31 October 2016

Independent Hospital Pricing Authority
Level 6, 1 Oxford Street
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submissions.ihpa@ihpa.gov.au

RE: Pricing Framework for Australian Public Hospital Services 2017-18

For nearly 80 years The Society of Hospital Pharmacists of Australia (SHPA) has represented and advocated for pharmacists working in hospitals and other healthcare settings in relation to ensuring the best possible care for patients.

Hospital pharmacists operate at the highest levels of pharmacy and healthcare, and represent the greatest expertise in the design and development of professional pharmacy services to support positive patient health outcomes. Therefore SHPA is pleased to have the opportunity to be part of the consultation process for the development of the Pricing Framework for Australian Public Hospital Services 2017-2018.

SHPA members lead the Pharmacy Departments at all 30 of the principal referral hospitals in Australia, as well as the vast majority of both Public Acute A and Public Acute B hospitals. Furthermore, 75% of all hospitals (public and private) have their Pharmacy Departments led by a SHPA member. SHPA members are also employed in a range of innovative outreach and liaison services in community healthcare settings.

SHPA is committed to facilitating the safe and effective use of medicines, which is the core business of pharmacists, especially in hospitals. We support pharmacists to meet medication and related service needs, so that both optimal health outcomes and economic objectives are achieved for individuals, for the community as a whole and for healthcare facilities within our systems of healthcare.

Thank you for the opportunity to provide this submission. Please find our responses to key questions in your consultation paper following. If further information from SHPA would be beneficial please do not hesitate to contact us on (03) 9486 0177.

Yours sincerely,

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Kristin Michaels
Chief Executive Officer

4. Classifications used by IHPA to describe public hospital services

What additional areas should IHPA consider in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?

IHPA should consider including the following additional areas that affect pharmacy care:

Standardised Mini-Mental State Examination
SHPA supports continued work and data collection for incorporating the Standardised Mini-Mental State Examination as a tool for costing geriatric evaluation and management services, as differing levels of cognitive impairment in patients affects the nature of care provided, and is a significant cost-driver in delivering these services.

Non-Admitted Multi-Disciplinary Case Conferences
SHPA appreciates and supports the continuing work undertaken with jurisdictions to price non-admitted multidisciplinary case conferences where the patient is not present for future iterations of the NEP.

Shared care arrangements with community pharmacies for patients taking S100 medicines
SHPA believes IHPA should also consider classifying, costing and pricing subacute and non-acute hospital services for outpatients in Tier 2 Non-Admitted Services such as shared care arrangements for the supply of clozapine, HIV antiretrovirals and other Section 100 medicines, in partnership with community pharmacies. In these scenarios, where it is not practical for patients to visit a hospital to access their medicines and receive pharmacy services, hospital pharmacies establish shared care arrangements with the patient's local community pharmacy. This is beneficial for patients so that their medicines procured from the hospital pharmacy can be supplied in a timely and convenient manner via the patient's preferred community pharmacy, with the provision of the pharmacy service (screening for appropriateness of therapy and patient counselling) undertaken by the hospital pharmacist.

6. The National Efficient Price for Activity Based Funded Public Hospital Services

What are the priority areas for IHPA to consider when evaluating adjustments to NEP17? What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

In alignment with previous submissions to IHPA on the National Efficient Price and other related Activity Based Funding policy consultations, SHPA recommends that the following priority areas be considered:

Patient obesity
Giving greater consideration to the impact of obesity (such as: obese class 2 or 3 i.e. BMI > 35) on the cost of care and length of stay. There are additional costs for these patients such as the need for reinforced / different wheelchairs, beds, imaging machines (some patients need to be scanned at veterinary facilities), theatre and morgue facilities etc. as well as increased costs associated with the complexity of treating patients where 'normal' treatment guidelines are inappropriate or insufficient. For example, it may take a longer period of time and at a greater cost to monitor and achieve the effective dose of a new medicine; or much higher doses of an existing medicine may be required. SHPA notes that the new *Australian Obesity Management Algorithm* has been released jointly by the Australian Diabetes Society, Obesity Surgery Society of ANZ and the ANZ Obesity Society.

Benefit of 'follow up' services
Introduction of a 'follow-up' service in Tier 2 Non-Admitted services that complements 40.04 Clinical Pharmacy for shorter pharmacy consultations that require regular follow-up / review i.e. smoking cessation clinics, anticoagulation dosing clinics, chemotherapy management. A 2011 study conducted at The Alfred Hospital found that pharmacist intervention improved the ability of heart failure patients to self-adjust their diuretic dose by using a flexible dosing regimen based on weight, resulting in quality of life improvement and significantly decreased hospital readmissions due to fluid overload, a common event for heart failure patients[1].

Cost of inpatient medicines
SHPA is cognisant that there is great complexity in accurately costing inpatient medicine use. Pricing according to Diagnosis-Related Groups reflect the cost of medicines and treatments provided to patients for the specific disease/condition, but the cost of the patient's other regular medicines, also supplied to inpatients, is not captured. These significantly contribute to the overall expenditure of $2.7 billion[2] on pharmaceuticals for admitted hospital patients. Consideration should be given to recognise this by price weight adjustments according to patient's age and/or comorbidities

8. Treatment of other Commonwealth Programs

SHPA notes that IHPA has declared no intention to change the treatment of pharmaceutical programs funded by the Commonwealth for NEP17. However, SHPA would like to register its concern that gaps continue to exist in the funding of these programs which have not been addressed.

SHPA agrees that where the cost of medicines described in this section are covered by Commonwealth programs, it is appropriate for IHPA to discount the funding already provided. However, this funding only covers the cost of the medicine, and that there are other associated costs related to the procurement, storage, preparation and administration that are not commensurately captured.

It is important to note that while Section 94 hospital pharmacies who supply medicines under *Pharmaceutical Reform Agreements – Pharmaceutical Benefits Scheme Access Program* attract the 11.1% wholesaler mark-up, medicines supplied under the various Section 100 programs do not attract any mark-up, despite the cost and usage of Section 100 medicines increasing from $208 million in 2005-06 to $2.1 billion in 2014-15[3].

This is particularly pertinent with Section 100 medicines which tend to be complex and specialised medicines that have significant storage requirements, as well as short shelf lives once compounded. SHPA believes that the inherent financial risk of storage, preparation and potential wastage (due to change of therapy etc) should be acknowledged in the pricing

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[1] Korajkic A, Poole SG, MacFarlane LM, Bergin PJ, Dooley MJ. Impact of a pharmacist intervention on ambulatory patients with heart failure: A randomised controlled study. Journal of Pharmacy Practice and Research 2011; 41:126-131
[2] Australian Institute of Health and Welfare 2012. Australia's health 2012. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW.
[3] Department of Health 2016. *Pharmaceutical Benefits Scheme (PBS)* | *PBS Statistics*. [online] Pbs.gov.au. Available at: https://www.pbs.gov.au/info/browse/statistics [Accessed 31 Oct. 2016].

model. SHPA also believes that more broadly, pharmacy infrastructure costs (sterile manufacturing facilities, cytotoxic drug safety cabinets, automated medication dispensing systems etc) should be costed and considered in the same vein of other hospital infrastructure such as operating suites.

NSW and ACT are not signatories to the *Pharmaceutical Reform Agreements – Pharmaceutical Benefits Scheme Access Program* and hence the cost of medicines for patients on discharge and some outpatient settings are borne by the hospital. As such, this could result in aberrations and potentially anomalies in the data collected by the National Hospital Cost Data Collection and lead to inaccurate costing of pharmacy services when data is evaluated at a national and aggregate level.

At present, the federal government is also conducting a wide-ranging Review of Pharmacy Remuneration and Regulation which is examining how pharmacy services and the supply of medicines is remunerated in both the acute and ambulatory settings. The outcomes of this review can potentially alter the cost, scope and provision of pharmacy services and thus affect how pharmacy services and medicines are costed. In SHPA's submission to the Australian Government's Review of Pharmacy Remuneration and Regulation, SHPA stated that we believe consumer need should be the central driver for all medicine funding and pharmacy services, regardless of the care setting.

11. Pricing and funding for safety and quality

Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?

Yes. SHPA would like to highlight that Version 2 of the Australian Commission on Safety and Quality in Health Care's *National Safety and Quality Health Service Standards* will be released in late 2017, which has potential to affect the cost of safety and quality activities as hospitals evaluate and transition to the new standards.

What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?

SHPA supports IHPA developing a risk adjustment methodology to which considers different patient complexity levels or specialisations across various jurisdictions and hospitals. Medicine specific factors that should be considered are:

- Cost of storage, preparation and administration of high cost medicines or medicines with special requirements
- Specialist hospitals in oncology, paediatrics and women's health generally bear the risk of carrying more expensive and specialised medicine, and also carry a higher inherent risk of wastage of said medicine due to the short shelf-life of these medicines and the criticality of timely preparation and administration

Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding for safety and quality?

SHPA supports the use of these assessment criteria.

11.5 Sentinel Events

Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?

SHPA does not believe that hospitals should be penalised for events that are not preventable and therefore does not support not funding sentinel events unless it was proven that the hospital was fundamentally not compliant with relevant regulations. Greater detail regarding the impact and implementation would be needed before SHPA would support the proposal.

Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?

SHPA supports the proposal to include a sentinel events flag, however the implementation of how it is used for funding purposes requires more detail before it can be explicitly supported.

11.6 Hospital Acquired Complications

What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC?

While in principle it is logical that assessment of DRG, and subsequently funding, should not be increased by iatrogenic harm, this option may create issues around potential under-reporting or misreporting of HACs if there are potential negative implications for funding of the relevant hospital. IHPA may wish to consider how it would audit the reporting of HAC's at the hospital level to ensure that any under-reporting could be captured.

SHPA requests that the Joint Working Party of IHPA and the Australian Commission on Safety and Quality in Healthcare seek hospital pharmacist representation on any subgroup or working party tasked to further define medication related HACs and the approach to pricing acute admitted episodes with a HAC. SHPA is willing to put forward suitable nominees.

Do you agree with IHPA's assessment of this option? What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates?

SHPA agrees that it is important to measure and benchmark HACs on the hospital level to identify trends and where improvements can be made, and potentially reveal systemic issues. The complexity of this option would be how to compare and stratify hospitals to reflect the inherent differences population samples, case mixes and resources available. Whilst stratification of hospitals within peer groups and peer sub-groups is logical, it would also be a challenge for IHPA to determine the 'acceptability' rate of HACs for hospitals.

Option 2 also suggests that funding reductions could occur for hospitals that exceed a specified HAC rate. While well-intentioned, this could potentially encourage under-reporting or misreporting of HACs. Furthermore, high incidence of HACs may be related to lack of funding and resources, which funding reductions from IHPA could potentially exacerbate the issue. Therefore SHPA is concerned about the implications of this option.

Do you agree with IHPA's assessment of this option? What are the advantages and disadvantages of the approaches to risk adjustment? What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties?

SHPA has similar concerns on Option 3 as Option 2. Despite funding incentives provided to hospitals and jurisdictions that perform well with low HAC rates, high incidence of HACs may be related to lack of funding and resources, which funding reductions from IHPA could potentially exacerbate. IHPA may wish to consider how consistently poor performing

hospitals may be recognised and supported to improve HAC rates within the incentive program.

Do you agree with IHPA's assessment of this option? Are there any other pricing or funding options that IHPA should consider in relation to HACs?

The option chosen by IHPA should adequately incentivise hospitals to proactively monitor and report HAC rates, as well as encourage the implementation of strategies to reduce their incidence. IHPA should consider how funding policies can also be used to help the poorest performing hospitals to improve their performance. The risk of financial penalties can lead to perverse incentives and entrench poor performance in poorly resourced hospitals.

SHPA also believes that IHPA should give consideration to the notion that not all HACs are preventable when deciding which diagnoses will be determined as a HAC, and assessing its preventability. SHPA supports the development of expert working groups to further define the HACs list and determine the process of pricing or funding according to predicted preventability. SHPA requests that hospital pharmacists are included amongst the membership of the expert working groups.

11.7 Avoidable hospital readmissions

What approach is supported for setting timeframes within which avoidable hospital readmissions are measured?

SHPA appreciates that it would be useful to have timeframes for which avoidable hospital readmissions are measured, however a one-size-fits-all approach would not accurately portray the multitude of reasons why a hospital readmission may occur. SHPA believes it is appropriate to have different readmission timeframes that account for different conditions and patient-related factors.

For example, medicine-related hospital readmissions can take as little as 12 hours (i.e. unintended warfarin overdose) or over the course of a few months (i.e. medicine-induced nephrotoxicity)

A literature review into medication safety in Australia found that there are 230,000 medicine-related hospital admissions annually, representing 2-3% of all hospital admissions[4]. The review considered literature with readmission timeframes from as little as 5 days up to 90 days. There is also emerging evidence that suggests that shorter readmission timeframes may be better indicators of quality, as the longer the readmission timeframes, the larger the influence of community-based factors have in contributing to readmission.

Due to the number of medication related hospital admissions SHPA requests that IHPA and the ACSQHC include expert hospital pharmacist(s) in working groups tasked with progressing pricing for avoidable hospital readmissions.

Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes?

SHPA is not aware of evidence relating to condition specific readmission timeframes. However, significant evidence exists relating to patient-specific, patient-group-specific, and medicine-specific risk factors increasing risk of medicines related readmission. These are

[4]Australian Commission on Safety and Quality in Health Care 2013, Literature Review: Medication Safety in Australia. ACSQHC: Sydney

captured in the SHPA Fact Sheet 'Risk factors for medication-related problems' and Standards of Practice for Clinical Pharmacy Services[5].

Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN?

Yes, SHPA believes pricing and funding models should be based on avoidable hospital readmissions within the same LHN. The discussion paper raises a salient point in that patients can have a readmissions but to another hospital within the same LHN. This is particularly important given that 20-30%[6] of admissions in patients aged 65 or over are medication-related, and this population are often discharged from general hospitals but be readmitted into hospitals specialising in aged care and rehabilitation which can be misrecorded as a new admission.

When should a pricing and funding approach for avoidable readmissions be implemented?

A pricing and funding approach for avoidable readmissions should be implemented on when an evidence-based, qualitative and quantitative pricing and funding approach is developed and consulted on and agreed to by all major stakeholders.

11.8 Implementing a pricing and funding approach

What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?

It is important that pricing and funding approaches for safety and quality ensure that the objectives outlined in the Australian Charter of Healthcare Rights, the National Safety and Quality Health Service (NSQHS) Standards, the SHPA Standards of Practice for Clinical Pharmacy Services and the various standards from the Australian Commission on Safety and Quality in Health Care (ACSQHC) can be achieved.

Do you agree that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models?

SHPA agrees that the impact of new measures would need to be back-casted.

[5] SHPA 2013. Standards of Practice for Clinical Pharmacy Services. Journal of Pharmacy Practice and Research. Vol 43. Supplement.
[6] Australian Commission on Safety and Quality in Health Care 2013, Literature Review: Medication Safety in Australia. ACSQHC: Sydney