the hospital pharmacy sector in the PBS has enabled it to further support the key objectives of the NMP, specifically with respect to timely access and quality use of medicines. In this submission, SHPA makes a range of recommendations to further support access equity and quality use of medicines for all Australians. If you have any queries or would like to discuss our submission further, please do not hesitate to contact Jerry Yik, Head of Policy and Advocacy on jyik@shpa.org.au.

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SHPA Recommendations to the Review of the NMP

Recommendation 1: **In order for the NMP to be reflective of a national strategy, New South Wales and the Australian Capital Territory should become signatories of the Pharmaceutical Reform Agreements to achieve the proposed principle of equity and access to medicines.**

Recommendation 2: **The NMP should recognise the necessity of the 'continuity of care' as a fifth objective focusing on the exchange of health information across the transitions of care to facilitate safe and effective medicine use and access.**

Recommendation 3: **The NMP's definition of medicines should be expanded to include vaccines and medical devices which are used to deliver or administer medicines, and future-proofed to include emerging therapies and technologies.**

Recommendation 4: **The NMP should acknowledge digital health technologies as important elements of the healthcare sector which impacts medication safety and quality use of medicines and strive for a connected, interoperable digital health ecosystem.**

Recommendation 5: **The principles and objectives of the NMP relating to access and equity should include patient access to novel and high-cost unsubsidised medicines used in hospitals to treat complex and rare diseases.**

Recommendation 6: **Consumer centricity and engagement should be strengthened in the NMP through greater diversity and inclusion, understanding of their expectations of healthcare delivery and health literacy levels.**

Recommendation 7: **Existing forums between state and federal governments, such as the COAG Health Council and HCEF should be formally recognised as stakeholders in future governance arrangements for the NMP.**

Recommendation 8: **To inform policies and investments to achieve the objectives of the NMP, consistent and high-quality data on medicines use, medicines-related outcomes and pharmacy services should be collected systematically.**

Terms of Reference 1: Evaluate the current NMP objectives and determine whether these should be modified or additional objectives included. This includes consideration of the proposed Principles to be included within the NMP.

A. Are these proposed principles appropriate? With regard to the proposed principles, is anything missing or needing to change?

SHPA supports the proposed principles of equity, consumer centred approach, partnership based, accountability and transparency, and stewardship for inclusion in the refreshed NMP.

To meet the principle of equity for consumers, SHPA believes that the Commonwealth should make the PRAs a uniform policy in Australia and enter into PRAs with New South Wales and Australian Capital Territory. This would ensure a consistent standard of care for vulnerable patients who have just had a major health event requiring hospitalisation and reduces the need for individuals to immediately seek an appointment with their general practitioner on discharge from hospital to continue receiving vital medicines. Patients being discharged from public hospitals in NSW and ACT are currently supplied 3-7 days' worth of discharge medicines, which contrasts with the other jurisdictions who are able to supply a months' worth of discharge medicines. The expansion of PBS into public hospitals has allowed more hospital pharmacists to be employed and provide clinical pharmacy activities to patients, as well as allow investment into specialised pharmacy services, such as pharmacists specialising in oncology, paediatrics, emergency medicine and geriatric medicine. These services are necessary to safeguard and maximise the federal government's investment into new PBS medicines that treat complex conditions.

Recommendation 1: In order for the NMP to be reflective of a national strategy, New South Wales and the Australian Capital Territory should become signatories of the Pharmaceutical Reform Agreements to achieve the proposed principle of equity and access to medicines.

The principle of equity should also not just be limited to effective, safe, high-quality, and affordable medicines, but also expanded to be complemented by clinical pharmacy services delivered which are necessary to support the quality use of medicines and patient safety. Medicines have the capacity to cause harm either through side effects, drug interactions or inappropriate dosing. Literature suggests that there are 250,000 hospital admissions resulting from medication-related problems each year, costing the healthcare system $1.4 billion annually.[1] However, several inequities exist with respect to funding that prevents patients from receiving the comprehensive suite of clinical pharmacy services in SHPA's Standards of Practice for Clinical Pharmacy Services[2], which include:

- taking a medication history and ensuring medications are charted correctly and available at admission to be administered in a timely manner
- regular review of the safety, quality, storage and supply of medications during hospital stay
- review of discharge prescriptions, dispensing a sufficient supply of medications to take home, counselling patients on their medications and communicating changes to primary healthcare providers
- ensuring appropriate follow-up and monitoring of medications post-discharge including in specialised clinics and outpatient services and checking for adverse reactions to medications

The inequities in remuneration for the supply of PBS medicines to hospital pharmacists as per Table 1, have downstream impacts on hospital pharmacy departments capacity to deliver comprehensive clinical pharmacy services to patients. The lack of dispensing fees, wholesale mark ups and administrative handling and infrastructure (AHI) fees means fewer hospital pharmacists are employed to deliver key services to patients that are vital to medication safety and quality use of medicines.

SHPA supports recognition of and funding for clinical pharmacy services in all settings of care and should be devolved from the cost of the medicine. Consumers expect to receive the same quality of care regardless of the healthcare setting, however different funding and service levels across different care settings prevent this.

	Public hospitals	Private hospitals	Community pharmacy
Section 85 medicines	Ex-manufacturer price + 7.52% wholesale mark-up	Ex-manufacturer price + 7.52% wholesale mark-up + 1.4% pharmacy mark-up + Dispensing Fee	Ex-manufacturer price + 7.52% whole-sale markup + AHI fee + Dispensing Fee
Section 100 medicines	Ex-manufacturer price	Ex-manufacturer price + 4-tier s100 pharmacy mark-up + Dispensing Fee	Ex-manufacturer price + 4-tier s100 pharmacy mark-up + Dispensing Fee

Table 1. Public and private hospital pharmacy renumeration fee structure for Section 85 and Section 100 medicines
Adapted from Review of Pharmacy Remuneration and Regulation Discussion Paper and updated with 2019 Federal Budget reduction to hospital pharmacy wholesale mark-up[3]

Another inequity is the exclusion of public hospitals from participating in the Closing the Gap (CTG) PBS Co-payment Measure (the Measure). Whilst the Measure provides co-payment relief for concessional patients in the community, indigenous patients discharging from hospital are not eligible for co-payment relief and are often discharged without any medicines. SHPA members have observed that the need to pay a co-payment per PBS medicine, where treatment regimens sometimes exceed ten medications for complex needs patients, is a significant financial hurdle to many Aboriginal patients. The lack of discharge medicines greatly increases their risk of readmission.

Without access to the Measure, individual hospital policies (which require a co-payment as specified by PBS procedures) often prevent Indigenous patients from receiving their medicines at discharge to avoid incurring operational cost. If patients are unable or unwilling to pay the co-payment, they must attend a community pharmacy to receive discharge medicines. Research shows that these patients have lower medicines adherence compared to other population groups[4], and that over a quarter of patients fail to make it to a local pharmacy until days later to have their discharge prescription dispensed.[5]

B. Are these four Objectives still relevant? Should any be modified, or any additional objectives be considered? If so, how and why?

SHPA believes the four objectives of the NMP remain highly relevant, and that the NMP should consider a fifth objective of 'continuity of care' to reflect the importance of maintaining and protecting safe and quality use of medicines at transitions of care. The World Health Organisation's (WHO) third Global Patient Safety Challenge: Medication Without Harm also identified that in order for preventable medicine-related harm to be reduced, focus should be given to polypharmacy, high-risk medicines and high-risk situations which specifically includes transitions of care.

Recommendation 2: The NMP should recognise the necessity of the 'continuity of care' as a fifth objective focusing on the exchange of health information across the transitions of care to facilitate safe and effective medicine use and access.

Medicine use throughout transitions of care is complex. There is often involvement of multiple clinicians at any given time as patients transition between community and healthcare services. Half of all medication errors in hospital occur upon admission, during transfer and on discharge from hospital, of these medication-related errors, 30% have the potential to cause patient harm.[6]

Medication reconciliation by pharmacists remains the most important means of reducing errors in medication use.[7] Without continuity of care, optimal health outcomes cannot be achieved, and patients are at risk of medication-related harm. Pharmacists have demonstrated that they possess the skills to obtain the most accurate medication histories compared to other health professionals[8,9] and are highly valued by doctors[10] as this ensures patients do not unintentionally skip doses of vital medicines when unexpectedly admitted to hospital. In September 2020, broadcast of the *Sixty Minutes: The Greatest Loss* report on the tragic deaths of

Mr Bryan Ryan and Mr Allan Wells highlighted worst possible impacts of absent and poor medication reconciliation practices, where preventative medicines for stroke and cardiovascular disease were omitted during transitions of care.

Upon discharge, hospital pharmacists are integral to ensuring continuity of care through providing updated medicines lists for patients who often have significant changes to their medicines during their admission, including initiation and cessation of medicines, increased or reduced dosage of medicines, and uptitrating or downtitrating of medicines to achieve stability. Increasingly in Australian hospitals, hospital pharmacists are responsible for the medication summary section of the patient's discharge summary and are integral to providing information to the patient's community-based care providers to ensure a safe transition back into care.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) in their report on Safety Issues at Transitions of Care recognised transitions of care as a substantial risk of harm to patients including harms directly caused by medication errors.[11] They identified six areas where prioritisation needed to occur and these correlate to the principles proposed under the NMP, all of which hospital pharmacists are integral to achieving.

- Improvement in person-centred care
- Better responsibility and accountability for communication at transitions of care
- Better engagement of patients in care planning and communications
- Better access to complete and current health and social information
- Better opportunities for medication reconciliation
- Better discharge planning

Additionally, the Australian Pharmaceutical Advisory Council (APAC) Guiding Principles to Achieve Continuity in Medication Management[12] provides the framework for clinicians on how to provide optimal continuity of care with respect to patient's medicines as they transition between different care settings. However, due to funding challenges in hospital pharmacy departments exacerbated by remuneration inequities, it is difficult for the vast majority of hospitals to deliver all ten Guiding Principles systematically across their entire health service for every patient.

Terms of Reference 2: Consider the definition of medicines and whether the NMP needs to be expanded to include health technologies.

A. **Should the current NMP definition of medicines be expanded to include medical devices and vaccines? Why or why not? How would a change in definition of medicines be reflected in the policy's high-level framework?**
B. **Does the policy's current title, the "National Medicines Policy", reflect the breadth of health technology developments within the policy's scope? If not, how best can these and future health technologies be better represented in the policy's title?**

SHPA supports the expansion of the NMP's current definition to include vaccines and medical devices which are used to deliver or administer medicines. The objectives in the NMP with respect to timely access and quality use of medicines are highly applicable to vaccines and medical devices.

Recommendation 3: The NMP's definition of medicines should be expanded to include vaccines and medical devices which are used to deliver or administer medicines, and future-proofed to include emerging therapies and technologies.

The COVID-19 pandemic has demonstrated the importance of vaccines to the Australian community to prevent disease and is the most important line of defence against a global pandemic. Given the high demand and complexities of manufacturing vaccines, it is appropriate that they are included in the purview of the NMP to ensure timely access for Australians.

Medical devices which are used to deliver or administer medicines should also be under the remit of the NMP as without them, as there are extremely limited alternatives when they are unavailable. For example, syringes are recognised by the Therapeutic Goods Administration (TGA) as medical devices and are critical to the delivery of medicines via intravenous, subcutaneous and intramuscular injection. These include anti-cancer therapies, biological medicines, antimicrobials and vaccines just to name a few.

During the initial stages of the COVID-19 vaccine program rollout, there were concerns from Australian hospitals that the specific low dead space syringes required for COVID-19 vaccines approved in Australia were unable to be procured in the quantities required, necessitating the use of other syringes which would increase the unnecessary wastage of vaccine doses. Recently the WHO reiterated that global shortages of syringes remain a real possibility in the short to medium term future based on projected need and manufacturing capacities[13].

Additionally, devices such as nebulisers, metered dose inhalers and dry powder inhalers commonly used to administer inhaled medicines to treat respiratory diseases are critical and should be considered by the NMP.

To future-proof the National Medicines Policy, the definition of medicines under the NMP should also include emerging medicines and technologies such as gene therapies (i.e. chimeric antigen receptor (CAR) T-cell therapy), immunotherapies, and personalised medicine. These emerging technologies are high-cost, complex and have the capacity to revolutionise how genetic diseases, autoimmune diseases and cancers are treated. Given their specialised nature, these therapies are administered in hospitals and sit alongside conventional therapies when treatment options are decided upon, thus it is imperative the entire continuum of medicines and therapies are included under the NMP's consideration.

Terms of Reference 3: Assess the NMP's utility in the context of rapidly evolving treatment options, population changes, interconnected relationships, and system-wide capacities.

A. **How has the NMP been able to maintain its relevance and respond to the changes in the health landscape?**

B. **How could the NMP be refreshed so that the policy framework is able to better address current and future changes in the health landscape? What is missing and what needs to be added to the policy framework, and why?**

The NMP has maintained relevance over time as its objectives remain desirable and appropriate in setting out how Australians are able to access safe and high-quality medicines in a timely manner. SHPA also believes the NMP should acknowledge the increasing importance of digital health technologies which have a major impact on how patients use and access medicines, quality use of medicines and healthcare outcomes. SHPA is pleased to see the discussion paper acknowledges the Australian Digital Health Strategy and the My Health Record, which is increasingly utilised by hospital pharmacists to undertake medication reconciliation upon entry into hospitals and to support safer transitions of care.

Beyond My Health Record, digital health investments into electronic medical records (EMR) around Australian hospitals have in the last decade, shifted hospitals from paper systems to electronic systems. EMRs aim to improve the safety and quality of healthcare, and hospitals have been able to introduce electronic medication management as part of EMR systems to improve the quality and safety of prescribing, ordering and administering medicines to hospital patients.

However, many hospitals are implementing EMR systems in a fragmented approach, without integrating clinical decision-making software, pathology and laboratory data systems, medication administration charts, prescribing and dispensing systems or covering all areas of the hospital which provide medicines. This prevents the implementation of best practice closed loop medication management[14] and necessitates transcription and parallel systems (i.e. paper-based, and electronic medical records), ultimately limiting the benefits an integrated system intended to improve efficiency and reduce prescribing and dispensing errors.

EMRs, which have been implemented in public hospitals operated by state governments, sit alongside the My Health Record's implementation at a federal level without strong awareness of one another. These dual systems still have varying levels of interoperability which require significant investment from hospitals to connect their EMRs to a patient's My Health Record. For example, hospital pharmacists routinely provide updated medication lists/charts and medication management plans to patients and primary care providers upon discharge, but currently have no mechanism to upload these important documents to a patient's My Health Record to ensure a safer transition of care. Much of the transitions of care in relation to digital health technologies at the moment, currently differs greatly between hospitals, depending on the level of hospital pharmacy resourcing available, the time of discharge and what local arrangements exist between the hospital and community pharmacies.

Recommendation 4: The NMP should acknowledge digital health technologies as important elements of the healthcare sector which impacts medication safety and quality use of medicines and strive for a connected, interoperable digital health ecosystem.

Rapidly evolving treatment options which have changed the profile of new medicines being brought to market, have increasingly highlighted issues around access and equity. As stated earlier, twenty years ago at the inception of the NMP, new medicines were predominantly small molecules for lifestyle-related non-communicable diseases. In recent years, advancements in medical technology and research have seen

more complex and high-cost medicines being brought to market to treat diseases requiring acute hospital or outpatient care, such as cancers, autoimmune diseases and genetic diseases.

Public hospitals and hospital pharmacy departments play a crucial role in access to novel, usually high-cost and/or off-label medicines to treat complex and uncommon diseases before these medicines are registered on the Australian Register of Therapeutic Goods (ARTG) and well before they are listed on the PBS. They are also integral to patient access to clinical trials.

Due to the complex and specialised nature of these medicines, as well as their cost, patient access to these medicines differs greatly between hospital networks and between jurisdictions. They are subject to various factors including:

- fixed hospital pharmaceutical budget constraints
- varying access to compassionate access schemes
- local Drug and Therapeutic Committee policies and decisions
- access to specialist clinicians
- proximity to large hospitals
- varying out-of-pocket expenses determined by local and jurisdictional policies

This issue of access inequity for new and specialised medicines in hospitals is also explored in Pharmacy Forecast Australia 2021[15], and calls for structural funding reforms to reduce access inequities and ensure they are fit-for-purpose and sustainable.

Recommendation 5: The principles and objectives of the NMP relating to access and equity should include patient access to novel and high-cost unsubsidised medicines used in hospitals to treat complex and rare diseases.

Terms of Reference 4: Consider the centricity of the consumer within the NMP and whether it captures the diversity of consumers' needs and expectations

A. How can the NMP's focus on consumer centricity and engagement be strengthened? Is anything missing, and what needs to change?

SHPA believes consumers should be central not only in the development of the NMP as indicated in the proposed principles but rather be recognised as an empowered participant in their healthcare continuum in line with the Australian Charter of Healthcare Rights. There needs to be recognition that consumers are more active and informed in the context of broader health policy through the readily available access of general and personal health care information and have increased expectations on health services and health professionals.

Consumers who navigate between different care settings such as hospitals, aged care and community care, have the same expectation of service delivery regardless of their setting of care. For pharmacy services, this means consumers expect doctors and pharmacists to be working together to provide multidisciplinary care, irrespective of whether it is in a hospital or community setting, to enhance their quality use of medicines.

The NMP must acknowledge consumer diversity and broad representation on consultations including Aboriginal and Torres Strait Islander people. The Medication Safety Forum: Informing Australia's 10th National Health Priority Area[16] recognised certain populations should be part of national health priority strategy to achieve improved medication safety and quality use of medicines.

Recommendation 6: Consumer centricity and engagement should be strengthened in the NMP through greater diversity and inclusion, understanding of their expectations of healthcare delivery and health literacy levels.

SHPA believes the NMP should also acknowledge the importance of health literacy and that varying levels of health literacy will impact on a consumer's ability to make informed decisions and take medicines in a safe and quality manner.

It is recognised that poor health literacy results in worse health outcomes and health behaviours due to[17]:

- lower engagement in health services and preventative measures
- higher hospital readmissions rates
- poorer understanding of medication instructions (including non-adherence, improper usage)
- lower ability to self-manage care

A longstanding example of health literacy issues is the current provision of Consumer Medicines Information (CMI) leaflets with medicines. CMIs need to be shorter, more concise summaries of medicine information which cater to varying health literacy levels in the community. Current CMIs are impractical at communicating key pieces of medicines information to patients and are under-utilised despite being compulsory and readily available. They are lengthy, complex and difficult to use and can cause confusion and be overwhelming. Some hospital pharmacies and hospital pharmacy departments have instead developed their own medicines information leaflets for high-risk medicines – such as oral anticoagulants and opioid medicines – which are maximum two pages long and written in plain English.

Terms of Reference 5: Identify options to improve the NMP's governance; communications, implementation (including enablers) and evaluation.

A. What opportunities are there to strengthen governance arrangements for the NMP? What would these be, and why?

SHPA believes that to strengthen governance arrangements for the NMP, there should be more robust and dedicated engagement between state and federal counterparts to ensure consistent policies and aims around medicines access and quality use of medicines to achieve the objectives of the NMP.

Currently there is significant discrepancy in the access of medicines on discharge in non-PRA jurisdictions, as well as for Aboriginal and Torres Strait Islander patients who would otherwise have access to PBS medicines with co-payment relief. As mentioned above, there are also inequities in access to complex, high-cost specialised therapies from public hospitals, where access varies according to geographical location and hospital networks.

As discussed earlier, there also exists variations in the provision of hospital pharmacy services delivered to patients at the bedside, upon discharge and for outpatients. These are caused by piecemeal funding approaches and exacerbated by an imbalance of remuneration for dispensing medicines for hospital pharmacies.

At the government level, there exists the Council of Australian Governments (COAG) Health Council which is comprised of health ministers. The COAG Health Council is supported by the Health Chief Executives Forum (HCEF), formerly the Australian Health Ministers' Advisory Council (AHMAC), comprised of the heads of federal and state health departments.

Despite this, a review of all meeting communiques published[18] do not show inequities of medicines access or clinical pharmacy services for patients – either by jurisdiction or metropolitan/non-metropolitan – being discussed at these meetings. SHPA believes these bodies should form an important part of the governance arrangements of the NMP.

Recommendation 7: Existing forums between state and federal governments, such as the COAG Health Council and HCEF should be formally recognised as stakeholders in future governance arrangements for the NMP.

SHPA also believes that consistent and high-quality data on medicines use, medicines-related outcomes and pharmacy services should be collected to inform policy actions designed to achieve principles and objectives of the NMP. This would build on the work undertaken by the Independent Hospital Pricing Authority (IHPA) who collect data on sentinel events, hospital acquired complications and avoidable hospital readmissions, all of which can implicate the inappropriate use of medicines to cause harmful outcomes.

At present, data on PBS medicines use is systematically collected by Services Australia and the Department of Health, however there is no data collection on non-PBS medicines use in all settings of care, including the use of unregistered medicines and off-label medicines.

Data relating to medicine-related outcomes is also not collected systematically, with key statistics such as the 250,000 medicine-related hospital admissions annually being pieced together by an extensive literature review. The reporting of adverse events caused by medicines is also undertaken on a voluntary basis. For hospital pharmacists, when adverse events are reported, this often requires a duplication of the same report to both the TGA as well as local incident management reporting systems, which may then be further examined by state governments.

There is also no mechanism to measure or collect data on what extent hospitals are delivering the clinical services described by the SHPA Standards of Practice for Clinical Pharmacy Services to ensure medicines

safety and quality use of medicines. Data collection and benchmarking on service provision would allow health policymakers to further understand where service gaps exist and make strong links between how service provision impacts on the quality use of medicines and medicines access around Australia. SHPA believes that at a minimum, the following data points relating to medicines use in hospitals should be collected at the individual hospital level:

- Rate of medication reconciliation undertaken within 24 hours of admission
- Rate of daily medication chart review for inpatients
- Incidence of adverse drug events
- Rate of updated medication list/chart provided to patients, carers, and community care providers upon discharge
- Rate of discharge medicine counselling being provided to patients and/or carers

At present, the ACSQHC is undertaking the National Baseline Report on Quality Use of Medicines and Medicine Safety, which is focusing on medicines use in aged care and medication safety in vulnerable populations. The possibility of these reports to be expanded to include data collection on the above parameters in hospitals and health services should be explored.

Recommendation 8: To inform policies and investments to achieve the objectives of the NMP, consistent and high-quality data on medicines use, medicines-related outcomes and pharmacy services should be collected systematically.

B. How can communication about the NMP be enhanced or improved?

C. What would be effective mechanisms to support communication about the policy?

SHPA recommends that there is more engagement, opportunity and resourcing for hospital pharmacy representatives to participate in programs and policies relating to the NMP. This would improve the communication around the NMP and the policies and programs designed to achieve its objectives, where all stakeholders can play an active role in communicating updates to their membership cohorts and professional communities.

In recent years, SHPA has increased the representation of hospital pharmacy stakeholders on the Medicines Shortages Working Party convened by the TGA, the Health Services Medication Expert Advisory Group (HSMEAG) convened by ACSQHC, several NPS MedicineWise committees as well as the Pharmacy Profession Compliance Roundtable convened by the Department of Health. Representation on these groups has informed the work of government to be more aware and understanding of the role of hospital pharmacists and medicines use, and in turn has allowed SHPA to provide timely updates and news to its hospital pharmacist members regarding medicines policy.

This could be broadened to include representation of, or dialogue with hospital pharmacy representatives, on existing bodies convened by the Federal government such as the Pharmaceutical Benefits Advisory Committee and its sub-committees, Australian Technical Advisory Group on Immunisation (ATAGI), TGA advisory groups, Access to Medicines Working Group, Generic Medicines Working Group and others.

Terms of Reference 6: Review the NMP partners and provide options for building greater accountability including addressing conflicts of interest.

A. How should the NMP's 'partnership-based' approach be defined?

B. What is missing from the policy's reference to the NMP partners? Are there other partners that should be included in the policy? Who would they be and why?

SHPA supports the groups which are identified in the discussion paper as being responsible for advancing the NMP's objectives, however believes some groups that are missing from the listed partners include:

- automation industry (robotics, automated dispensing cabinets, webster packing etc.)
- medicines compounding services
- medical software industry stakeholders and EMR vendors
- individual healthcare organisations such as hospitals, aged care facilities and general practices

Whilst individual healthcare practitioners, federal and state governments are identified, SHPA believes individual healthcare organisations such as hospitals, aged care facilities and general practices are a significant omission as healthcare facilities will often have varying local policies and programs which impact on medicines access and quality use of medicines. As such, they should be explicitly recognised separately as NMP partners.

C. How could the NMP be refreshed to support greater accountability amongst the NMP partners? How could the partnership approach be improved?

Each partner should be acutely aware of their role in delivering the objectives of the NMP and be held accountable for their progress and contribution to this with clear recording and reporting on targets and key performance indicators. As discussed earlier, consistent and high-quality data pertaining to medicines use, medicines-related outcomes and pharmacy services should be collected systematically to inform work and accountability by partners and stakeholders. There also needs to be transparency across partners to build trust and prevent unnecessary duplication.

D. How are conflicts of interest currently managed and should more be done to address this amongst the NMP partners? What approaches could be taken?

Conflicts of interests should be declared openly and transparently and documented in formal submissions to a governing body for review.

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