SHPA Submission to Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24, July 2022

The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for more than 6,100 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 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).

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.

Section 2: Impact of COVID-19

Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP (National Efficient Price) 23?

SHPA acknowledges the potential significant longer-term implications caused by COVID-19 in the discussion paper, such as more complex future surgeries as non-critical surgeries were delayed, as well as impact on workforce shortages. These implications are already being felt by hospital pharmacy departments where workforce shortages have been exacerbated by the COVID-19 pandemic, with chronic understaffing adding to the stress and fatigue caused by caring for patients in a challenging environment.

The possibility of more complex surgeries is a real one, however this also extends to in general, more complex and acute care for all patients, as not just surgeries, but diagnoses are also delayed due to lower access to primary healthcare services. This has been supported by the Australian Bureau of Statistics' report on Patient Experiences in Australia which found Australians delayed care and diagnoses during the pandemic.

The potential impacts of this has been attempted to be quantified For example, research conducted by the Cancer Council of Australia and published in The Lancet, had projections suggesting an overall 51% increase in the number of new cancer cases and a 36% increase in the number of cancer deaths over the 25-year projection period.

Compounding this is the decreasing average length of stay per admission, as pressures mount on a constrained hospital system to discharge patients and free up beds. For some patients, this means being discharged before they are fully ready, which increases their hospital readmission risk.

Demands associated with the COVID-19 pandemic and the associated models of care have necessarily entailed the delivery of pharmacy activities under various models; dedicated healthcare hubs, telehealth services, outpatient clinics and hospital-in-the-home services and the Independent Hospital Pricing Authority (IHPA) must take into account the costs associated with these new models of care, which will remain well after the pandemic.

Section 5.1: Admitted acute care

Are there any barriers or additional considerations to using the Australian Refined Diagnosis Related Group (AR-DRG) Version 11.0 to price admitted acute services for NEP23?

As mentioned earlier, hospital pharmacy departments are chronically understaffed and are not funded sufficiently to have the requisite number of hospital pharmacists to provide comprehensive and optimal clinical pharmacy services to hospital patients. SHPA recommends that pharmacist-to-patient staffing ratios outlined in SHPA's Standards of Practice Series should be considered in the context of AR-DRGs weighted activity units and consequently, the NEP23, which will assist with commensurate resourcing for clinical pharmacy services.

Section 6.2: Adjustments to the national efficient price

Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?

Cost of medicines procurement

As discussed in SHPA's submission earlier this year to IHPA Work Program and Corporate Plan 2022-2023 Public Consultation**,** 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.

Currently, there are simultaneous reviews undertaken by the Commonwealth into the National Medicines Policy (NMP), Section 100 Efficient Funding of Chemotherapy (EFC) and Pharmaceutical Reform Agreements (PRA). 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. 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.

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 recently signed Strategic Agreements between the Commonwealth and Generic and Biosimilar Medicines Association (GBMA) and Medicines Australia also contain various major 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.

New clinical care standards

Additionally, the newly published *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard* and *Sepsis Clinical Care Standard* are anticipated to significantly increase the level of necessary hospital pharmacy input for admissions relating to surgery and perioperative medicine, pain management, infectious diseases, critical care and emergency medicine. SHPA recommends that the pricing and weighting of the

impacted admission types should be updated to reflect these additional requirements pertaining to opioid stewardship, which will make hospital care safer for patients receiving treatment with high-risk opioid medicines.

What cost input pressures that may have an impact on the national pricing model and are not included in the National Hospital Cost Data Collection (NHCDC) should be considered in the development of NEP23?

With recent medication shortages and interruptions in supply, procurement costs to hospital pharmacy departments have increased, compounding risks described above with respect to medicine procurement costs from government policy and reviews. The lack of availability of suitable medications has resulted in not only delays to treatment, but less effective medicines being utilised, all of which potentially contribute to prolonged hospital inpatient admissions.

Section 7.3: Quality assurance of public health expenditure data

What cost pressures for regional or remote hospitals should be considered in the development of NEC (National Efficient Cost) 23?

For hospital pharmacies in rural and remote areas, a limiting factor is having the requisite hospital pharmacy workforce for chemotherapy services. Recruitment and retention of specialised and experienced hospital pharmacy staff is significantly more challenging than in urban settings, due to a smaller pool of available pharmacists with the requisite skills where funding is primarily recognised in PBS reimbursement and not upon the complexities in care. Where IHPA does not report clinical pharmacy interventions associated with patient care, appropriate guidance and funding cannot be provided to hospitals of need including those in rural and remote settings. In SHPA's submission for the Review of the Section 100 Efficient Funding of Chemotherapy (EFC), recommendations included a funding model that properly recognises the overheads, ongoing costs uniquely associated with the provision of Section 100 EFC medicines separate to other PBS medicines to support sustainability and access to chemotherapy, particularly in smaller hospitals in regional and rural settings.

Given the importance of economies of scale on the viability of chemotherapy services, funding models and/or remuneration fee structures for provision of Section 100 EFC medicines are inadequate and should be tiered to recognise this including the marginal costs of chemotherapy services provided in hospitals of different sizes and capacities which will facilitate improved patient access in regional and rural settings. This would aim to reflect and cost-recover the true costs in the provision of health care services for increased workload relating to logistics of ordering, transportation, receiving, storing and dispensing of chemotherapy in rural and remote settings. This transparency in recording activities and funding will also more accurately reflect and validate support in the recruitment of appropriately skilled and trained pharmacists that have experience in or specialise in chemotherapy services. This could come in the form of targeted service fees for regional, rural and remote specialised chemotherapy services to improve viability and access of these services.

Section 8.3: Trialling innovative models of care

How is virtual care delivery captured in information systems and data collections?

It is unclear how virtual care delivery is captured in information systems in a consistent and rigorous manner. Given the necessity to rapidly roll out everchanging models of care over the COVID-19 pandemic, these have been iterative processes, responding to changing restrictions and case numbers. Across many hospital pharmacy departments, services that were delivered virtually, such as medication chart review, medication counselling and supply of outpatient medicines, may not necessarily have been recorded in patient medical records as having been delivered virtually. The following are also examples of virtual care delivery pharmacy services which continue to proliferate among Australian hospital pharmacy departments.

Virtual Clinical Pharmacy Service (VCPS) models for inpatients has been used in some parts of rural and remote Australia to address the gaps in clinical pharmacist medication reconciliation, management and review. Western NSW Local Health District has recently undertaken a scalability study to show that virtual clinical pharmacy services are a feasible option in healthcare delivery. VCPS aims to provide and support individualised and culturally appropriate medication reconciliation, education and counselling to patients including those with complex or extensive medication regimes as is required under the Medication Safety Standard of the National Safety and Quality Health Service Standards. Results suggest there are measurable outcomes such as decreasing patient readmissions to hospital, minimising medication related harms whilst improving communication around medication information at transitions of care.

Telehealth models in outpatient settings in the Torres and Cape Hospital and Health Service in rural and remote areas of Queensland have also proven successful with the Torres and Cape Hospital trial reflecting a high level of patient satisfaction. Additionally, results demonstrated the cost-effectiveness in enabling telehealth pharmacy services to be delivered to remote communities as the average cost of telehealth pharmacy was $214.66, inclusive of fixed costs. Without this care model, pharmacy services would not be delivered to patients at all, and has enabled the clinical pharmacist workforce to provide patient counselling and medicines review to optimise the quality use of medicines and achieve positive health outcomes.

Electronic medication management systems aid the establishment of innovations such as TeleChemotherapy to improve patient access to specialised cancer care, especially in rural and remote areas where it is difficult to or not feasible to recruit dedicated pharmacist resources for very small patient cohorts. Funding and enabling of TeleChemotherapy could allow for patients based in regional, rural and remote areas to receive their chemotherapy without travelling to an urban area, whilst still receiving comprehensive pharmacy care by suitably trained and experienced pharmacists. One such example is the Western Australia Country Health Service TeleChemotherapy Pharmacy Service, which has received national recognition for its innovation in delivering chemotherapy treatment to regional, rural and remote patients. Thus far, this service has allowed dozens of patients in these regions receive lower-risk chemotherapy locally with the support of specialist metropolitan-based clinicians via telehealth services.