SHPA Submission on the Consultation Draft - National Medicines Policy March 2022

Aim

The Policy's aim is to create the environment, in which appropriate structures, processes and accountabilities enable medicines and medicines-related services to be accessible in an equitable, safe, timely, and affordable way and to be used optimally according to the principles of person-centred care and the quality use of medicines, so that improved health, social and economic outcomes are secured for individuals and the broader community.

Using the scale below, please indicate your level of agreement with the Policy's aim.

Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA supports the Policy's aim to create structures, processes and accountabilities to enable medicines and services to be accessible, safe, timely and affordable according to the principles of patient centred care and the quality use of medicines. However, this support is caveated by the Policy to be updated to reflect and address the following issues.

SHPA highlights that in order for the NMP to be reflective of a national strategy, New South Wales and the Australian Capital Territory should become signatories to the Pharmaceutical Reform Agreements to achieve the proposed principle of equity and access to medicines, ensuring a consistent standard of care for vulnerable patients suffering major health events requiring hospitalisation and reducing 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 enabled hospital pharmacists to provide clinical pharmacy activities to patients, 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.

The principle of equity should be expanded to clinical pharmacy services which are essential to support the quality use of medicines and patient safety. Literature suggests there are 250,000 hospital admissions resulting from medication-related problems each year, costing the healthcare system $1.4 billion annually. However, several inequities exist with respect to funding, preventing patients receiving the comprehensive suite of clinical pharmacy services in SHPA's Standards of Practice for Clinical Pharmacy Services:

- taking medication histories and ensuring medications are charted correctly on admission and administered in a timely manner
- regular review of the safety, quality, storage and supply of medications during hospital stay
- review of discharge prescriptions, dispensing sufficient supplies 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

Inequities in remuneration for the supply of PBS medicines to hospital pharmacists have downstream impacts on hospital pharmacy department's 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.

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 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 co-payment as specified by PBS procedures) often prevent Indigenous patients receiving their medicines at discharge to avoid incurring operational costs. If patients are unable or unwilling to pay the co-payment, they must attend a community pharmacy to receive subsidised medicines. Research shows lower medicines adherence and over a quarter of patients fail to make it to a local pharmacy until days later in order to have their discharge prescription dispensed.

SHPA believes that patient-centred care cannot be achieved without recognising 'continuity of care' as part of the NMP's pillars focusing on exchange of health information across transitions of care to facilitate safe and effective medicine use and access.

Medicine use throughout transitions of care is complex with 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, 30% have the potential to cause patient harm.

Medication reconciliation by pharmacists remains the most important means of reducing errors in medication use. Pharmacists have demonstrated they possess the skills to obtain the most accurate medication histories compared to other health professionals and are highly valued by doctors as this ensures patients do not unintentionally skip doses of vital medicines when unexpectedly admitted to hospital.

Upon discharge, hospital pharmacists are integral to ensuring continuity of care through providing updated medicines lists for patients. Increasingly, hospital pharmacists are responsible for the medication summary section of patients discharge summaries and integral in providing information to community-based care providers ensuring 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. They identified six areas of prioritisation 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

The Australian Pharmaceutical Advisory Council (APAC) Guiding Principles to Achieve Continuity in Medication Management 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, 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.

Scope

The Policy's scope refers to the term 'medicine' covers a broad range of products that are used to prevent, treat, monitor or cure a disease. These products include prescription medicines, over-the-counter medicines and complementary/traditional medicines and encompass biologic and non-biologic medicines, including gene therapies, cell and tissue engineered products and vaccines.
This broad scope ensures the policy is adaptive and responsive to new and emerging treatment options. It also recognises that the definitions of medicines may vary across Commonwealth, state and territory legislation and regulation. Notwithstanding, the Policy's principles and pillars are applicable to all the above products and their clinical use as well as being applicable to relevant future advanced therapies. The Policy's scope can be found on pages 2-3.

Using the scale below, please indicate your level of agreement with the Policy's scope.

Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA supports the expansion of the NMP's current definition to include vaccines, biologics and non-biologic medicines, medical devices used to deliver or administer medicines and its adaptive and responsive scope to include relevant future advanced therapies. SHPA welcomes the inclusion of 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.

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.

However, this support is caveated by the Policy to be updated to reflect and address the following issues.

SHPA believes 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.

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, and calls for structural funding reforms to reduce access inequities and ensure they are fit-for-purpose and sustainable.

Principles

The Policy includes key principles, that should be evident in the planning, design and implementation of all policies, strategies, programs, and initiatives related to the Policy. These can be found on page 4.

Using the scale below, please indicate your level of agreement with the inclusion of each of the Policy's Principles and their descriptions.

Person-centred	Strongly Agree
Equity	Strongly Agree
Partnership-based	Strongly Agree
Accountability and transparency	Strongly Agree
Shared responsibility	Strongly Agree
Innovation	Strongly Agree
Evidence-based	Strongly Agree
Sustainability	Strongly Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA strongly supports the principles outlined in the NMP. However, this support is caveated by the Policy to be updated to reflect and address the following issues.

SHPA believes 'continuity of care' should be a central pillar of the NMP as it underpins the NMP's principles and associated principles-in-action, those being patient-centred care, equity, partnerships, accountability and transparency, shared responsibility, innovation, evidence-based and sustainability. 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.

SHPA also believes in order to achieve person-centred care, consumer centricity and engagement must be strengthened through greater diversity and inclusion, improved consumer understanding and expectation of healthcare delivery and increased health literacy levels. 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 recognised certain populations should be part of national health priority strategy to achieve improved medication safety and quality use of medicines.

SHPA believes the NMP should acknowledge 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:

- 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

SHPA strongly supports a need to focus on the continuing exchange of health information across transitions of care to facilitate safe and effective medicine use and access. 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. Medicine use throughout transitions of care is complex with 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, 30% have the potential to cause patient harm.

Medication reconciliation by pharmacists remains the most important means of reducing errors in medication use. Pharmacists have demonstrated they possess the skills to obtain the most accurate medication histories compared to other health professionals and are highly valued by doctors as this ensures patients do not unintentionally skip doses of vital medicines when unexpectedly admitted to hospital. Upon discharge, hospital pharmacists are integral to

ensuring continuity of care through providing updated medicines lists for patients. Increasingly, hospital pharmacists are responsible for the medication summary section of patient's discharge summaries and integral in providing information to community-based care providers ensuring safe transition back into care.

As previously mentioned, to meet the principle of person-centricity and equity for consumers, SHPA believes the Commonwealth should make 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 provide clinical pharmacy activities to patients. These services are necessary to safeguard and maximise the federal government's investment into new PBS medicines that treat complex conditions.

Inequities in remuneration for the supply of PBS medicines to hospital pharmacists 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.

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 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 co-payment as specified by PBS procedures) often prevent Indigenous patients receiving their medicines at discharge to avoid incurring operational costs. If patients are unable or unwilling to pay the co-payment, they must attend a community pharmacy to receive subsidised medicines. Research show lower medicines adherence and over a quarter of patients fail to make it to a local pharmacy until days later in order to have their discharge prescription dispensed.

Enablers

The NMP influences, and is also influenced by, related policies, programs, and initiatives of the wider health system. Seven enablers are identified in the Policy as being critical to the Policy's success. These can be found on page 5.

Using the scale below, please indicate your level of agreement with the inclusion of each of the Policy's Enablers and their descriptions.

Health literacy	Strongly Agree
Leadership and culture	Strongly Agree
Health workforce	Strongly Agree
Research	Strongly Agree
Data and information	Strongly Agree
Technology	Strongly Agree
Resources	Strongly Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA strongly welcomes the inclusion of the Pharmaceutical Reform Agreements in Figure 3 as an example of implementation mechanisms led by the Commonwealth. SHPA reiterates the importance of New South Wales and the Australian Capital Territory becoming signatories of the Pharmaceutical Reform Agreements to achieve meaningful implementation of the National Medicines Policy.

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.

SHPA supports health literacy and consumer engagement to achieve consumer centricity under the NMP. Consumer engagement should be strengthened through greater diversity and inclusion as well as understanding of consumer expectations of healthcare delivery and health literacy levels. SHPA believes the NMP should also acknowledge 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:

- 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.

SHPA supports the NMP's reference to 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. 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 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.

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, and calls for structural funding reforms to reduce access inequities and ensure they are fit-for-purpose and sustainable.

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. 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 recognised certain populations should be part of national health priority strategy to achieve improved medication safety and quality use of medicines.

SHPA recommends an updated Pharmacy Workforce Planning study as part of the enabler for the NMP. The last comprehensive Pharmacy Workforce Planning study was undertaken within Community Pharmacy Agreements in 2008. Since then, Health Workforce Australia released Australia's Health Workforce Series – Pharmacists in Focus which showed that pharmacists have a relatively young workforce which may reflect difficulty in sustaining or growing an experienced workforce where some recent indications have seen student uptake of pharmacy courses declining significantly in some states leading to some pharmacy schools closing. Therefore, SHPA strongly reiterates the need to gain clarity around the future of the hospital pharmacy workforce who are essential to achieving the NMP.

Governance

The Policy describes a governance approach that is focused on co-ordination and shared problem solving and accountability. It also recognises that each partner is responsible and accountable for achieving the NMP's aim and intended outcomes.

14. Using the scale below, please indicate your level of agreement with the proposed governance.

Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA's support for this section is caveated by the Policy to be updated to reflect and address the following issues. 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.

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 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.

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.

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.

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.

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.

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.

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. There also needs to be transparency across partners to build trust and prevent unnecessary duplication. Conflicts of interests should be declared openly and transparently and documented in formal submissions to a governing body for review.

Central Pillars

The Policy includes four Central Pillars. The function of these pillars is to guide and focus collective actions to deliver the Policy's aim. Each of these Pillars includes intended outcomes associated with their realisation, a description of the Pillar including their related components, and key responsible partners.

15. Pillar 1: "Timely, equitable and reliable access to needed medicines at a cost that individuals and the community can afford".

Strongly Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA supports the proposed principles of equity, consumer centred approach, partnership based, accountability and transparency, and stewardship for inclusion in the refreshed NMP. SHPA's support for this section is caveated by the Policy to be updated to reflect and address the following issues.

As previously mentioned to meet the principle of equity for consumers, SHPA believes the Commonwealth should make PRAs uniform policy in Australia and join in PRAs with New South Wales and Australian Capital Territory. This would ensure consistent standard of care for vulnerable patients suffering 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 to 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.

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 be expanded to clinical pharmacy services which are essential to support the quality use of medicines and patient safety. Literature suggests there are 250,000 hospital admissions resulting from medication-related problems each year, costing the healthcare system $1.4 billion annually. However, several inequities exist with respect to funding, preventing patients receiving the comprehensive suite of clinical pharmacy services in SHPA's Standards of Practice for Clinical Pharmacy Services:

- taking medication histories and ensuring medications are charted correctly on admission and administered in a timely manner
- regular review of the safety, quality, storage and supply of medications during hospital stay
- review of discharge prescriptions, dispensing sufficient supplies 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

Inequities in remuneration for the supply of PBS medicines to hospital pharmacists 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.

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 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 co-payment as specified by PBS procedures) often prevent Indigenous patients receiving their medicines at discharge to avoid incurring operational costs. If patients are unable or unwilling to pay the co-payment, they must attend a community pharmacy to receive subsidised medicines. Research show lower medicines adherence and over a quarter fail to make it to a local pharmacy until days later in order to have their discharge prescription dispensed.

16. Pillar 2: "Medicines meet appropriate standards of quality, safety and efficacy."

Strongly Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA 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.

17. Pillar 3: "Quality use of medicines and medicines safety."

Strongly Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

There is 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.

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.

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.

18. Pillar 4: "Responsive and sustainable medicines industry and research sector with the capability, capacity and expertise to meet current and future health challenges."

Strongly Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

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.

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.

Implementation

The NMP functions as a co-ordinating framework that sets out the Pillars and intended outcomes for all partners to work towards. As no single partner can be completely responsible for achieving the policy's aim, its implementation approach is a collective responsibility appropriately documented at the program level by each partner.

19. Using the scale below, please indicate your level of agreement with the proposed implementation approach.

Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA strongly welcomes the inclusion of the Pharmaceutical Reform Agreements in Figure 3 as an example of implementation mechanisms led by the Commonwealth. SHPA reiterates the importance of New South Wales and the Australian Capital Territory becoming signatories of the Pharmaceutical Reform Agreements to achieve meaningful implementation of the National Medicines Policy.

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.

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 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.

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.

As previously mentioned, 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.

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.

Evaluation

Australia's NMP describes the intended outcomes that the partners should collectively strive to achieve. The monitoring and evaluation of the collective progress towards the intended outcomes will enable the acknowledgement of achievements and identification of emerging priorities.

20. Using the scale below, please indicate your level of agreement with the proposed evaluation approach.

Agree

You can explain your selection or provide comments in the text box below if you wish (1000 words)

SHPA's support for this section is caveated by the Policy to be updated to reflect and address the following issues. SHPA also believes that to properly evaluate the NMP, 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.

General Comments

21. Please provide any additional comments you may have on the draft Policy

SHPA supports the long-awaited review of the NMP as the medicines landscape has shifted significantly in the last twenty years. SHPA notes that there are also two other concurrent reviews that majorly impact the hospital pharmacy sector, those being the Review into Section 100 Efficient Funding of Chemotherapy and the Review of Pharmaceutical Reform Agreements, both reporting to government by 30 June 2022. These reviews are important as PBS data demonstrates an increasing proportion of the PBS is being expended in the hospital setting.

In this context, and to allow the Commonwealth to further consider the extensive feedback it has received from stakeholders during the NMP consultation process, SHPA believes it would be appropriate to finalise the NMP after stakeholders have had a chance to digest the outcomes of these two reviews, to ensure that the finalised NMP is fit-for-purpose and supported by all stakeholders.