



Submission to:  
**Federal Budget  
2017-18**

The Society of Hospital Pharmacists of  
Australia

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## Introduction

In order to produce better health outcomes for Australians, and a greater return on Australia's health budget, The Society of Hospital Pharmacists of Australia (SHPA) believes that funding for medicines and pharmacy services should focus upon the achievement of health outcomes, rather than volumetric measures of prescription dispensing and delivery of services.

Funding medicines and pharmacy services is a substantial component of the federal health budget (\$4.5 billion through the Pharmaceutical Benefits Scheme alone). Silos of funding, divided between community and hospital services, provide few opportunities for the voices of expert practitioners in medicines management to outline efficiencies, innovations and improvements to the allocation of funding which would ensure expenditure results in the achievement of quality health outcomes. SHPA members are well aware of the pressures of health funding and believe that unnecessary duplication and poor integration of pharmacist services between hospital and community care contributes to this expense.

SHPA is taking the opportunity presented by the federal budget call for submissions to flag key areas of federal health policy where changes to budgeted funding could drive significant improvements in line with Australian federal government objectives.

In particular hospital pharmacists are keen to contribute to the achievement of core government policies such as Health Care Homes through better collaboration between hospital pharmacists and primary care services at times of patient transition. This is especially relevant for patients classified as Tier 2 and 3 whose level of complexity includes a high risk of acute care and emergency department admission. The inclusion of practice-based pharmacists in general practice, and revision of elements of Closing The Gap Pharmaceutical Benefits Scheme Co-payment Measure, would improve this provision of care.

Pharmacists are also keen to see reduced red-tape related to the funding of medicines and pharmacy services. Pharmacy, which dispenses medicines and provides clinical services to patients, has always been a complex area, however as use of federally-funded PBS medicines grow, the complications of adhering to funding requirements are becoming more onerous. Changes in the Community Pharmacy Agreement, negotiated between the federal government and the Pharmacy Guild of Australia, directs activities of private hospital-based services but also directly impacts public-hospital-based services. SHPA members oversee 20% of the federal government's PBS expenditure each year. As an illustration, there are 14 different factors which influence the PBS funding of a medicine for each patient, which must be reviewed and decided by a pharmacist for every prescription.

Hospital pharmacists are patient-centred advocates for clinical excellence and quality medicines management. SHPA is the national membership organisation for more than 4,000 pharmacists, associates and pharmacists in training working in Australia's public and private hospital system.

## Recommendations

### 1. Negotiation of future pharmacy remuneration

- 1.1 Include a range of stakeholders, including SHPA, in the negotiation of remuneration for pharmacy services where our members are strongly involved.
- 1.2 Remove the arbitrary cap of 20 services per month for the provision of Home Medicine Reviews conducted by accredited pharmacists in regional and rural areas for patients over 70 years of age, as funded through the Community Pharmacy Agreement.

### 2. Support pharmacy in primary health care

- 2.1 Fund pharmacists with relevant experience and accreditation to work in primary healthcare settings such as general practice through the Medicare Benefits Schedule, or the provision of funding incentives for General Practices.

### 3. Improve Indigenous access to pharmacy services

- 3.1 Review arrangements and eligibility criteria for the Closing The Gap Pharmaceutical Benefits Scheme Co-payment Measure and the Section 100 Remote Area Aboriginal Health Services Program to improve the delivery of medicines and pharmacy services to all Aboriginal and Torres Strait Islander patients being discharged from public hospitals.
- 3.2 Fund clinical pharmacist positions in Aboriginal Health Services to provide greater access to pharmacy services for Aboriginal and Torres Strait Islander consumers to enable pharmacists to effectively manage the provision of medicines, Quality Use of Medicines activities, to reduce medicine misadventure and achieve Closing The Gap objectives.

### 4. Fund innovation to improve care in pharmacy

- 4.1 Fund a pilot of a hospital-directed liaison service aligned with UK's New Medicines Service which saw an improvement in medicine adherence by 10%, to ensure that pharmacy continues to grow its services for the benefit of the health of the Australian community.
- 4.2 Fund a pilot program to test the effectiveness of enabling pharmacists to prescribe in hospital settings as part of a collaborative practice model.

### 5. Consider public hospital funding

- 5.1 Encourage New South Wales and the Australian Capital Territory jurisdictional governments to adopt the PBS Public Hospital Pharmaceutical Reforms remuneration model for outpatient medicines (including chemotherapy) in order to support better quality patient care and supply of 30 days of necessary medicines.
- 5.2 Provide an incentive for pharmacist services in Principal Referrer Hospitals to be offered after hours and on weekends in order to improve patient care.

## Policy discussion

### 1. Negotiation of future pharmacy remuneration

*1.1 Include a range of stakeholders, including SHPA, in the negotiation of the Pharmaceutical Benefits Scheme remuneration for pharmacy services where our members are strongly involved.*

In Australia pharmacy services have traditionally been divided into largely separate spheres of pharmacy activity: those within a community retail pharmacy; and those in institutional setting such as hospitals. However the remuneration of medicines and associated pharmacy services as delivered to outpatients and in clinics by hospital pharmacists is traditionally negotiated exclusively with The Pharmacy Guild of Australia, a membership organisation reflecting the interests of pharmacists who own community pharmacies. This is despite the fact that [twenty per cent of PBS expenditure](#) is managed by pharmacists in public or private hospitals. This statistic has risen steadily year on year and will continue as highly specialised and expensive medicines continue to be listed on the PBS while regular medicines (commonly dispensed by community pharmacies) will no longer attract government subsidy due to a combination of Price Disclosure policies and increased co-payments against CPI.

SHPA awaits the recommendations of the Pharmacy Remuneration Review in mid-2017 and welcomes greater involvement with the development of the remuneration framework for pharmacy. This would enable hospital pharmacists to advocate for savings related to reducing red-tape associated with the cumbersome funding of medicines and the inefficient funding of pharmacy services in the community. This is discussed in more detail in our [submission to the Pharmacy Remuneration and Regulation Review](#).

*1.2 Remove the 20 person cap on the provision of funding for Home Medicine Reviews in regional and rural areas for patients over 70 years of age, as funded through the Community Pharmacy Agreement.*

Introduction of funding for the Home Medicines Review Program (HMR) in 2001 through the Community Pharmacy Agreement recognised the value of pharmacist conducted reviews of medicines in collaboration with GPs in reducing misadventure and subsequent patient harm as demonstrated by [230,000 medicine-related hospital admissions each year](#). Research conducted at a major hospital network in metropolitan Melbourne demonstrated that [pharmacist-led medication reviews reduced the prevalence of unplanned hospital admissions](#) and presentations to the emergency department.

SHPA believes HMRs have potential to play a valuable role in improving health outcomes for a population that has [higher health needs and poorer health outcomes than their metropolitan counterparts](#), however access to HMRs remains a significant barrier.

Since early 2013, to rein in a projected overspend for the HMR Program which represented less than 0.5% of the entire Fifth Community Pharmacy Agreement budget, an arbitrary cap was introduced across the board limiting the number of HMRs an accredited pharmacist can conduct per month due to concerns about excessive claims in metropolitan areas.

SHPA believes this cap is having a significantly negative impact on people living in regional and rural areas and should be removed. In rural and regional Australia there is a poor ratio of HMR accredited pharmacists and typically multiple general practitioners often refer eligible patients to a single accredited pharmacist. There is also a larger proportion of high risk patients due to the demographics of older populations in regional areas. However once the accredited pharmacist in a regional centre has conducted 20 reviews they must put all others off. As medicine misuse and adverse effects from medicines uses becomes increasingly risky for patients over time, this delay can be costly.

In addition many areas have no local accredited pharmacist so they must organise for one to visit which the cap reduces incentive. Frequently there is excessive demand for reviews as well as substantial physical distance to be travelled. Greater flexibility in travel costs, in volume of reviews and in mode of delivery such as telehealth, could all make a key contribution to improving the health outcomes of rural Australians.

## **2. Support pharmacy in primary health care**

*2.1 Fund pharmacists with relevant experience and accreditation to work in primary health care settings such as general practice through the Medicare Benefits Schedule, or the provision of funding incentives for general practices.*

SHPA supports increased utilisation of pharmacists in primary health care in settings such as general practice. Analysis by [Deloitte Access Economics](#) stated that each dollar invested in integrating a non-dispensing pharmacist into general practice clinics could return \$1.56. This positive finding aligns with developing best practice internationally which has seen the incorporation of pharmacists in the UK, USA, New Zealand and Canada and supports the successful implementation of the Health Care Home program which focuses on coordinated comprehensive care.

In general practice settings, [experienced pharmacists can provide a range of cognitive services](#) that support treatment for chronic diseases; review medications; monitor medicine-related side effects, especially relevant for mental health medicines which impact negatively on physical health; and provide additional patient counselling for people taking new medicines or with special needs. Due to the highly clinical nature of pharmacist consults in primary health care, SHPA believes accreditation would be beneficial for pharmacists intending to be employed in general practice.

## **3. Improve Indigenous access to pharmacy services**

*3.1 Review funding for the Closing The Gap Pharmaceutical Benefits Scheme Measure (the Measure) to improve the delivery of medicines and pharmacy services to all Aboriginal and Torres Strait Islander patients being discharged from public hospitals.*

Since they were implemented in 2010 the Measure and RAAHS s100 program have significantly improved the access of Aboriginal and Torres Strait Islander people to medicines and pharmacy services. However, despite their admirable aims, as both the CTG and the RAAHS programs are limited by location, they do not adequately cover the needs of contemporary Australian communities. Substantial gaps still remain around the access of people away from home whether visiting family in a regional town or receiving treatment for

serious illness in a metropolitan hospital. In these common situations Aboriginal and Torres Strait Islander people are subject to typical hospital pharmacy service delivery which limits the provision of essential medicines on discharge, even though the CTG Measure recognise that this group do require special access. Revising elements of the CTG Measure to increase access to medicines for Aboriginal and Torres Strait Islander people regardless of their location would ensure greater achievement of the public health aim. These could include:

- Enable hospitals discharging patients registered as Closing The Gap patients to access the Closing The Gap funding necessary to provide a complete medication supply and Dose Administration Aids as required.
- Revise registration of patients for Closing The Gap PBS co-payment measure, to also include patients typically accessing medicines through Remote Area Aboriginal Health Services, to enable consistent and adequate medicine supply at times of hospital discharge.
- Revise the prescriber categories for Closing The Gap prescriptions to include both Remote Area Aboriginal Health Services and hospitals to enable provision of key medicines to Aboriginal and Torres Strait Islander patients regardless of setting.
- Add the provision of Dose Administration Aids to the list of medicines funded through Closing The Gap and s100 remuneration programs to improve the safe adherence of medicines by patients at high risk of medicines misadventure.

*3.2 Fund clinical pharmacist positions in Aboriginal Health Services to provide greater provision of pharmacy services to Aboriginal and Torres Strait Islander consumers to enable pharmacists to effectively manage the provision of medicines, Quality Use of Medicines activities, to reduce medicine misadventure and achieve Closing the Gap objectives.*

Access to pharmacy services remains a challenge for people living in regional and remote areas. Data from the Australian Institute of Health and Welfare (AIHW) illustrates that access to the [pharmacy workforce is poor in very remote and outer regional areas](#), and proximity to a pharmacy is inversely related to a patient's remoteness. For Aboriginal and Torres Strait Islander people this situation is exacerbated by higher rates of chronic conditions and multiple comorbidities, resulting in more complex medication needs compared to the general population. This means that clinical pharmacy skills in medicines management including counselling and patient education, medication reviews and collaboration with the broader healthcare team are potentially even more valuable. SHPA supports an increase of funding for Aboriginal Health Services to enable greater employment of pharmacists, either through hospital liaison roles or in community, to provide expert medicine dispensing, patient counselling and medicines review for Aboriginal and Torres Strait Islander communities.

#### 4. Fund innovation in pharmacy

*4.1 Fund a pilot of a hospital-directed liaison service aligned with UK's [New Medicines Service](#) which saw an improvement in medicine adherence by 10%, to ensure that pharmacy continues to grow its services for the benefit of the health of the Australian community.*

As the burden of chronic disease grows the need for personalised and timely medicines management services increases. Self-management of medicines is key to prevention of complex and costly flare-ups of chronic conditions, and to reduce the risk of medicines misadventure for people taking courses of chemotherapy medicines. A New Medicines Support Service would identify people diagnosed with flagged conditions beginning a new medicine as they are discharged from hospital for either a face-to-face or telehealth consultation.

*4.2 Fund a pilot program to test the effectiveness of enabling pharmacists to prescribe in hospital settings as part of a collaborative practice model.*

Substantial evidence has demonstrated that non-medical prescribing by pharmacists and nurses for acute and chronic disease management can be an asset for patient care, and of [equal quality and safety as medical prescribing](#). Particularly SHPA is keen to see pharmacists able to prescribe medicines as part of their existing bedside clinical duties in a hospital setting. In a hospital setting non-medical prescribers have convenient access to medical support to facilitate a collaborative practice model. This approach is supported by the then Health Workforce Australia's [Health Professionals Prescribing Pathway](#) model of collaborative prescribing and the [National Prescribing Service's Prescribing Competencies Framework](#) which is adaptable for all health professionals.

#### 5. Consider public hospital funding

*5.1 Encourage New South Wales and the Australian Capital Territory jurisdictional governments to adopt the PBS Public Hospital Pharmaceutical Reforms remuneration model for discharge and outpatient medicines (including chemotherapy) in order to support better quality patient care and supply of 30 days of necessary medicines.*

Feedback from New South Wales and Australian Capital Territory SHPA members, including directors of pharmacy, has indicated ongoing concern at the detrimental effect and inherent risks of rehospitalisation for patients. This is due to poor transitions-of-care arrangements after serious health episodes in New South Wales and the Australian Capital Territory due to their public hospitals' continued exclusion from the Pharmaceutical Benefits Scheme.

Since the adoption of the PBS Public Hospital Pharmaceutical Reforms in all other states and territories in the last decade, public hospital patients receiving care as an outpatient, including chemotherapy, are able to access their medicines free of charge at their hospital. Patients being discharged from public hospitals are also able to access one-month supply of PBS medicines subsidised by the federal government. This ensures a consistent standard of care for vulnerable people, and reduces the need for individuals to immediately seek an appointment with their general practitioner on discharge from hospital.

Despite recent moves by the NSW Government which prevent some charges being issued, access to medicines for Australians not living in participating states/territories remains a

challenge, with 7-day supply and invoices a common occurrence. SHPA feels strongly that our NSW and ACT patients would receive safer, better quality care, if the NSW and ACT jurisdictional governments made signing up to the PBS Reforms a priority. Therefore we encourage the federal government to make all efforts to enable this to occur.

*5.2 Provide an incentive for pharmacist services in Principal Referral Hospitals to be offered after hours and on weekends in order to improve patient care*

Internationally, [providing extended weekend and after hours pharmacy services to patients in major hospitals](#) has increasingly been recognised as routine practice to improve the quality and safety of patient care. Research [internationally](#) and [locally](#) indicates that patient mortality is higher over weekends, where there is reduced clinical services compared to traditional business hours. In some smaller hospital in rural areas, great effort has gone into utilising technology (internet and automation) to ensure round the clock access to pharmacy services to [maximise patient safety](#).

A [major Australian hospital-based study](#) found that for every dollar spent on a clinical pharmacist to initiate changes in medicines therapy or management, approximately \$23 was saved on length of stay, readmission probability, medicines, medical procedures and laboratory monitoring. Supporting hospital pharmacies to transition to extended-hours clinical services (including after hours and at weekend) would enable hospital pharmacists to achieve the principles espoused in [SHPA's Standards of Practice for Clinical Pharmacy Services](#).

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