SHPA Submission to the Mid-term Review: National Health Reform Agreement Addendum 2020-25, June 2023

The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for more than 6,200 hospital pharmacists, and their hospital pharmacy intern and technician colleagues working across Australia's hospitals and health system. Hospital pharmacists are core to medicines management and optimising the safe and quality use of medicines in all setting of a hospital, whilst also contributing to system-wide governance activities to reduce medicine complications and hospital-acquired complications (HAC) stemming from medicines. The role of hospital pharmacists in health services are highlighted in 12 out of the 16 HAC information kits published by the Australian Commission for Safety and Quality in Health Care (the Commission).

SHPA welcomes the opportunity to provide input to the independent Mid-term Review of Australia's National Health Reform Agreement (NHRA) Addendum 2020-25. Hospital pharmacists as medicines experts operatively manage and clinically ensure the safe, efficient and effective use of medicines within Australia's hospital system.

Hospital pharmacists are responsible for almost a quarter of all Pharmaceutical Benefits Scheme (PBS) medicines expenditure, accounting for just over $3 billion in expenditure from public and private hospitals each year when providing care and supplying medicines to hospital patients.

SHPA notes the context and timing of the mid-term NHRA Addendum 2020-25 review with several other reviews undertaken by the Commonwealth over the past year pertaining to medicines. The findings and recommendations of these reviews will have an impact on the funding and cost of medicines, and the level of clinical pharmacy service required in hospitals to support safe care and quality use of medicines. SHPA's full submissions, containing several recommendations, to each of these significant reviews are attached:

- SHPA submission to National Medicines Policy (NMP) (Attachment A)
- SHPA submission to Section 100 Efficient Funding of Chemotherapy (EFC) (Attachment B)
- SHPA submission to Pharmaceutical Reform Agreements (PRA) (Attachment C)

After the long-awaited review of Australia's National Medicines Policy (NMP), the updated document published in 2022 affirmed the Australian Government's priority to resource equitable and affordable medication access and care that meets patient need, regardless of location or care setting. SHPA's submission outlines specific areas where the NHRA can be strengthened to deliver on the central pillars of the NMP and achieve sustainable and optimal access to health technologies for all Australians in the short and in the emergent longer term.

Both the Section 100 EFC and PRA are essential for attempts by hospitals and hospital pharmacists to facilitate equitable, timely and affordable access to medicines subsidised on the Pharmaceutical Benefits Scheme (PBS) for cancer patients, and hospital patients receiving medicines upon discharge or from outpatient clinics.

Since Section 100 EFC and PRAs have been enabled throughout most jurisdictions, hospital pharmacists have never been provided appropriate or equitable remuneration compared to community pharmacists for supplying the same PBS medicines. Pharmacy Forecast Australia 2022[1], a survey of hospital pharmacist leaders, found that 71% of respondents believe that within the next five years, remuneration for PBS-funded chemotherapy will have fallen below the point at which it can be safely provided. Furthermore, access to the

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PBS medicines and non-PBS medicines is variable across hospitals due to confounding factors which are explored further throughout this submission.

In this submission, SHPA makes a range of recommendations to ensure the NHRA Addendum 2020-25 is being delivering on its objectives and able to facilitate safe, quality, equitable and cost-effective healthcare to all Australians receiving treatment in the acute care setting.

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.

Recommendations

Recommendation 1: Transition to independent five-year, nationally consistent Hospital Pharmacy Agreement for the public hospital pharmacy sector aligned to National Health Reform Agreements, with the Commonwealth, jurisdictional governments and SHPA as signatories.

Recommendation 2: Significantly improve governance arrangements for Pharmaceutical Reform Agreements (PRAs) via:

a. Regular consultative forums between Commonwealth, jurisdictions and SHPA on PRA implementation and delivery and impact of new PBS listings on hospital pharmacy sector
b. Inclusion of clauses for dispute resolution and variations to PRAs
c. Remove the current risk-sharing ceiling arrangements in the Pharmaceutical Reform Agreements as they are ineffective and not enforced

Recommendation 3: Implement Pharmaceutical Reform Agreements (PRAs) in New South Wales (NSW) and Australian Capital Territory (ACT) to achieve equitable access to Pharmaceutical Benefits Scheme (PBS) medicines, support safer discharges and transitions of care and ease reliance on primary healthcare systems.

Recommendation 4: 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 5: Develop a single-funder model for health technologies provided in hospitals that funds the whole cost of therapy, including required ancillary services, to facilitate early and equitable access to high-cost and complex medicines.

Recommendation 6: Enable hospital pharmacists to supply all medicines, including those listed under Section 100 programs, to Indigenous Australians under the Closing the Gap (CTG) PBS Co-Payment Measure**,** to reduce cost-shifting and improve equity of access to medicines and support medication adherence.

Recommendation 7: Cost and time barriers prohibiting sponsors of generic medicines from applying for HTAs should be addressed to expedite access to health technologies in Australia.

Recommendation 8: Remove the 6.5% Commonwealth funding growth cap that limits public hospitals from expanding their services and delivering person-centred, cost-effective, evidence-based clinical services to their patients.

Recommendation 9: Funding pathways for medicines used in hospitals should account for innovative, patient-centred models of care aiming to provide care to patients where they wish to receive it, without compromising medicines access and quality use of medicines.

Recommendation 10: Adopt SHPA Standards of Practice pharmacist-to-patient ratios into funding agreements to ensure equity of access to safe and comprehensive patient care and medicines management.

Recommendation 11: Support scope of practice expansion such as enabling collaborative prescribing pharmacists in hospitals as prescribers to authorise PBS prescriptions such that they can prescribe medicines that are eligible for PBS subsidy, to further increase the efficiency of our medical and pharmacy workforces.

Terms of Reference

a. Implementation of the long-term reforms and other governance and funding arrangements, and whether practice and policy in place delivers on the objectives of the Addendum;

Implementation of National Health Reform Agreement (NHRA) long-term health reforms:

1. Nationally cohesive Health Technology Assessment

SHPA strongly advocates for a nationally cohesive, efficient, and responsive health technology assessment (HTA) framework to inform government investment and disinvestment decisions in Australia. The concurrent government review into HTA policy and methods is an opportunity for reform that can enable rapid and transparent innovation, providing Australians with access to early, equitable and affordable health technologies when and where they are needed. SHPA's full submission to this review which contains several recommendations, can be found at Attachment D.

The emergence of innovative, targeted and complex therapies has highlighted the lack of flexibility in our current funding assessment pathways. Many new and novel treatments do not neatly fit into either the PBS or the MBS funding models. HTAs must consider the broader implications of a health technology on the health system and fund the whole cost of therapy, not just the individual health technology, if we are to ensure person-centred and equitable access to health technologies, as outlined in the NMP.

Public hospitals and hospital pharmacy departments play a crucial role in access to novel, 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. According to the Council of Australian Therapeutic Advisory Groups (CATAG), virtually all therapeutically complex and/or new drugs are first used in hospitals, with 73% used in public hospitals.[2]

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. More recently, limitations have been applied to the use of PBS in public hospitals for high-cost medicines requiring initiation in the inpatient hospital setting, in many cases resulting in inequity of consumer access.[3] Public hospitals are sometimes unable to fund treatment for high-cost medicines without PBS support. This highlights the tension emblematic of historical federal-state funding conflicts.[4]

The lack of suitable funding pathways that provide subsidy for the whole cost of therapy results in inequity in access as not all hospital budgets will be able to absorb these additional costs and therefore access becomes a matter of postcode lottery. It also creates perverse incentives to delay the initiation of certain high-cost treatments until the point of discharge to access PBS subsidy, impacting on patient health outcomes and further costing the health system. These therapies include, antipsychotic depot injections, iron infusions, hepatitis C medications, infusions for osteoporosis, and several cancer therapies.

Unachieved outcomes in the National Health Reform Agreement – Long-term Health Reforms Roadmap[5]:

Several of the outcomes outlined are yet to be achieved. In addition to the lack of national consistency and transparency, and the duplication between HTA bodies, as highlighted above the current HTA process does not deliver on outcomes relating safe, effective, efficient, financially viable care that improves population health.

Significant structural reform is required to ensure medicines funding mechanisms in Australia remain fit for purpose and sustainable. Development of single-funder models for medicines in hospitals is essential to fully enabling patient-centred and timely access to care when and where it is required.

2. Paying for value and outcomes

Hospital pharmacists are skilled in providing clinical services which ensure quality and effective use of medicines for patients improving overall health outcomes. Improved patient health outcomes enable the federal government to mitigate unnecessary health costs by reducing medication wastage, reducing medication-related harms, optimising medication use, decreasing patient length of stay in hospital and reducing hospital readmissions and their associated Medicare costs.

The value of clinical pharmacy services is well documented in literature, with an Australian economic analysis indicating a $23 return for every $1 spent on clinical pharmacy services.[6] The COVID-19 pandemic has also shown that hospital pharmacists are critical in the co-ordination, distribution and supply of critical medicines as well as in the review and governance of the ongoing treatment of complex and serious health conditions.

Funding models that support the provision of healthcare in the right place, at the right time, and by the right workforce, are essential to delivering cost-effective, efficient, safe and quality care to Australians in public hospitals. Hospital pharmacists often lead research and conduct trials exploring new and innovative models of care that support efficiency and improve patient health outcomes.

Examples of innovative hospital pharmacy-based models include virtual pharmacy to inpatients in rural and remote NSW hospitals,[7] centralised telehealth antimicrobial stewardship services in Queensland, telehealth services for cardiology patients in rural Victoria,[8] and telechemotherapy for patients in rural Western Australia.[9] The COVID-19 pandemic has further hastened development and implementation of innovative care services that place quality patient care and safety at the centre, as well as meeting changing capacity and resources of health services, and changing consumer expectations.

The Partnered Pharmacist Medication Charting (PPMC) model is another example of an innovation that demonstrates value and outcomes. PPMC was the first iteration of pharmacist prescribing in Australia. In this model, an appropriately credentialed pharmacist conducts an interview with the patient/carer and obtains the best possible medication history (BPMH), then co-develops a medication plan for that patient with the treating doctor, patient/carer and nurse, and charts the patient's regular medications and the doctor charts any new medications. This model has been proven to reduce the proportion of inpatients with at least one medication error on their chart by 62.4% compared with the traditional medication charting method, while also reducing the length of inpatient stay by 10.6%.[10]

Naturally, as hospital pharmacists' roles have evolved to allow more time for clinical activities and direct patient care, hospital pharmacy technician roles have also expanded to support medication management functions on hospital wards. Tech-check-tech is a model where pharmacy technicians who have successfully completed training, can check the accuracy of a dispensed item against the corresponding prescription or medication order. This can also include the supply of inpatient medication orders. A meta-analysis of accuracy checking proficiency demonstrated that pharmacy technicians demonstrated a higher level of accuracy than pharmacists, with pharmacist accuracy rate at 99.27% compared to 99.72% for items checked by an accuracy checking pharmacy technician.[11]

Another example of an innovative model of care that demonstrates value and outcomes is the Bedside Medication Management (BMM) model where pharmacy technicians coordinate and streamline timely supply of medications, maintain appropriate storage of medications, and remove ceased or unwanted medications from patient care areas. This promotes cost effective medication stock management at a ward level, timely supply of newly initiated medications, and reduces the risk of administration of expired or incorrect medications. A study exploring missed doses on inpatient wards found that the ward-based pharmacy technician involvement in the BMM model reduced the omission rate per medicine episode from 1.18% to 0.30%.[12]

Unachieved outcomes in the National Health Reform Agreement – Long-term Health Reforms Roadmap

a. An important short-term outcome that is yet to be achieved is the 'increased number of successful contemporary care models scaled up, systematised and funded recurrently to ensure benefits are realised and ongoing.' Whilst the PPMC, Tech-check-tech, and BMM models have been implemented in some hospitals across various jurisdictions, the scaling-up of these effective models of care is not occurring in a systematic manner due largely to the lack of funding. The adhoc implementation of these services across various hospitals leading to inconsistencies and inequities in the health system. Healthcare models that have been proven to deliver better patient health outcomes and cost-savings to the government, should have available to all Australians regardless of geographical location.

   Given the current constrained resource environment in the Australian healthcare system, value and outcomes can only be achieved when all healthcare professionals are supported to work collaboratively, at the top of their scope of practice. Hospital pharmacists are medication experts who work collaboratively in a multi-disciplinary team-based care model. Hospital pharmacists supervise and train junior doctors in prescribing and advise senior medical staff on medicine and treatment selection, dosing, medicine administration requirements, therapeutic drug monitoring (TDM), and monitoring of adverse effects. Hospital pharmacists also advise doctors about the most appropriate time to perform therapeutic drug monitoring (TDM) and the interpretation of the results. This highly skilled workforce should be better utilised to alleviate pressures on the current healthcare system.

   Hospital pharmacists should be permitted to undertake collaborative prescribing in acute care settings and practice to their full scope across the entire patient journey, from admission through to inpatient, discharge, and outpatient clinics, to improve the safety and quality of healthcare and the capacity of the Australian hospital system. The demonstrated health and economic benefits from the PPMC model, along with the international experience, should be leveraged to expand collaborative pharmacist prescribing across all Australian hospitals, allowing hospital pharmacist prescribers to authorise their own prescribing, freeing up doctors to undertake more diagnostic and clinical activities. Pharmacist prescribing however, must be enabled by the PBS in order to be of use to patients and afford them equitable access to medications upon discharge from hospital regardless of whether the prescription was written by a doctor or pharmacist prescriber.

b. Another unmet outcome is the increased flexibility in national funding arrangements supports more effective and efficient resource allocation and focuses on the outcomes that matter to patients. The national funding cap limiting the overall growth in the Commonwealth's contribution to 6.5% each year inhibits the expansion of much needed clinical pharmacy services.

   There are a wide variety of pharmacist-led outpatient services that can be conducted by hospital pharmacists to ensure safe and effective use of medicines in patients, ultimately reducing the cost of medication-related problems on Australians. These can include anticoagulant dosing, opioid analgesia de-escalation and management, chemotherapy medicines review, transplant rejection medicines review and others. Queensland hospital health services have implemented many of these pharmacist-led outpatient clinics and are responsible for approximately 90% of the national Clinical Pharmacy 40.04 outpatient clinics, a Tier 2 Non-admitted service under Activity Based Funding. The limitation of the national funding cap leads to all hospital pharmacy departments in Australia having to decide between resourcing inpatient services or outpatient clinics rather than taking a person-centered approach and supporting both.

   In addition, the current singular Tier 2 Clinic 40.04 Clinical Pharmacy should be complemented by other Tier 2 Non-Admitted Services with varying levels of funding, so that the breadth of hospital

pharmacy outpatient services can be implemented. Incorporating a tiered level consultation structure for hospital pharmacy outpatient services would support broader utilisation in Australian hospitals, and ultimately provide higher quality and safer care that reduces admissions.

3. Joint planning and funding at a local level

The current health system remains largely fragmented and siloed creating inefficiencies and frustrations for both patients and health care professionals and costing the government. As healthcare delivery continues to innovate and change to a more person-centred model facilitating care to patients wherever they require it, it continues to highlight the lack of integration across care settings.

The need for joint planning and funding is highlighted by recent changes to Commonwealth drug pricing and its downstream impacts on hospital pharmacy resourcing. No meaningful impact assessments on recent changes to Commonwealth medicines pricing policies on public hospitals were undertaken. The Australian Government and the Generic and Biosimilar Medicines Association (GBMA) entered into a new five-year strategic agreement (GBMA Agreement), commencing 1 July 2022 which included a suite of policy agreements on pricing arrangements and stockholding requirements to bolster medicine supply and availability through the PBS.

Historically, medicine prices offered to public hospitals are excluded from price disclosure calculations undertaken by the Commonwealth, which has usually resulted in public hospitals being able to secure preferential pricing leveraging its large procurement volumes from wholesalers, compared to purchasing arrangements in the retail pharmacy setting.

From 1 October 2022, medicines on the PBS which have reached the seventh cycle of price disclosure have been included in price disclosure calculations, thus removing incentives for wholesalers to offer pricing arrangements that are preferential to retail pharmacy settings and increasing the cost of medicines procurement for Australian public hospitals.

Additionally, written into the GBMA agreement was the introduction of a new $4 floor price for PBS medicines. PBS medicines with an approved price less than $2 increased to $2.50 and PBS medicines with an approved price between $2 and $3.50 increased by up to $0.50 to a maximum of $3.50.

This strategic agreement did not include joint planning with public hospital stakeholders and did not undertake an impact assessment on Australian hospitals. SHPA estimates that the impact of this policy means Australian hospital pharmacies will have to unexpectedly incur an additional $50 million annually in medicine procurement costs from within their fixed pharmaceutical budgets.

Unlike community pharmacies, hospital pharmacies are not funded for the various dispensing fees community pharmacies are able to access via the Community Pharmacy Agreement, and thus the majority of dispensing activity in public hospitals is not a cost-recoverable activity. This pricing policy change has downstream impacts on the ability for pharmacy departments to recruit and fund pharmacists and pharmacist technicians from within their fixed operational budgets.

<u>Unachieved outcomes in the National Health Reform Agreement – Long-term Health Reforms Roadmap:</u>

a. An important short-term outcome that is yet to be achieved is the increased effective collaboration between primary, community and acute health care organisations. The responsibility to manage transitions of care between acute and primary care settings is often lost in a vacuum of fragmented funding streams which do not put the patient at the centre of care. A major risk in the transition of care process is the misalignment of hospital and community services post-discharge, leaving a gap for patients at a critical time, increasing their risk of medication errors or mismanagement, and heavily compromising medication safety risking readmission.

   The immediate post-discharge challenges in transitioning between care settings can best be addressed by hospital-led interventions. As large institutions with comprehensive clinical

governance frameworks, these institutions are well placed to lead systemic improvements for medication management for patients transitioning in and out of primary care and aged care settings.

Transitions of Care pharmacists provide continuity in care, including medication management, for patients discharging from hospital into primary care. Pharmacist interventions may include medicines reconciliation, discharge medicine counselling, post-discharge follow-up and liaising with primary care providers. Pharmacist-led Transition of Care services not only improve patient satisfaction around understanding their medications, but also decrease hospital readmissions.[13,14]

Pharmacists working in hospital-led outreach services such as the Hospital Admission Risk Program (HARP) in Victoria, provide specialist care planning, education and support to help those with chronic and complex health issues manage independently in the community and reduce the risk of being admitted to hospital. Another tool which aims to reduce hospital readmission rates are Hospital Outreach Medication Review (HOMR) services, which include a home visit or virtual review by a hospital pharmacist to assess a patient's medication management and potential ways to optimise their treatment.

Additional capacity however requires greater resourcing for public hospitals in order to achieve downstream savings for aged and primary care settings. Better uptake of health technology including, Electronic Medical Records (EMR) and My Health Record (MHR) would also work to streamline processes and improve transparency of information sharing across all healthcare professionals in all settings of care.

b. Another outcome yet to be achieved is the increased number of enduring joint planning and funding initiatives to define and agree on local outcomes in alignment with the Quadruple Aim which is improved patient experience, improved provider experience, improved health outcomes and sustainable cost. Given the changes to healthcare delivery in the acute setting and provision of acute services to inpatients at home in the community through outreach programs such as Hospital in the Home (HITH), health care services must consider joint planning and funding initiatives that support care regardless of who is delivering it and in what setting it is being delivered.

   For example, for a HITH patient (a hospital inpatient receiving acute care at home) who runs out of supplies to their regular medicines that are not related to their hospital admission, there is ambiguity amongst hospital pharmacists regarding which pharmacy is responsible for supplying additional supplies of medicines to the patient. Whilst the most important thing is that the patient receives their medicine regardless of their setting of care, arbitrary funding rules and the lack of joint planning to achieve person-centred care often leads to scenarios like that ultimately impact on patient health outcomes.

4. Prevention and wellbeing

As discussed earlier in the *Paying for value and outcomes* section, hospital pharmacists are prevented from leading and implementing outpatient clinics which are supported by evidence to reduce preventable hospital admissions and increase the safety and quality of care. The 6.5% funding growth cap is a significant contributor to this as growth is focused on inpatient services, meaning hospitals are hamstrung when trying to meaningfully tackle preventive measures that reduce demand on hospitals in the longer term.

Various hospitals have implemented outreach and in-reach services for older Australians that are either led by pharmacists or have significant pharmacy involvement, to reduce preventable admissions by older

Australians. Examples of these services are listed in Appendix 1 of SHPA's Geriatric Medicine Outreach Pharmacist Services Practice Update[15]. These services require dedicated and consistent funding to enable widespread implementation, as opposed to limited funding that requires regular renewal and inadvertently causes access inequity.

5. Enhanced health data

Treatment for minority populations and rare diseases that require the use of non-PBS and off-label medicines and medicines that are not registered in Australia, is often provided or initiated in a hospital setting. There is significant crossover between what would be considered off-label and off-formulary in a hospital.

When hospital pharmacists or prescribers require the use of a medicine that is not on the hospital formulary, typically they will need to make an Individual Patient Usage (IPU) application that is reviewed by the Hospital DTCs, that evaluates the literature for the indication that it is meant to treat, what the treatment success markers are, and the projected costs to allow for a cost-efficiency analysis. IPUs that are approved by the DTCs require regular reporting by the applying prescriber on the patients' prognosis and measurement of the identified treatment success markers, to make the case for continued approval of the IPU.

IPU datasets held by individual hospitals and hospital networks are a critical and untapped database that would likely have a wealth of independent clinical evidence and information to assist with the identification of medications for registration in Australia. The Australian government in collaboration with state and territory governments should develop a repository of non-PBS, off-label and Special Access Scheme (SAS) medicine data gathered from all hospitals across Australia. This data sharing measure would support more timely decision making and provide Australians with early access to medicines needed in the acute care setting.

Hospital pharmacists are well placed to tap into this resource and utilising their own clinical experience treating patients with non-PBS, off-label and Special Access Scheme (SAS) medicines, provide reliable information to the Australian government on medicines that need to be registered for local use. SHPA is the ideal conduit between hospital pharmacists and the Australian Government through the 30+ speciality practice groups we convene of pharmacists with specialised expertise in various therapeutic areas.

Improved data collection and analysis to support person-centred care

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 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.

The systematic collection of this significant information is a person-centred measure to inform future funding decisions of non-PBS medicines commonly used, and policies, regulations and clinical guidelines to prevent future medicine-related hospital admissions.

Objectives of the Addendum that are not yet met

5a. deliver improvements in outcomes that matter most to people and communities:

An objective of the NHRA Addendum is to deliver improvements in outcomes that matter most to people and communities. Accessible and affordable, high-quality healthcare are essential outcomes to most Australians yet, as outlined thus far in this submission, access to affordable medicines and clinical services to public hospital inpatients are not always readily available when and where patients require them, creating inequities in healthcare across the country and varied patient experiences.

7a. improve outcomes and access to services, supporting innovative models of care and trialling new funding models:

An objective of the NHRA Addendum is for the Commonwealth and the States to work in partnership to implement arrangements for a nationally unified and locally controlled health system which will improve outcomes and access to services, supporting innovative models of care and trialling new funding models. As discussed above under 'paying for value and outcomes', successful, evidence-based innovative models of care that deliver health and economic benefits are often not supported in scaling up to facilitate a nationally unified approach to healthcare. Not meeting this objective creates further inconsistencies and inequities in access to services across the country.

7d. improve safety and quality of health services through hospital pricing reforms; and

14 b. funding the Pharmaceutical Benefits Scheme to ensure timely and affordable access to safe, cost-effective and high quality medicines;

An objective of the NHRA Addendum is for the Commonwealth and the States to work in partnership to implement arrangements for a nationally unified and locally controlled health system which will improve safety and quality of health services through hospital pricing reforms. Incentivising quality care through the incorporation of quality-based reimbursement models

The IHPA's Pricing Framework for Australian Public Hospital Services 2022–23 requires the agency to discount Commonwealth funding provided to public hospitals through programs other than the National Health Reform Agreement.

Both the Section 100 EFC and PRA are essential for attempts by hospitals and hospital pharmacists to facilitate equitable, timely and affordable access to medicines subsidised on the Pharmaceutical Benefits Scheme (PBS) for cancer patients, and hospital patients receiving medicines upon discharge or from outpatient clinics.

Since Section 100 EFC and PRAs have been enabled throughout most jurisdictions, hospital pharmacists have never been provided appropriate or equitable remuneration compared to community pharmacists for supplying the same PBS medicines. SHPA's submission to the Review of Pharmaceutical Reform Agreements (PRA) (Attachment C) further explores these issues in detail and illustrate policy and funding settings that do not lead to timely and affordable access to PBS medicines where patients need them in a manner that sufficiently remunerates hospital pharmacy providers to maintain these services.

Furthermore, access to the PBS medicines and non-PBS medicines is variable across hospitals due to confounding factors which are explored in SHPA's submissions to these reviews. This underpins our recommendations for improved governance arrangements and the need for independent five-year, nationally consistent Hospital Pharmacy Agreement for the public hospital pharmacy sector aligned to National Health Reform Agreements, with the Commonwealth, jurisdictional governments and SHPA as signatories.

Given the complexity of PBS medicines access and funding, any future changes to policy settings – noting the PRA Review is yet to report – should not suggest that the subsidy and funding for PBS medicines should be amalgamated into any future Commonwealth hospital funding agreement. This would dilute the attention

required to a policy and program area that is vital to the healthcare and wellbeing of all Australians, and would likely cause different iterations of cost-shifting incentives that already currently occur. Cost-shifting can be abated through appropriate remuneration for hospital pharmacies for safe and quality supply, and access parameters to PBS medicines for patients wherever they are required in a patient-centred manner.

Another example of these inequities is the exclusion of public hospital pharmacies from the Closing The Gap PBS Co-Payment Measure. Unlike community pharmacies, public hospital pharmacists are currently unable to supply PBS medicines to Aboriginal and Torres Strait Islander patients under the Closing The Gap PBS Co-Payment Measure, which hamper Australia's efforts to close the gap in healthcare outcomes for Aboriginal and Torres Strait Islander peoples. This results in inequitable, higher out-of-pocket costs and co-payments for Aboriginal and Torres Strait Islander patients, or missing out on medicines altogether and increasing their risk of readmission to hospital.

SHPA notes that under IHPA's strategic objective to refine and develop hospital activity classifications, its rigorous statistical analysis includes specialist input from clinicians, but SHPA is not aware of input from medication management and pharmacy experts in the collection of appropriate data to identify the complexities and value in medication related activities and interventions.

SHPA believes that IHPA must consider the outcomes of these reviews as part of its findings and recommendations will have an impact on the cost of medicines, and the level of clinical pharmacy service required in hospitals to support safe care and quality use of medicines.

The Strategic Agreements between the Commonwealth and Generic and Biosimilar Medicines Association (GBMA) and Medicines Australia also contain changes to drug pricing policies. SHPA believes IHPA should undertake an impact assessment of these Strategic Agreements on hospital drug pricing, given the cost of medicines for each admission type or procedure is factored into National Weighted Activity Unit (NWAU) determinations. Most notably is the impact of public hospitals being compelled to participate in Price Disclosure for PBS medicines, with data collection commencing on 1 October 2022. Given the commercial arrangements for medicines procurement in hospitals, it is anticipated that this major policy change will likely lead to an increase in the cost of medicines for hospital purchasers.

d. whether any unintended consequences such as cost-shifting, perverse incentives or other inefficiencies that impact on patient outcomes have arisen, and the capacity of Parties to adopt and deliver innovative models, as a result of financial and other arrangements in this Addendum;

Lack of access to PBS subsidised medicines for hospital inpatients

The lack of access to PBS subsidised medicines for public hospital inpatients results in cost-shifting incentives remaining at the expense of efficient, quality and safe healthcare delivery and impacting patient healthcare outcomes.

Without PBS subsidy for public hospital inpatients, there are perverse incentives to delay initiation or restart of certain higher cost treatments until the point of discharge to access PBS subsidy, such as but not limited to:

- antipsychotic depot injections,
- iron infusions
- Hepatitis C medications
- infusions for osteoporosis
- cancer therapy

In some cases, patients are provided outpatient prescriptions for high-cost medicines to be dispensed under the PBS in the community, and bring it to the hospital for administration as an inpatient. These arbitrary funding rules present clinicians with challenging ethical dilemmas as they endeavour to provide their patients with the best possible and affordable access to life-saving medicines.

Increasing frequency of hospital outpatient appointments

Incentive to claim for an episode of care each time a patient attends an outpatient appointment can at times be a perverse incentive to increase the frequency that that patient must present to receive treatment, although it may not always be necessary. Certain formulations of medicines that require administration in outpatient clinics, are at times prescribed over other more convenient formulations that can be self-administered at home to ensure clinics can continue to claim episodes of care.

Examples:

- Patients requiring methotrexate to treat rheumatoid arthritis or psoriasis, for whom the oral tablet formulation is unsuitable, can often be prescribed methotrexate pre-filled syringes, however some of these patients are prescribed other parenteral formulations to ensure they continue to attend the outpatient clinic
- Ocrelizumab and natalizumab used to treat multiple sclerosis are intravenous formulations often prescribed for patients whilst ofatumumab, a subcutaneous formulation also used to treat multiple sclerosis is available for self-administration

f. arrangements for approval and funding of high cost therapies offered in public hospitals, as outlined in Schedule C (clauses C11 and C12) and Appendix B; and

Lack of funding pathways for high-cost medicines in hospitals that account for the whole cost of therapy

Rapidly evolving treatment options which have changed the profile of new medicines being brought to market, have increasingly highlighted issues around access and equity. Twenty years ago new medicines were predominantly small molecules for lifestyle-related non-communicable diseases. In recent years, advancements in health 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 ARTG and well before they are listed on the PBS. They are also integral to patient access to clinical trials. According to the Council of Australian Therapeutic Advisory Groups (CATAG), virtually all therapeutically complex and/or new drugs are first used in hospitals, with 73% used in public hospitals.

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

More recently, limitations have been applied to the use of PBS in public hospitals for high-cost medicines requiring initiation in the inpatient hospital setting, potentially resulting in inequity of consumer access.[3]

Examples:

- Nusinersen is PBS subsidised medication used to treat spinal muscular atrophy in children, however if a child has scoliosis, they are administered this medication under general anaesthetic with guided imaging and require a hospital admission for a day or two for recovery. In this case, the cost of the anaesthetic, the staff required to administer the medication, and the additional hospital admission, is not meaningfully recognised by hospital funding mechanisms such as activity based funding
- The active agent in some chemotherapy preparations is subsidised via the PBS however the cost of the infusion fluid, excipients and the administration aids necessary are not. This adds a significant layer of complexity for hospitals and patients in fee arrangements given the use of both PBS and non-PBS medicines.

Whilst Schedule C clauses C11 and C12 outline a shared funding model for certain high-cost therapies, they are not the widely available across all health services in Australia. Some patients are forced to relocate homes and cross borders to receive the life-saving treatment they need. The limited funding pathways that provide subsidy for the whole cost of therapy, including ancillary services, drive inequity in access as not all hospital budgets are able to absorb these additional costs and therefore access becomes a matter of postcode lottery.

Significant structural reform is required to ensure medicines funding mechanisms in Australia remain fit for purpose and sustainable. Development of single-funder models for medicines in hospitals will reduce inequity of patient access to high-cost and complex medicines, and enable patient-centred and timely provision of treatment when and where patients require them, aligning with Australia's National Medicines Policy.[16]

Attachments

A: SHPA submission to the Review of the National Medicines Policy (NMP)
B: SHPA submission to the Review of the Efficient Funding of Chemotherapy (EFC)
C: SHPA submission to the Review of the Pharmaceutical Reform Agreements (PRA)
D: SHPA submission to the Review of the Health Technology Assessment (HTA) policy and methods

References

[1] The Society of Hospital Pharmacists of Australia. (2022). Pharmacy Forecast Australia 2022: Executive Summary. Accessed at: https://shpa.org.au/publicassets/e2fda00d-6e01-ed11-9106-00505696223b/Pharmacy-Forecast-Australia-2022-Executive-Summary.pdf
[2] Council of Australian Therapeutic Advisory Groups. (2019). About – Infographic. Accessed at: https://catag.org.au/wp-content/uploads/CATAG-Infographic.pdf
[3] Australian Healthcare Associates. (2017). PBS Pharmaceuticals in Hospitals Review. Accessed at: https://www.pbs.gov.au/reviews/pbs-pharmaceuticals-in-hospitals-review-files/PBSPharmaceuticals-in-Hospitals-Review.pdf.
[4] Misko J et al. (2022). Navigating the Pharmaceutical Benefits Scheme: federal versus state government funding for high-cost medicines - a problem for public hospitals. Aust Health Rev 2022. Accessed at: https://www.publish.csiro.au/ah/AH22002
[5] Australian Health Ministers. (2021). National Health Reform Agreement Long -term Health Reforms Roadmap. Accessed at: https://www.health.gov.au/sites/default/files/documents/2021/10/national-health-reform-agreement-nhra-long-term-health-reforms-roadmap.pdf
[6] Dooley, M. J., Allen, K. M., Doecke, C. J., Galbraith, K. J., Taylor, G. R., Bright, J., & Carey, D. L. (2004). A prospective multicentre study of pharmacist-initiated changes to drug therapy and patient management in acute care government funded hospitals. British Journal of Clinical Pharmacology, 57(4), 513-521. doi:10.1046/j.1365-2125.2003.02029.
[7] Chambers B, et al. Virtual clinical pharmacy services: A model of care to improve medication safety in rural and remote Australian health services. AM J Health-Syst Pharm 2022/ Early access published 2022 Mar 15; https://doi.org/10.1093/ajhp/zxac082
[8] Livori A, et al. (2021). Towards Optimising care of regionally-based cardiac patients with a telehealth cardiology pharmacist clinic (TOPCare Cardiology). Heart Lung Circ 30(7):1023-1030.
[9] WA Country Health Service. (2021). TeleChemotherapy comes to Narrogin and Broome. Accessed at: https://wacountry.health.wa.gov.au/News/2021/01/07/TeleChemotherapy-comes-to-Narrogin-and-Broome
[10] Tong EY, Mitra B, Yip GS, Galbraith K, Dooley M, PPMC Research Group. (2020). Multi-site evaluation of partnered pharmacist medication charting and in-hospital length of stay. Br J Clin Pharmacol (Feb); 86(2): 285-90.
[11] Snoswell C.L., (2020). A meta-analysis of pharmacists and pharmacy technicians' accuracy checking proficiency, Research in Social and Administrative Pharmacy, Volume 16, Issue 6, 760-765, ISSN 1551-7411,
[12] MacNab K., Palma C., Musa H., Soriano M. Chris O'brien Lifehouse Sydney. (2022). Ward-based pharmacy technicians- ensuring missed does aren't missed! Presented at SHPA Medicines Management.
[13] March K.L, Peters M.J, Finch C.K, Roberts L.A, McLean K.M, Covert A.M, Twilla J.D.(2022). Pharmacist Transition-of-Care Services Improve Patient Satisfaction and Decrease Hospital Readmissions. J Pharm Pract. Feb;35(1):86-93. doi: 10.1177/0897190020958264. Epub 2020 Sep 18. PMID: 32945206.
[14] Phatak A., Prusi R., Ward B., Hansen L.O., Williams M.V., Vetter E., Chapman N., Postelnick M.(2015). Impact of pharmacist involvement in the transitional care of high-risk patients through medication reconciliation, medication education, and postdischarge call-backs (IPITCH Study). J Hosp Med. 2016 Jan;11(1):39-44. doi: 10.1002/jhm.2493. Epub 2015 Oct 5. PMID: 26434752.
[15] The Society of Hospital Pharmacists of Australia. (2022). Hospital Pharmacy Practice Update: Geriatric Medicine Outreach Pharmacist Services. Accessed at: https://shpa.org.au/publicassets/c42dc71d-2d54-ed11-910e-00505696223b/Geriatric%20Medicine%20Outreach%20Pharmacist%20Services.pdf?c6cbfc7f-b660-ed11-9110-00505696223b
[16] Australian Government. (2022). National Medicines Policy. Accessed at: https://www.health.gov.au/sites/default/files/2022-12/national-medicines-policy.pdf