IHACPA consultation on the Pricing Framework for Australian Public Hospital Services 2026–27

June 2025

Introduction

Formerly known as the Society of Hospital Pharmacists of Australia (SHPA), Advanced Pharmacy Australia (AdPha) is the progressive voice of Australian pharmacists and technicians, built on 80 years of hospital innovation that puts people and patients first. AdPha supports all practitioners across hospitals, transitions of care, aged care and general practice clinics to realise their full potential. We are the peak body committed to forging stronger connections in health care by extending **advanced pharmacy expertise from hospitals to everywhere medicines are used**.

AdPha welcomes the opportunity to contribute to the consultation on the Pricing Framework for Australian Public Hospital Services 2026–27. Hospital pharmacists are the **medicines experts** within Australia's hospital system, responsible for both the operational management and clinical optimisation of medicine use. They play a central role in the safe, effective, and efficient delivery of care—contributing to **over $3 billion in Pharmaceutical Benefits Scheme (PBS) expenditure** across public and private hospitals annually.

Hospital pharmacists are skilled in providing clinical services in line with AdPha's *Clinical Pharmacy Standards*[1], which ensure quality and effective use of medicines for patients improving overall health outcomes. These clinical services 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; an Australian economic analysis indicating a **$23 return for every $1 spent on clinical pharmacy services.**[2]

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Hospital pharmacists also support system-wide safety and quality by contributing to governance efforts aimed at reducing medicine-related complications. Their **expertise is recognised in 12 of the 16 Hospital-Acquired Complication (HAC) information kits** developed by the Australian Commission on Safety and Quality in Health Care.[3]

Given the increasing complexity of medicine use and pharmacy's expanded clinical role, it is critical that **pricing models accurately reflect the true costs and value of hospital pharmacy services**. AdPha is therefore keen to ensure that these contributions are visible and appropriately recognised within the pricing framework.

If you have any queries or would like to discuss our submission further, please contact Jerry Yik, Head of Policy and Advocacy at jyik@adpha.au.

Response to submission questions

The Pricing Guidelines

1. **Are stakeholders supportive of revising the promoting harmonisation Pricing Guideline to: "Promoting harmonisation: Pricing should facilitate best practice provision of equivalent care across appropriate settings, sites and modalities"?**

Yes, AdPha supports the revised wording. AdPha has publicly endorsed the Nous Group Virtual Care Project – Final Report, which highlighted best practice virtual care models, including those in clinical pharmacy. Various virtual clinical pharmacy models have also been showcased at AdPha's Medicines Management Conference, demonstrating innovative virtual pharmacy practice across Australia.

We note a strong alignment between this revised principle and **collaborative pharmacist prescribing models**. These models demonstrate how equivalent care can be delivered effectively across settings through team-based prescribing approaches. AdPha is currently involved in a **Virtual Partnered Pharmacist Medication Charting** research project funded by NSW Health which examines the nexus of virtual health and scope of practice expansions. However, policy changes are still required to enable pharmacists to prescribe pharmaceutical benefits on the Pharmaceutical Benefits Scheme (PBS), which would support full realisation of this principle.

Admitted Acute Care

2. **What, if any, barriers are there to pricing admitted acute episodes of care using the Australian Refined Diagnosis Related Group (AR-DRG) Version 12.0 without a shadow pricing period for NEP26?**

No comment.

Non-admitted Care

3. **Are there any other refinement areas IHACPA should consider for the Tier 2 Non-Admitted Services Classification for NEP26?**

AdPha advocates for the **removal of 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. 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-centred approach and supporting both.

AdPha advocates for a **wider range of non-admitted clinical pharmacy items** to be incorporated in the Tier 2 Non-Admitted Services Classification for 2026-27 to encompass the breadth of hospital pharmacy outpatient services being delivered in Australian public

hospitals.

A wide variety of pharmacist-led outpatient services are being conducted by hospital pharmacists to ensure safe and effective use of medicines in patients, ultimately reducing the cost of medication-related problems on the Australian healthcare system. These include anticoagulant dosing, opioid analgesia de-escalation and management, chemotherapy medicines review, transplant rejection medicines review and others.

Queensland health services have implemented many of these pharmacist-led outpatient clinics and are responsible for over **75% of Tier 2 Clinic 40.04 Clinical Pharmacy activity**, a Tier 2 Non-admitted service under Activity Based Funding. Further research is needed to understand why this funding model is underutilised in other jurisdictions and how it can be better promoted to support more equitable access across Australia.

The current singular Tier 2 Clinic 40.04 Clinical Pharmacy, however, does not differentiate between the levels of care provided with each service and should therefore be complemented by other Tier 2 Non-Admitted Services items with varying levels of funding. For example, a pharmacist-led anticoagulant dosing service would require a shorter consultation compared with the significantly more complex chemotherapy medicines review or transplant rejection medicines review.

This has led to various pharmacist-led clinics in hospitals being funded through other means, with this activity going undetected or under-represented by national data collection efforts.

Incorporating a **tiered level consultation structure** for hospital pharmacy outpatient services would support broader implementation and utilisation in Australian hospitals, better reflect contemporary pharmacy practice and ultimately provide higher quality and safer care that reduces hospital admissions.

4. What considerations should inform the potential introduction and pricing of a Tier 2 class for hospital-based non-admitted voluntary assisted dying (VAD) services?

The introduction and pricing of a Tier 2 class for hospital-based, non-admitted VAD services must account for the significant access and delivery barriers faced by people residing in rural and remote areas. This classification should capture the full range of service components, including medical consultations as well as allied health and clinical nurse specialist interventions, to reflect the true cost of safe, patient-centred delivery of VAD, particularly in under-served regions.

Under the current interpretation of the Criminal Code Act, electronic communication (including phone, email, and videoconferencing) regarding VAD—such as discussions about eligibility, administration, or follow-up—is prohibited. This legal constraint has serious implications for service delivery, and is exacerbated in geographically large jurisdictions such as Western Australia, where the inability to use electronic communications for VAD care makes providing VAD services very resource intensive.

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In-person only care: Individuals who are often frail and unwell must attend every VAD-related appointment in person or wait for a healthcare professional to travel to their home. This places a disproportionate burden on patients and clinicians in rural and remote areas.

Unaccounted service costs: The current pricing models do not reflect the true costs of clinician travel time, transport, and the resource-intensive nature of in-person-only care. These services require significant investment that is not adequately captured under existing funding arrangements. Clinicians could also include an interpreter or speech pathologist.

Pharmacy logistics: VAD prescriptions must be hand-delivered to pharmacies, and pharmacists providing VAD substances are unable to follow up with patients or families via telehealth. Any support or information must be provided during a subsequent in-person visit, adding to the complexity and cost of care.

Barriers to multidisciplinary care: Effective VAD delivery often requires multidisciplinary collaboration. However, the prohibition of electronic communication severely limits real-time coordination between providers—such as between doctors, pharmacists, nurses, and social workers—compromising both efficiency and patient-centred care.

These constraints highlight the need for a pricing model that:

- Recognises the higher resource requirements in rural and remote settings;
- Supports flexible, patient-centred care models;
- Compensates for clinician travel and time;
- Accounts for the limited ability to use digital tools for communication and follow-up; and
- Reflects the complexities introduced by legislative barriers.

Without such considerations, the delivery of safe, equitable, and culturally appropriate VAD services in non-admitted settings—particularly outside metropolitan areas—will remain limited and unsustainable.

Impact of COVID-19

5. Are there any barriers to removing the remaining temporary measures introduced to manage the impact of COVID-19 for NEP26?

AdPha neither agrees nor disagrees with the removal of the remaining temporary measures, but highlights the importance of recognising the evolving landscape of medicines access and procurement. COVID-19 illustrated how quickly responsibilities and cost burdens can shift between funding levels.

A key example is the Federal Government's decision to cease procurement of COVID-19 medicines for the National Medical Stockpile. This shift transferred the financial responsibility for these high-cost medicines to state and territory hospital budgets,

placing significant pressure on pharmacy departments. In some jurisdictions, this has resulted in millions of dollars in additional annual drug expenditure, for example, case modelling at the time estimated approximately **$10 million** in added costs to hospital pharmacy budgets.

While IHACPA's Activity Based Funding (ABF) model does account for the cost of medicines within clinical episodes, **COVID-19 treatments remain high-cost** and often fall outside the PBS. These medicines can represent a substantial proportion of a patient's care episode cost and, without specific adjustments, may not be adequately captured in standard ABF mechanisms.

We recommend that any removal of temporary measures be accompanied by a review of how ABF accounts for high-cost, non-PBS medicines to ensure pricing remains fair, reflective, and sustainable at the service level.

Intensive Care Unit adjustment

6. **In cases where AR-DRG price weights account for ICU cost variations, should ICU costs be bundled?**

No comment.

Indigenous adjustment

7. **In addition to reviewing the interactions underpinning the calculation of the Indigenous adjustment, are there other technical refinements to the existing pricing models that could support high-quality, culturally appropriate care for First Nations peoples?**

First Nations Australians experience significantly poorer health outcomes compared to the broader population, with a burden of disease 2.3 times that of other Australians.[4] This disparity is exacerbated by **barriers to accessing medicines** and clinical pharmacy services, which are critical to managing chronic disease and supporting continuity of care. Strengthening equity in access to medicines requires a multifaceted approach that addresses systemic gaps and prioritises culturally safe, patient-centred care.

AdPha recommends technical refinements to pricing models to support equitable access to medicines for First Nations peoples, particularly during transitions of care. Gaps in access to medicines can contribute to **avoidable readmissions** and poorer health outcomes, especially when community-based services are not accessible, appropriate, or trusted.

For example, the inability to provide **Dose Administration Aids (DAAs)** upon discharge in some jurisdictions can create barriers to safe and effective medicines use. In many remote settings or where patients have no fixed address, hospitals are unable to refer patients to community pharmacies, and patients may not present due to geographical, cultural, or trust-based factors. In these cases, hospitals often serve as the primary,

trusted source of care, and pricing models should enable hospitals to continue this support where appropriate.

In jurisdictions like the Northern Territory, where over 26% of the population identifies as Indigenous, practical challenges such as **delays in medicine transport** to remote communities, the need for DAAs, and **complexities in medication supply under the S100 Remote Area Aboriginal Health Services (RAAHS) program** significantly impact medication continuity at discharge.

Hospitals frequently take on additional, unfunded roles, including preparing DAAs and extended supply to ensure patients safely return to care in their communities. This support is particularly critical given language barriers, high comorbidities, and a lack of trusted or accessible primary care services. Existing policies, such as the absence of Pharmaceutical Reform Agreements in key jurisdictions like NSW, further limit hospitals' ability to provide discharge medicines.

Refining pricing models to explicitly **support medicines access at discharge** and enable flexible, hospital-based supply where needed would improve cultural appropriateness, continuity of care, and health equity for First Nations peoples.

Other adjustments and their eligibility criteria

8. What principles and processes could guide model simplification in relation to IHACPA's adjustments and pricing models?

AdPha supports simplification efforts that maintain fairness and reflect the diverse service delivery contexts across jurisdictions. Simplified models must remain fit for purpose and ensure healthcare equity, particularly for states and territories with unique geographic and demographic challenges

For example, jurisdictions with smaller populations, such as WA and SA, may have a high proportion of services concentrated in capital cities, while Queensland's decentralised population creates additional complexity in delivering services such as emergency care, medicines supply, and telehealth. These variations directly impact cost structures and service accessibility.

AdPha would support a mid-term review process to ensure any model simplification remains responsive to such jurisdictional differences, and does not unintentionally disadvantage services operating in more complex or remote environments.

9. After accounting for current pricing model adjustments and block funding arrangements, what are some drivers of unmet cost variation in public hospital service delivery for people residing in rural and remote areas of Australia?

One key driver of unmet cost variation in rural and remote areas is the disparity in access to digital infrastructure, particularly Electronic Medical Records (EMRs) and telehealth capabilities.

Hospitals in these regions often face higher implementation and maintenance costs for EMR systems due to connectivity challenges, workforce limitations, and the need for tailored training and support. Similarly, the cost of establishing and sustaining telehealth services - essential for access to specialist care, is often higher due to limited broadband access, technology support, and local digital literacy barriers.

These additional costs are not always fully captured by existing pricing adjustments, contributing to ongoing service delivery gaps and limiting the ability of rural and remote hospitals to deliver care that is equivalent to metropolitan counterparts.

10. After accounting for current pricing model adjustments and block funding arrangements, what are some cost drivers that impact the ability of hospitals and local health networks to achieve economies of scale under the ABF model?

Several key cost drivers limit the ability of hospitals—particularly smaller and rural facilities—to achieve economies of scale under the Activity Based Funding (ABF) model. These challenges create inequities in access and sustainability, especially for high-cost, highly specialised therapies.

Major cost drivers include:

- **Rising costs of medicine supply and delivery:** The provision of therapies such as chemotherapy, CAR-T, and gene therapies involves significant overheads. These include the cost of advanced technologies, reconstitution equipment, sterile compounding environments, and highly trained staff. Many of these costs are fixed, meaning they are incurred regardless of whether a hospital prepares one or one hundred doses—making it harder for smaller facilities to operate efficiently.
- **Updated standards for compounding suites:** Recent changes to Australian standards for sterile compounding[5] have increased infrastructure and compliance costs for hospitals. Upgrading existing facilities or establishing new compliant suites represents a substantial investment, particularly for regional and rural hospitals that may not have the volume of patients to offset these fixed costs. Furthermore, AdPha will be publishing its *Standard of practice for pharmacy production services* in due course, replacing the *SHPA Guidelines for Medicines Prepared in Australian Hospital Pharmacy Departments (2010)* which will guide best practice medicines compounding practices in Australia.
- **Workforce and infrastructure requirements:** Delivering these complex therapies demands specialist pharmacists, technicians, and supporting infrastructure such as temperature-controlled storage and automated preparation systems. The maintenance of this capability is expensive and often not scalable in smaller sites.
- **Lack of scale adjustment in funding models:** Current ABF pricing models do not always adequately compensate for the loss of economies of scale in smaller or rural settings. As a result, some services are outsourced to private providers, which can introduce further inefficiencies, coordination challenges, and delays in care.

- **Equity of access:** Without appropriate scale-sensitive pricing adjustments, rural and remote hospitals may be unable to safely and sustainably deliver these services, forcing patients to travel to larger metropolitan hospitals. This exacerbates health inequities and increases out-of-pocket and system-level costs.

To address these challenges, ABF pricing models should incorporate refined adjustments that account for fixed overheads, compliance requirements, and diseconomies of scale faced by smaller services. This would support more equitable access to high-quality care across all settings while reducing reliance on outsourced, fragmented service models.

11. What, if any, evidence is there to suggest that the actual costs of care are not being accurately reflected in cost data collections and how can IHACPA support jurisdictions in reporting these?

There is growing evidence that the current cost data collections do not fully capture the true scope or cost of pharmacy clinical services in hospitals, as they often focus predominantly on the *supply* of medicines rather than the broader clinical activities pharmacists provide.

Key issues include:

- **Undervaluation of clinical pharmacy services**: Pharmacists increasingly provide direct patient care services including medication reconciliation, therapeutic drug monitoring, discharge planning, opioid stewardship, and collaborative prescribing. However, these activities are not consistently coded or reported as discrete, costed services in national datasets, leading to underrepresentation of their contribution and resource requirements.
- **Lack of coding for expanded scope**: As pharmacists take on expanded roles, including prescribing under collaborative models and managing outpatient clinics, the absence of dedicated activity codes means these services may be misattributed or overlooked in cost reporting. This creates gaps between the actual services delivered and the way costs are captured, which in turn affects funding adequacy and workforce planning.
- **Impact on service planning and investment**: Without accurate data reflecting the full cost and benefit of clinical pharmacy services, there is limited ability to benchmark, invest, or expand these roles effectively—despite growing evidence of their impact on patient safety, quality, and system efficiency.

To support improvement, AdPha suggests IHACPA:

- **Introduce or refine Tier 2 classifications** to better reflect pharmacy-led clinical activities, particularly in non-admitted and ambulatory settings.
- **Encourage jurisdictions to report expanded scope activities** under appropriate cost buckets or work with IHACPA to develop new ones that better align with

contemporary practice.

- **Support workforce and service mapping exercises** to help jurisdictions more accurately cost and record pharmacist-led models of care, including collaborative prescribing clinics.
- **Promote education and standardised guidance** for health services on how to code and cost expanded pharmacy services consistently across jurisdictions.

Addressing this gap is essential to ensure fair recognition of pharmacy's evolving role and to support equitable funding for services that contribute directly to patient care outcomes.

Supporting the pricing of mental health care

12. What, if any, further measures are required in NEP26 to support the second year of community mental health care services transitioning to ABF?

No comment

Harmonising price weights across settings

13. What, if any, clinical reasons are there for patients requiring chemotherapy, dialysis, interventional imaging or gastrointestinal endoscopy to be treated in an admitted versus non-admitted setting, and how could this be accounted for in a price harmonisation methodology?

While the clinical need may not always require hospital admission for services such as chemotherapy, dialysis, or interventional procedures, patients are often treated in an admitted setting due to administrative, funding, or logistical constraints, rather than medical necessity.

For example, a patient admitted for an unrelated condition may also be due for their next chemotherapy dose. However, under the current Pharmaceutical Reform Agreements (PRAs), Pharmaceutical Benefits Scheme (PBS) funding for chemotherapy is generally only available in non-admitted settings. If administered during admission, the cost must be absorbed by the state or hospital. This misalignment in funding creates inefficiencies and can discourage appropriate care delivery.

Further, recent restrictions on the initiation of certain high-cost PBS medicines in public hospitals have introduced additional access barriers. Even when the active chemotherapy agent is PBS-subsidised, associated costs—such as infusion fluids, excipients, and administration aids—often are not. This fragmentation complicates billing arrangements and may deter hospitals from providing full courses of treatment, particularly when hospital budgets are already stretched.

Without a comprehensive funding mechanism that captures the total cost of therapy—including both PBS and non-PBS components—patients can face significant inequities. These funding shortfalls may force hospitals to limit access to certain treatments based

on budget constraints, leading to postcode-dependent care availability.

To address this, price harmonisation methodology should:

- Recognise and **align funding** across both admitted and non-admitted settings;
- Account for **ancillary costs** not covered under the PBS;
- Support **flexible models** that reflect real-world treatment pathways (e.g. mixed PBS/non-PBS treatment episodes); and
- **Prevent cost-shifting** that drives inefficiencies or inequities in access.

Such an approach would help ensure that clinical decisions are driven by patient need rather than funding rules, and that equitable access is maintained regardless of setting or geography.

Review of block funding criteria and arrangements

14. What policy principles and considerations should guide IHACPA's workplan for the review of the various existing block funding criteria and arrangements?

No comment.

High cost, highly specialised therapies

15. As the current arrangements for high cost, highly specialised therapies have been in place since 2020, what, if any, refinements are required to ensure they remain fit-for-purpose?

16. What pricing considerations are pertinent for these and other high cost, highly specialised services?

Note: Both question 15 and 16 answered together below.

Since 2020, the delivery landscape for high-cost, highly specialised therapies has evolved significantly, revealing several areas where current funding and pricing arrangements are no longer fit-for-purpose.

Key issues include:

Gaps in funding for the full cost of treatment: While the active ingredients of some therapies (e.g. chemotherapy) are PBS-subsidised, essential components such as infusion fluids, excipients, and administration aids are not. This leaves hospitals to absorb these costs, despite their clinical necessity. The lack of a comprehensive funding mechanism that reflects the *true cost of therapy* leads to inequities in service delivery.

Inconsistencies under the PRAs: Access to PBS funding in public hospitals is often limited to non-admitted patients. When high-cost therapies are required during inpatient care—such as when a patient is hospitalised for another condition—the cost is shifted to the

state or hospital budget. This misalignment discourages flexible, patient-centred treatment and can result in delays or missed doses.

Infrastructure and workforce demands: Delivering high-cost therapies requires specialised infrastructure, cold-chain logistics, trained multidisciplinary teams, and digital support systems. Many hospitals, particularly in rural and remote areas, lack the infrastructure and funding to support this safely and sustainably. These hidden or indirect costs are not captured under current pricing models.

Geographic inequity: In some cases, patients must travel interstate to access certain high-cost therapies due to limited availability in their home jurisdiction. This imposes significant emotional, logistical, and financial burdens on patients and families, and highlights postcode-based disparities in access.

Refinements needed to ensure fit-for-purpose pricing models include:

- Developing an **integrated funding approach** that covers all components of therapy (PBS and non-PBS), including ancillary and supportive medicines.
- **Reviewing PRA arrangements** to ensure equitable access to PBS-subsidised medicines in both admitted and non-admitted settings.
- Incorporating the **real infrastructure and workforce costs** required to deliver highly specialised therapies safely.
- Embedding **equity considerations** into pricing to prevent access being dictated by geography or service capacity.

A modernised pricing framework that reflects the complexity and true cost of delivering high-cost, specialised care will better support equitable, sustainable access across Australia's hospital system.

17. Given high quality cost data is a key input to informing the NEP, how can IHACPA ensure the data received through the NHCDC continues to be accurate, robust and fit-for-purpose?

To ensure the NHCDC remains accurate and fit-for-purpose, IHACPA should clarify how pharmacy services—particularly clinical pharmacy activities—are currently captured in cost data and address known gaps. While medicine supply is typically recorded, expanded clinical roles such as medication reconciliation, therapeutic monitoring, discharge support, and pharmacist-led outpatient care are often underrepresented or inconsistently reported. This misalignment risks underfunding and limits the visibility of pharmacy's contribution to patient care. IHACPA should work with jurisdictions to improve data collection guidance, differentiate supply from clinical functions, and undertake targeted costing studies to better reflect the true cost and value of contemporary pharmacy services within the NEP.

18. What potential areas of refinement could IHACPA consider to support the future sustainability and predictability of public hospital costs and funding?

No comment.

19. What evidence, if any, is there to suggest that costs in categories such as labour and on-costs have increased since 2022–23 and will be reflected in future NHCDC cycles?

Since 2022–23, new enterprise bargaining agreements (EBAs) have been introduced with specific commitments to pharmacist-to-patient ratios, as outlined in AdPha's *Clinical Pharmacy Standards*.[1] These changes, along with the increasing complexity of medicines and patient care, have driven demand for a more specialised pharmacy workforce. This shift necessitates higher levels of expertise and justifies improved remuneration.

As a result, labour and on-costs for pharmacy services have increased and should be appropriately reflected in future NHCDC cycles. Further recognition through AdPha's Australian and New Zealand College of Advanced Pharmacy (ANZCAP) also highlights the growing trend towards advanced pharmacy practice roles.

20. What, if any, barriers are there to collecting EVC data submissions and how can IHACPA help jurisdictions to overcome these barriers?

No comment.

21. What are some further refinement areas for the EVC data request specifications?

No comment.

22. What, if any, are additional risk factors IHACPA should consider in the risk adjustment models for HACs and AHRs?

AdPha recommends IHACPA incorporate pharmacy-related risk factors in its risk adjustment models for Hospital Acquired Complications (HACs) and Avoidable Hospital Readmissions (AHRs) to better reflect the impact of medication safety on patient outcomes. Medication complication risks, including polypharmacy and high-risk medicines like anticoagulants and chemotherapy, are major drivers of readmissions and poor patient outcomes. Limited access to clinical pharmacy services such as medication reconciliation, discharge planning, and follow-up increases these risks, particularly in rural or socioeconomically disadvantaged areas.

Patient factors like health literacy and fragmented transitions of care further compound the problem. Hospital pharmacists are central to mitigating these risks and improving safety, as recognised in 12 of the 16 HAC information kits by the Australian Commission on Safety and Quality in Health Care.[3] The majority of suggested pharmacist quality improvement interventions include multidisciplinary collaboration and clinical risk assessment. Adequate funding for clinical pharmacy services is therefore essential to reducing preventable harm and supporting safer, more sustainable hospital care.

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