SHPA submission to Review of Pharmaceutical Reform Agreements – March 2022

Introduction

The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation representing the over 6,100 Hospital Pharmacists, their hospital pharmacy interns and hospital pharmacy technicians working across Australia's hospitals and healthcare system. 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 Pharmaceutical Reform Agreement (PRA) and notes its context and timing with concurrent reviews with into the National Medicines Policy (NMP) and the Section 100 Efficient Funding of Chemotherapy (EFC) program, as a crucial opportunity to get policy settings for medicines access in hospital settings fit-for-purpose and achieving the needs and expectations of patients.

Since the first PRAs were implemented over twenty years ago, there have been significant reforms and changes in public hospital funding via establishment of National Health Reform Agreements (NHRA), medicines access and medication management programs in the primary care sector via Community Pharmacy Agreements (CPA), as well as for the pharmaceuticals sector via Strategic Agreements with major stakeholders. Each of these important agreements are openly available to the public and periodically reviewed to ensure they are appropriate and meet the anticipated needs of the next five years, however this is not the case for PRAs.

SHPA believes fundamentally, the PRA Review is an opportunity to change this and have more contemporary governance arrangements for a program that enables the supply of approximately $3 billion of Pharmaceutical Benefits Scheme (PBS) medicines to hospital patients at discharge, outpatient clinics and at day treatment facilities.

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.

Hospital Pharmacists are integral to achieving the aims of Australia's NMP, and addressing Medicines Safety and Quality Use of Medicines, Australia's Tenth National Health Priority Area. Medication management services such as medicines reviews are proven to reduce hospital readmission rates and medication-related hospital admissions, of which there are 250,000 annually costing the Australian healthcare system $1.4 billion each year.

Prior to PRAs being established, 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 obtained from Services Australia, hospital pharmacy accounted for 23% of all Pharmaceutical Benefit Scheme (PBS) expenditure, which included a majority of Section 100 EFC and Highly Specialised Drugs Program (HSDP) expenditure.

The Society of Hospital Pharmacists of Australia
PO Box 1774 Collingwood Victoria 3066 Australia
(03) 9486 0177 | shpa.org.au | shpa@shpa.org.au | ABN: 54 004 553 806

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.

Furthermore, 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 PRAs were introduced, where listings were dominated by medicines for lifestyle-related non-communicable diseases.

In this submission, SHPA makes a range of recommendations to improve the governance and policy settings of PRAs to support access, efficiency, 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.

SHPA's Recommendations to the PRA Review

Recommendation 1: Enable public hospital pharmacies to supply PBS-subsidised medicines for public hospital inpatients to achieve equity and enhance quality use of medicines and medicines safety.

Recommendation 2: New South Wales and the Australian Capital Territory should become signatories of the Pharmaceutical Reform Agreements to achieve the proposed principles of a future PRA.

Recommendation 3: The governance arrangements for PRAs should be significantly improved to achieve the proposed principles of a future PRA of partnership based, accountability and transparency, and stewardship, via

a. **Establishment of five-year, nationally consistent PRAs for the public hospital pharmacy sector with the Commonwealth, jurisdictional governments and SHPA as signatories and aligned to National Health Reform Agreements**
b. **Publishing the PRAs to the general public similar to other major government programs and agreements**
c. **Regular consultative forums between Commonwealth, jurisdictions and SHPA on PRA implementation and delivery and impact of new PBS listings on hospital pharmacy sector**
d. **Inclusion of clauses for dispute resolution and variations to PRAs**

Recommendation 4: Enable hospital pharmacists to supply medicines to Indigenous Australians under Closing the Gap PBS Co-Payment Measure.

Recommendation 5: Provide consistent, appropriate and equitable remuneration for supplying PBS medicines to public hospital pharmacies that supports the delivery of the necessary clinical pharmacy services to ensure medicines safety, quality use of medicines and maximise investment into PBS medicines

Recommendation 6: The PRA should acknowledge digital health technologies as important elements which impacts medication safety and quality use of medicines, and prioritise and provide commensurate support to the hospital pharmacy sector

Recommendation 7: The PRAs should provide resourcing support to achieve hospital pharmacist staffing levels published in professional standards, to ensure full and meaningful adoption of the APAC guidelines.

Proposed principles for a future PRA

1. **Are these proposed principles appropriate? Is anything missing or needing to change?**

SHPA supports the five proposed principles of equity, person-centred, partnership-based, accountability and transparency, and stewardship. Whilst the discussion paper states these principles have been drawn from the current approach to PRAs, SHPA believes there are many existing gaps presently in achieving these under existing PRAs.

To achieve the principles of equity and person-centred, the PRAs should enable access to PBS-subsidised medicines for inpatient medicines, as is currently enabled for private hospital pharmacies. At present, public hospital inpatients are supplied and dispensed medicines without PBS subsidy, where public hospital pharmacists have to dispense two to fourteen days' worth of inpatient medicines depending on the expected length of admission. Upon discharge from hospital, hospital pharmacists are then able to and often do, resupply medicines at the point of discharge where PBS subsidy is enabled.

Recommendation 1: Enable public hospital pharmacies to supply PBS-subsidised medicines for public hospital inpatients to achieve equity and enhance quality use of medicines and medicines safety.

This is a major quality use of medicines (QUM) and medicines safety issue, which has been declared as Australia's Tenth National Health Priority Area in 2019. Where private hospital inpatients will have access to a PBS pack from admission, this assists with their overall medicines adherence and health literacy, as hospital pharmacists are able to counsel and educate patients on their regular, new or changed medicines using the medicine packaging as an important visual aid. For public hospital inpatients, given there is no PBS funding for medicines, patients will be supplied a blister strip or a small bottle of a few days' worth of medicines. This makes it very difficult for hospital pharmacists to educate and counsel patients meaningfully, if all their different inpatient medicines appear in the same packaging.

This is a QUM and medicines safety risk for nurses who administer the medicines, who again do not have the different visual aids of medicines primary packaging if PBS for inpatients were enabled, to discern between different medicines to ensure the correct medicine was administered. According to incident reporting data collected and reported within hospitals, SHPA members understand that this is a major risk area for nurses and patients who are administered the incorrect medicines against their medication chart.

Furthermore, the exclusion of PBS for public hospital inpatients is inefficient, as it means public hospital pharmacists have to dispense the same medicine twice, once upon admission and again upon discharge. This is inherently inefficient, especially for a workforce that has been experiencing workload pressures for a long time which have been exacerbated by the COVID-19 pandemic. By enabling public hospital inpatients to access PBS medicines, it brings forward dispensing of PBS medicines from the point of discharge to the point of admission, hence SHPA believes this would be at a relatively net-zero cost to the Commonwealth.

The improved efficiencies would also improve hospital bed flow through reducing the number of dispensing episodes required and also deliver a modest saving to public hospital pharmacy operations, which would be passed on to both the states and the Commonwealth.

The lack of PBS for public hospital inpatients also results in cost shifting incentives remaining at the expense of efficient, quality and safe healthcare delivery. Without PBS subsidy for public hospital inpatients, there are perverse incentives to delay initiation of certain higher cost treatments until the point of discharge to access PBS subsidy, such as antipsychotic drug depots, iron infusions, Hepatitis C medications and infusions for osteoperosis.

SHPA believes this can be achieved by existing governance arrangements in the Addendum to the NRHA 2020–25 for public hospital funding, where Commonwealth funding for blood products (through the National Blood Agreement) and Commonwealth pharmaceutical programs (PRA, S100 EFC and S100 HSD) is removed from public hospital funding calculations to avoid 'double-dipping'.

The lack of PBS for public hospital inpatients also causes issues for patients admitted to hospitals who are taking high-cost medicines in the community that are listed under S100 HSD or are high cost S85 medicines. If they present to hospital without their regular medicines, which is often the case due to public hospital admissions being unplanned, then public hospitals are faced with the choice of breaking PBS packs of very high cost medicines – such as newly listed medicines for cystic fibrosis – to ensure continuous therapy in hospital.

This is extremely inefficient and expensive for the public hospital, and in many instances, these vital medicines are not provided at all until a carer can bring in their PBS-dispensed pack from home, which does not always occur. Once a PBS pack is broken, it cannot be resupplied to another patient, and has a major risk of eventually expiring and having to be wasted. This is just another unintended consequence of this inequity that can be rectified by allowing PBS-subsidy for public hospital inpatient medicines.

Broken packs of medicines are also incompatible with dispensing robots and automated dispensing cabinets, which have been invested into by various hospitals around the country – well into the tens of millions, and increasing – to improve the accuracy and quality of dispensing. Where there are broken packs, parallel manual handling processes must occur which inadvertently cause issues with efficiency and safety.

Additional challenges in funding of medicines in public hospitals also stem from parallel procurement and funding systems for medicines supplied/procured under compassionate access schemes, clinical trials, Special Access Scheme, Authorised Prescriber Scheme and other niche and specialised access schemes.

Recommendation 2: New South Wales and the Australian Capital Territory should become signatories of the Pharmaceutical Reform Agreements to achieve the proposed principles of a future PRA.

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 3: The governance arrangements for PRAs should be significantly improved to achieve the proposed principles of a future PRA of partnership based, accountability and transparency, and stewardship, via

a. Establishment of five-year, nationally consistent PRAs for the public hospital pharmacy sector with the Commonwealth, jurisdictional governments and SHPA as signatories and aligned to National Health Reform Agreements

b. Publishing the PRAs to the general public similar to other major government programs and agreements

c. Regular consultative forums between Commonwealth, jurisdictions and SHPA on PRA implementation and delivery and impact of new PBS listings on hospital pharmacy sector

d. Inclusion of clauses for dispute resolution and variations to PRAs

At present, SHPA and jurisdictions understand that each of the six PRA jurisdictions has a slightly different PRA to one another, depending on when the PRA was established. Furthermore, the PRAs cumulatively result in over $3 billion of annual PBS expenditure, representing just under a quarter of the PBS. Given the large scale of expenditure, and its impact on how medicines are used not just in hospitals but also beyond hospital discharge, SHPA believes this does not meet public expectations regarding governance, transparency and consistency.

It is recommended that the Commonwealth establishes five-year Pharmaceutical Reform Agreements for the public Hospital Pharmacy sector with the Commonwealth, jurisdictional governments and SHPA as signatories. Given the current NRHA expires on 30 June 2025, this provides ample time for the concurrent PRA, S100 EFC and NMP reviews to conclude, to inform these five-year PRAs in the next iteration of NHRAs from 1 July 2025.

This would be similar to existing, publicly viewable, five-year Agreements entered into the Commonwealth in the pharmacy and pharmaceuticals sector including:

- Seventh Community Pharmacy Agreement with The Pharmacy Guild of Australia and Pharmaceutical Society of Australia
- Strategic Agreement with Medicines Australia
- Strategic Agreement with Generic Biosimilar Medicines Association

Similar to these existing agreements, SHPA also recommends there be regular consultative forums between the Commonwealth, jurisdictions and SHPA on the implementation and delivery of PRAs. This would also provide an opportunity to discuss the impact of new PBS medicines listings on the hospital pharmacy sector. Newly listed PBS medicines are increasingly complex, specialised and high-risk, often requiring an admission to initiate medicines and monitor patients, such as blinatomumab, venetoclax, macitentan, clozapine, multiple myeloma medicines to name a few. However, the hospital pharmacy sector is not engaged by either Pharmaceutical Benefits Advisory Committee or Department of Health to discuss whether these new PBS listings requiring inpatient are and monitoring can or will be appropriately managed in the hospitals sector, and are also not provided sufficient advance notice to prepare for the arrival of new PBS listings which will alter care provided by hospitals and hospital pharmacies. The lack of impact assessment on public hospitals for new PBS listings, particularly S100 medicines, is a risk to QUM and achieving the principles of PRA and the NMP.

In this context, the PRAs should also have provisions for dispute resolution and variations to the agreements in the spirit of good governance. SHPA believes that historically, the lack of these clauses in PRAs has favoured the Commonwealth who have enacted changes without consultation, such as the 2019 Federal

Budget $44 million cut to hospital pharmacies via a cut and a cap to the wholesale mark-up for public hospital pharmacies, which were again revised down approximately a year later, again without consultation. That the remuneration terms in PRAs are somewhat dictated by or reference remuneration arrangements in CPAs, is also inappropriate with contemporary governance principles.

2. **In thinking about future PRAs, what should new arrangements achieve? What are the emerging areas of interest to focus on?**

The new PRA arrangements should enable hospital pharmacists to supply medicines under the Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment Measure (the Measure). This policy currently excludes public hospitals from participating in these arrangements. The requirement for a co-payment to receive medications at discharge from a public hospital, has resulted in ongoing inequity in the provision of medications. Without access to the Measure, individual hospital policies (which often require a co-payment as specified by PBS procedures) often prevent Indigenous patients from receiving their medications at discharge. If patients are unable or unwilling to pay the co-payment, they must attend a community pharmacy to receive discharge medications.

Research shows that these patients have lower medication adherence compared to other population groups,[1] and that over a quarter of patients fail to make it to a local pharmacy until days later to have their discharge prescription dispensed.[2] Poor access to medications can potentially compromise a patient's health and cause preventable hospital readmissions. This also prevents the provision of expert advice related to the new medication regimen by the pharmacist who has counselled them during their inpatient stay.

Some states and territories have implemented PBS quantities on discharge and are using their hospital budget to absorb the co-payment costs, however this is not nationally consistent and defies the proposed PRA principles.

Recommendation 4: Enable hospital pharmacists to supply medicines to Indigenous Australians under Closing the Gap PBS Co-Payment Measure.

The new PRA arrangements should also achieve equitable funding arrangements for the supply of PBS medicines and medication management programs, as similarly provided in existing CPAs. 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 QUM 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.[3] 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[4], 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 QUM.

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, ensuring that remuneration supports the delivery of the necessary clinical pharmacy services to ensure medicines safety, QUM and maximise investment into PBS medicines. 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[5]

Recommendation 5: Provide consistent, appropriate and equitable remuneration for supplying PBS medicines to public hospital pharmacies that supports the delivery of the necessary clinical pharmacy services to ensure medicines safety, quality use of medicines and maximise investment into PBS medicines

The new PRAs should also acknowledge the 'patient journey' is no longer a simple pathway back and forth between hospital and community settings, and should be updated to enable quality access to medicines and pharmacy services in all the innovative models of care that have been, are in the process of, or will be developed as contemporary healthcare continues to evolve. Some examples are:

- Hospital in the home
- Hospital in the nursing home
- Pharmacist-led outpatient clinics
- Aged care outreach programs
- Post-discharge programs to prevent re-admission
- Models of care necessitated by COVID-19 pandemic
- Virtual care models, telehealth models
- District nursing services, community health services and Primary Health Networks

In this context, per our discussion around Recommendation 1, the exclusion of public hospital inpatient access to PBS medicines, but enabled for outpatient access and upon discharge, becomes increasingly not fit-for-purpose and fails to address contemporary needs as hospital care and delivery can no longer be simplified to the inpatient/outpatient binary. Rather, hospital and hospital pharmacy care has the flexibility to be delivered to patients in the setting and circumstances most appropriate to them via a patient-centred approach, and commensurate support from the PRAs is required to maximise investment, medicines safety and QUM of PBS medicines in all settings.

Recommendation 6: The PRA should acknowledge digital health technologies as important elements which impacts medication safety and quality use of medicines, and prioritise and provide commensurate support to the hospital pharmacy sector

The expansion and evolving nature of electronic and digital health provides another reason why PRAs should be periodically reviewed and consulted on to ensure contemporary developments in the healthcare and pharmacy sector are reflected in ongoing PRAs. Electronic and digital health technologies have a major impact on how patients use and access medicines, their QUM and healthcare outcomes.

PRAs should acknowledge policies and programs by the Australian Digital Health Agency (ADHA), including the Australian Digital Health Strategy, National Digital Health Strategy and Framework for Action and the My Health Record, to empower and provide support to hospital pharmacists to achieve medicines safety, QUM, especially at the transitions of care. The My Health Record 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[6] 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 are only just now beginning to be able to upload Pharmacists Shared Medicines List (PSML) to a patient's My Health Record to ensure a safer transition of care.

This also has significant implications for Electronic Prescribing (EP), which thus far has focused primarily on the community setting, where SHPA understands up to 98% of all community pharmacies have enabled EP, whereas no public hospitals are currently participating in EP from a federal PBS perspective, but are already running multiple different software and systems for digital prescribing at the intra-hospital level. SHPA supports consistency and priority in EP arrangements for the hospital pharmacy sector, to reduce further fragmentation and inconsistency.

The rollout thus far of EP has focused on community settings, with acute settings lagging behind, and this has been a noticeable trend with federal policies and programs pertaining to health where the community sector has been engaged more widely and earlier compared to the acute sector. A reformed PRA with renewed focus on the principles of partnership-based, accountability and transparency, and stewardship, would hopefully allow for improved engagement and consultation with the hospital sector, to ensure they are empowered to assist the Commonwealth to deliver its strategic policies, programs and aims, such as the many investments in digital health.

Term of Reference 1: The Review will examine the success of the current PRAs by evaluating their objectives and outcomes to date, including:

- **Leadership, responsibility, and accountability for medication management;**
- **Evidence of streamlined and consistent application of arrangements;**
- **Outcomes or evidence of improvements in medication access when transitioning between hospital and community settings**

1. **Have the PRAs met their objectives – providing easier and safer access to medicines for public hospital patients, ensuring adoption of APAC guidelines and reducing cost shifting incentives for state funded public hospitals? What does success look like? And if not, why not?**

The PRAs have met the objective of providing easier and safer access to medicines for public hospital patients on discharge, at outpatients and in day treatment facilities, particularly for patients requiring EFC medicines and other specialised, high-cost and complex medicines. It is time these provisions are also extended to the ACT and NSW whose hospital patients are at risk of poor QUM and medicines safety due to lack of easy and safe access to PBS medicines, particularly in the immediate discharge phase where readmission risk is higher, and a much more costlier outcome for the healthcare system if preventable readmissions are realised.

The PRAs have not met their objectives in ensuring adoption of APAC guidelines or reducing cost-shifting incentives. As discussed earlier, the exclusion of PBS-subsidy for public hospital inpatients has introduced new cost-shifting incentives that result in the delayed treatment of patients requiring higher cost PBS medicines. As per Table 1, the inequitable remuneration means in vast majority of cases, the remuneration provided for dispensing PBS medicines in hospitals does not provide cost recovery once the resources of pharmacists, procurement officers and pharmacy technicians are factored into overall cost of supply. Thus, to minimise the impact of this, it is typical for certain medicines to be delayed until the point of discharge to gain PBS subsidy. Beyond the cost-shifting issues this has created, it must also be noted this also can hold up discharge and provide a negative pressure on improving bed flow in hospitals, an issue that has been acutely felt during the COVID-19 pandemic.

There have been attempts by PRA states with varying success to adopt the APAC guidelines, however without dedicated staffing and resourcing, supported by the states and the Commonwealth, this makes it difficult and SHPA members report virtually all hospitals do not fully meet the APAC guidelines. These issues of workforce availability and funding must be addressed in partnership between the states and Commonwealth. SHPA has developed its Standards of Practice for Clinical Pharmacy Services in 2012 with pharmacist to patient staffing ratios in hospitals to support the full adoption of the APAC guidelines, however the vast majority of hospitals do not meet these staffing ratios, meaning the APAC guidelines are not adopted to their full extent, increasing the risk of medication-related harm for hospital patients.

Recommendation 7: The PRAs should provide resourcing support to achieve hospital pharmacist staffing levels published in professional standards, to ensure full and meaningful adoption of the APAC guidelines.

Furthermore, due to lack of governance, data collection and consultative forums on the PRA, it is extremely difficult for governments at all levels to even measure to what extent the APAC guidelines are being adopted, to identify gaps, which then makes providing targeted solutions beyond additional hospital pharmacy workforce investment, even more difficult.

Finally, the lack of staffing and resourcing also inhibits hospital pharmacy departments from meeting National Safety and Quality Health Service (NSQHS) Standards, particularly the Medication Safety Standard.

2. **Are there any population groups that are not receiving equitable access to medicines under the PRAs? What could be changed to improve access for these patients?**

As per Recommendation 2 and 4, indigenous patients, and patients in the ACT and NSW are not receiving equitable access to medicines due to inconsistent policies with the PRA.

Due to the lack of PBS-subsidy for public hospital inpatients, public hospital long-stay patients are typically disadvantaged when they require treatment of a high cost PBS medicine, however the hospital is unable to fund this treatment for inpatients. Public hospital long-stay patients can typically be geriatric patients and mental health patients.

It is in long-stay mental health patients where this issue is most apparent, where some patients on these wards may have a history of intravenous drug use and are subsequently diagnosed with Hepatitis C. However, given the cost of these medicines are in excess of $10,000, they are unable to be supplied to these vulnerable patients until they are discharged, which can take a long time.

3. **How has the risk sharing arrangement under the PRAs worked in practice? Does it remain an effective mechanism? Are there other useful approaches to risk sharing?**

SHPA understands the risk sharing arrangements under the PRAs have never been practically enforced, and exceptions were made when the listing of high-cost Hepatitis C medicines occurred.

This is an area where improving the transparency and governance of the PRAs as per Recommendation 3, can produce meaningful cooperation on risk sharing arrangements. The lack of consultative forums also means issues arising from risk sharing arrangements, analysis of forecasts and projected expenditure, is unable to be discussed in a consultative manner with all stakeholders involved. As discussed earlier, engagement with hospital pharmacy sectors, who are increasingly called upon to supply, dispense and administer newly listed complex and high-cost PBS medicines, is crucial ahead of PBS listings occuring, not only so they can prepare their clinical practices for new PBS medicines, but also to discuss any implications it will have on hospital pharmacy's PBS expenditure and subsequent impact on risk sharing arrangements.

There is also a risk that the existence of risk-sharing arrangements can again, inadvertently encourage cost-shifting incentives, where supply of PBS medicines are delayed or avoided to avoid reaching the ceilings, which end up contributing to care that is not patient-centred and potential adverse health outcomes. Hospital pharmacists are champions for reducing unnecessary use of medicines and work with doctors to deprescribe where possible, and by virtue of their clinical pharmacy services, improve PBS sustainability by improving healthcare outcomes. As such, given the focus of our sector already to reduce unnecessary medicines use, the need for risk sharing arrangements and their role should be examined further between the jurisdictions and the Commonwealth.

4. **How has medication management in public hospitals changed since the introduction of PRAs and how might the adoption of a PRA have affected this?**

As per our response to Question 1 in this section, the introduction of PRAs has improved medication management in public hospitals by enabling additional hospital pharmacy resource investment to implement the APAC Guidelines, address QUM and medicines safety which is a National Health Priority Area, and to meet NSQHS standards. However, due to lack of governance, data collection and consultative forums on the PRA, it is extremely difficult for governments at all levels to even measure to what extent the APAC guidelines

are being adopted, to identify gaps, which then makes providing targeted solutions beyond additional hospital pharmacy workforce investment, even more difficult.

It is clear when looking at hospital pharmacy workforce statistics published in the National Health Workforce Data Set, that a non-PRA state such as NSW, has the least hospital pharmacists per capita compared to all other PRA-states, and according to the Productivity Commission, has a higher rate of adverse events related to medicines.

	NSW	VIC	QLD
2011-12	2.4	2.1	2.1
2012-13	2.5	2.3	2.4
2013-14	2.6	2.2	2.4
2014-15	2.8	2.2	2.4
2015-16	2.8	2.1	2.4
2016-17	2.8	2.2	2.4
2017-18	3.1	2.1	2.4

Table 2. Adverse effects of drugs, medicaments and biological substances, events per 100 separations
Source: Productivity Commission, Report on Government Services

5. **How does the patient experience in a PRA hospital versus non-PRA hospital differ, including their experience of the continuum of care between hospital and community care?**

As discussed earlier, 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. This requires patients in ACT and NSW to immediately seek an appointment with their general practitioner (GP) on discharge from hospital to continue receiving vital medicines, such as preventative anticoagulants, antihypertensives and anti-cholesterol medicines to reduce the risk of another heart attack or stroke.

This is extremely difficult for patients who have just had a major – oft traumatic – healthcare event and are still transitioning back to home life, and further exacerbated for patients living in areas, - particularly rural and regional – where access to general practitioner services are challenging with wait times of up to three weeks for an appointment. This is a major QUM and medicines safety issue that contributes to hospital readmission.

By closing this gap and reducing the need for some patients to access GP services on discharge, it also improves Medicare Benefits Schedule (MBS) sustainability by reducing the need for MBS consultations simply to obtain another prescription in the immediate discharge phase, with another MBS consultation in another one to two weeks to conduct the post-discharge follow-up.

6. **What is the experience of hospital administrators and practitioners in a PRA hospital versus a non-PRA hospital? How has having a PRA in place impacted on system processes and hospital administration.**

Whilst PRAs have overall improved access to PBS medicines, PRA hospitals, by virtue of being able to supply PBS quantities on discharge, have had to make necessary adjustments to their layout and storage facilities to accommodate more medicines. Many hospitals can often find obtaining more floor space for storage facilities challenging due to the increased demand for healthcare services.

As discussed above, the lack of PBS medicines for inpatients can often lead to many inefficiencies with respect to dispensing robots and automated dispensing cabinets being incompatible with broken packs. Broken packs, particularly for high-cost medicines which have limited patient cohort, are at risk of being wasted and severely impact the operating budget of hospitals, particularly smaller hospitals with smaller overall budgets are wastage of high cost medicines account for a higher proportion of drug budgets.

The lack of PBS medicines for inpatients also causes issues with two parallel medicines funding systems occurring in hospitals, which makes it extremely difficult for administrators and managers to track expenditure and how medicines are used. SHPA has been engaged on discussions over the years on Special Pricing Arrangements and their proposed reforms, and reiterates that these parallel funding systems of medicines listed on the PBS that do not attract PBS subsidy when used for public hospital inpatients, makes the tracking of medicines throughout the supply chain extremely difficult.

7. **How consistent are PRA arrangements across jurisdictions? What are some examples of consistent or inconsistent implementation?**

PRA arrangements are variable across jurisdictions with respect to how much they can meet the APAC guidelines, which is a reflection the differing levels of hospital pharmacy workforce resourcing. An example of this is the extent to which hospital pharmacy departments have hospital pharmacy services provided after traditional business hours and on weekends, where patients are discharged. Without pharmacists present during these discharges that occur outside of business hours, this can contribute to unsafe discharges, medication errors on the discharge prescriptions not being detected, and contribute to hospital readmission.

Another example of this are PBS co-payment policies for Indigenous patients, given the exclusion of public hospital pharmacies to participate in the CTG PBS Co-payment Measure. SHPA understands some states charge the PBS co-payment to Indigenous patients, but some states do not and elect to absorb the cost themselves. This is inconsistent and inequitable, and we reiterate the need for Recommendation 4 to be adopted to include public hospital pharmacies in this measure.

Term of Reference 2: The Review will examine the alignment of the PRAs with current policies and legislation, and whether any future arrangements as an outcome of the Review should have a broader focus, providing clearer understanding as to the interaction between Australian Government funding for state and territory governments under the National Health Reform Agreement (NHRA) and under the PBS or other programs

1. **Should future PRAs include more flexible language to ensure all approved prescribers can participate in PBS access in hospitals? If so, what is the best way to reflect this flexibility in a PRA?**

SHPA believes this should be further explored and supports this in-principle to introduce consistency in PBS prescribing across the Australian healthcare system. It is also inefficient to allow PBS prescribers to prescribe medicines in certain circumstances but not others, and does not provide for a patient-centred approach to hospital care.

Additionally, ensuring this consistency and thus expanding the prescribers under the PRA where appropriate, can also potentially alleviate some of the workforce shortages and pressures experienced by our medical colleagues.

2. **How might Biosimilar uptake and electronic medication management be best supported under a future PRA. What performance measures could be incorporated to encourage best practice?**

Hospital pharmacists are champions of PBS sustainability and analysis of PBS data should demonstrate higher conversion and use of biosimilars compared to community pharmacists. Hospitals often have internal or state-wide policies that ensure the use of biosimilars wherever possible, and have robust enforcement mechanisms to ensure originator biologicals are only used in limited and clinically appropriate circumstances, due to adverse reaction or lack of evidence for switching to a biosimilar.

Hospitals often only stock one brand of medicine, and thus when biologicals are initiated in hospital, overwhelmingly it is the biosimilar that is prescribed and dispensed by hospital doctors and pharmacists, regardless of any preference a prescriber may have as the policy and guidelines must be adhered to. SHPA understands this contrasts with practices in the community sector.

Biosimilar uptake can be further supported with dedicated and additional research capacity for hospitals and hospital pharmacists to examine the safety of biosimilar switching protocols, to provide further evidence base for these clinical decisions which will enhance PBS sustainability.

As discussed earlier, the rollout thus far of EP has focused on community settings, with acute settings lagging behind, and this has been a noticeable trend with federal policies and programs pertaining to health where the community sector has been engaged more widely and earlier compared to the acute sector. The PRAs must acknowledge and provide support for EP to integrate seamlessly with existing EMRs, which have been implemented in public hospitals operated by state governments.

The rollout thus far of EP has focused on community settings, with acute settings lagging behind, and this has been a noticeable trend with federal policies and programs pertaining to health where the community sector has been engaged more widely and earlier compared to the acute sector.

SHPA understands there are incentives under the CPA for community pharmacists to take up electronic and digital health initiatives, and these should be considered under future PRAs to foster maximal engagement and provide sufficient resourcing to implement these key programs.

3. **What other key policy and program drivers might be incorporated into a future PRA? What performance measures could be incorporated to encourage best practice?**

As discussed earlier, the enabling of PBS-subsidy for hospital inpatients would close the gap on having parallel medicines funding systems occurring in public hospitals, which cause a lot of inefficiency and waste

that does not place the patient at the centre of care. This would also ensure that QUM, medicines safety and medicines access will be fit-for-purpose for all the contemporary healthcare models that continue to evolve. Some examples are:

- Hospital in the home
- Hospital in the nursing home
- Pharmacist-led outpatient clinics
- Aged care outreach programs
- Post-discharge programs to prevent re-admission
- Models of care necessitated by COVID-19 pandemic
- Virtual care models, telehealth models
- District nursing services, community health services and Primary Health Networks

In this context, per our discussion around Recommendation 1, the exclusion of public hospital inpatient access to PBS medicines, but enabled for outpatient access and upon discharge, becomes increasingly not fit-for-purpose and fails to address contemporary needs as hospital care and delivery can no longer be simplified to the inpatient/outpatient binary. Rather, hospital and hospital pharmacy care has the flexibility to be delivered to patients in the setting and circumstances most appropriate to them via a patient-centred approach, and commensurate support from the PRAs is required to maximise investment, medicines safety and QUM of PBS medicines in all settings.

The future PRA should also have a refreshed focus on transitions of care, as it is the immediate post-discharge phase where patients are most at-risk of hospital readmission. The 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.[7] They identified six areas where prioritisation needed to occur, all of which hospital pharmacists are integral to achieving. These provide a template for where performance measures could be built upon to encourage best practice.

- 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

SHPA also believes that consistent and high-quality data on medicines use, medicines-related outcomes and pharmacy services should be collected to measure success of PRAs and implementation of APAC guiding principles. 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.

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 the Commonwealth and jurisdictions 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 to achieve the objectives of the PRA and the Guiding Principles. 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.

Finally, a future PRA should also provide sufficient funding and access to hospital pharamcies to provide dose administration aids (DAAs) which are currently a major transitions of care gap, where hospitals are not supported or funded to do so, even when a patient's usual community pharmacy is unable to provide this service on demand, particularly outside of business hours.

Term of Reference 3: Examine recommendations from the Australian Healthcare Associates report PBS Pharmaceuticals in Hospitals Review

SHPA notes there are no questions under this term of reference, however would like to voice in-principle support of the Australian Healthcare Associates report on PBS Pharmaceuticals in Hospitals Review with respect to its findings and recommendations, particularly its suggested consideration of developing a single funder model of medicines in public hospitals, which our Recommendation 1 aims to address.

Term of Reference 4: The Review will examine the patient journey into and out of the public health setting, ensuring consistency with the principles of the quality use of medicines

1. **How has the patient's experience of the continuum of pharmaceutical care changed in the life of current PRAs? Has this experience varied across public hospitals or jurisdictions? If so why?**

As discussed earlier, the continuum of pharmaceutical care has evolved significantly over the life of the PRAs, and contemporary healthcare can no longer be simplified to the inpatient/outpatient binary. The 'patient journey' is no longer a simple pathway back and forth between hospital and community settings, and should be updated to enable quality access to medicines and pharmacy services in all the innovative models of care that have been, are in the process of, or will be developed as contemporary healthcare continues to evolve. Some examples are:

- Hospital in the home
- Hospital in the nursing home
- Pharmacist-led outpatient clinics
- Aged care outreach programs
- Post-discharge programs to prevent re-admission
- Models of care necessitated by COVID-19 pandemic
- Virtual care models, telehealth models
- District nursing services, community health services and Primary Health Networks

Hospital and hospital pharmacy care has the flexibility to be delivered to patients in the setting and circumstances most appropriate to them via a patient-centred approach, and commensurate support from the PRAs is required to maximise investment, medicines safety and QUM of PBS medicines in all settings.

Overall, this experience has varied across different public hospitals and jurisdictions, due to different levels of hospital pharmacy staffing and resourcing investment which are impacted by PRAs, as well as other policies such as Price Disclosure that impact on revenue. In the absence of dedicated funding for hospital pharmacist staffing as per our Recommendation 7, this will continue to be varied to the detriment of patients, and hinder the PRA's ability to meet the principle of being patient-centred and equitable.

An example of this is the extent to which hospital pharmacy departments have hospital pharmacy services provided after traditional business hours and on weekends, where patients are discharged. The services provided at these hours are very variable across the country. Without pharmacists present during these discharges that occur outside of business hours, this can contribute to unsafe discharges, medication errors on the discharge prescriptions not being detected, and contribute to hospital readmission.

2. **To what extent does having access to PBS medicines affect the pharmaceutical continuum of care in public hospitals?**

Having access to PBS medicines improves the pharmaceutical continuum of care in public hospitals, however substantial gaps remain which have been explored in our submission, particularly for public hospital inpatients, Indigenous patients, and patients requiring hospital and hospital pharmacy care outside of

traditional business hours. Without closing these gaps, this will contribute to delayed or lack of access to PBS medicines and increase the risk of hospital re-admission in the immediate post-discharge phase, particularly for vulnerable populations, resulting in a much costlier outcome for the healthcare system if preventable readmissions are realised.

Over the life of the PRAs, due to increasing availability of medicines used for non-communicable diseases and in the prevention of acute healthcare events, patients are on average taking more medicines than patients twenty years ago before the first PRA came into existence. Thus, having access to PBS medicines in hospitals means hospital pharmacists can contribute to the QUM and medicines safety for these patients, ensuring compliance and adherence to medicines that keep patients healthier and reduce the incidence of a major healthcare event and hospital admission. Thus, to further support public hospital pharmacists to achieve these efficiencies and quality improvement for patients and the healthcare system, they must also be supported by the PBS and PRAs to supply PBS medicines to public inpatients.

3. **What data is available to measure the patient's experience of the continuum of pharmaceutical care when moving into and out of hospital?**

There is limited data and resourcing to undertake this work, however this is critical to measure the impact of the Commonwealth's investment into the PBS and PRAs. For many patients who experience a significant healthcare event such as a stroke or heart attack, or are diagnosed with conditions in hospital during an admission, the initial prescribing and supply of PBS medicines in the hospital settings has a major impact on subsequent PBS prescribing and supply in the community setting, which should be of immense interest to the Commonwealth.

SHPA believes theoretically, this could be undertaken by examining Services Australia claiming data with respect to which prescriber types and pharmacy types are prescribing medicines over a time period. This would also allow medicines adherence and compliance to be monitored via PBS data. Related to this, analysis of MBS data can also show whether post-discharge follow-up is occurring, and whether appropriate continuing supplies of PBS medicines are occurring. Theoretically, where non-compliance is occurring according to PBS and MBS data, this could then be linked to hospital admission and readmission rates, to evaluate the impact of these services.

It must also be stated that given many of these medicines are initiated in the public hospital inpatient setting, the use of inpatient medicines will not be reflected in the PBS and MBS data, which means data analysis of medicines use will not provide the complete picture. This would be another benefit of allowing public hospital inpatients access to PBS medicines.

References

[1] Cass A, Lowell A, Christie M, Snelling PL, Flack M, Marrnganyin B et al. (2002) Sharing the true stories: improving communication between Aboriginal patients and health care workers. Med J Aust, 176(10):466- 470.
[2] Fallis BA, Dhalla IA, Klemensberg J, Bell CM (2013) Primary Medication Non-Adherence after Discharge from a General Internal Medicine Service. PLoS ONE 8(5): e61735.
[3] Pharmaceutical Society of Australia. (2019) Medicine Safety: Take Care. Canberra: PSA
[4] The Society of Hospital Pharmacists of Australia. (2013). 'Standards of Practice for Clinical Pharmacy Services'. Journal of Pharmacy Practice and Research 43(2):91-93
[5] Department of Health (Fed). (2016) Review of Pharmacy Renumeration and Regulation Discussion Paper. Australian Government
[6] The Society of Hospital Pharmacists of Australia. (2019). Closing the loop of medication management in hospitals to improve patient safety with barcoding technology on unit dose packaging. SHPA. Available from: https://www.shpa.org.au/sites/default/files/uploaded-content/website-content/Fact-sheets-position-statements/position_statement_-_unit_dose_packaging.pdf
[7] Australian Commission on Safety and Quality in Health Care. (2017) Safety Issues at Transitions of Care: Consultation report on perceived pain points relating to clinical information systems. Sydney: ACSQHC