Australian
Private Hospitals
Association

# Review of the National Medicines Policy (NMP)

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Australian Private Hospitals Association ABN 82 008 623 809

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# Executive summary

APHA welcomes the opportunity to contribute to the Review of the National Medicines Policy (NMP). Hospital based pharmacy in the private sector is dependent for its income on the Pharmaceutical Benefits Scheme (PBS). With the ageing of the population and the increased incidence of chronic conditions, the services provided by private hospitals are becoming more and more complex. This complexity is seen in the incidence of poly-pharmacy and medication related complications. At the same time medications are becoming more and more complex.

APHA supports the objectives and the principles of the policy. To enable a refresh of the NMP, APHA recommends:

- Inclusion within the first principle a strong focus on addressing security of supply.
- The addition of a fifth principle “ensuring a skilled and informed workforce”.
- The definition of medicines takes account of a broader definition of medicines and associated technologies and recognise the widening contexts of care, therapies and models provided by private hospitals and other health care providers. Further work should be undertaken to develop more comprehensive mechanisms for stakeholder engagement.
- The NMP recognise that treatment options are rapidly evolving. Interoperability and cooperation between hospital, pharmacy and ambulatory/community-based settings is becoming more and more important in improving medication management for both clinicians and consumers.
- The NMP promote nationally consistent reporting arrangements while at the same time providing flexible opportunities for the full range of health service providers, large and small, to be involved.

# Comments on the NMP Review Terms of Reference (ToRs)

## ToR 1: Evaluate the current NMP objectives and determine whether these should be modified or additional objectives included. This includes consideration of the proposed Principles to be included within the NMP.

APHA supports the four principles and advocates the addition of a fifth principle "ensuring a skilled and informed workforce".

The first principle should also include a strong emphasis on ensuring security in supply.

### Security of Supply

Under the first principle, APHA advocates that greater emphasis be paid to security of supply. The COVID-19 pandemic and other disruptions to international supply chains in 2020/21 highlighted how vulnerable Australia is to shortages in medicines supply. While the TGA has implemented processes to respond to shortages as they emerge there are additional measures that could be taken.

There needs to be recognition within funding arrangements that shortages in supply impose additional costs on health care providers, and private hospitals in particular:

- Funding models need to recognise the additional costs involved in managing medication shortages, sourcing alternative suppliers and paying a premium to suppliers in order to provide urgently required medications.
- Shortages in supply also force pharmacies to hold higher levels of inventory than would otherwise be the case including inventory that require specialised handling and storage.
- Wastage costs must also be taken into account when inventory is held past its expiry date.

### Ensuring a Skilled and Informed Workforce

This additional fifth principle needs to encompass:

- Recognition of the clinical role of the pharmacist across a variety of health care settings – hospital, community and aged care.
- Recognition of the role of pharmacists within interdisciplinary team-based care.
- Workforce planning to ensure an adequate workforce supply and availability of training and professional development opportunities to support the NMP.
- Making sure that all clinicians are aware of the policy and understand the implications of the NMP.

***The Clinical of Role of Pharmacists***

With the ageing of the population and the increased incidence of chronic conditions, the services provided by private hospitals are becoming more and more complex. This complexity is seen in the incidence of poly-pharmacy and medication related complications. At the same time medications are becoming more and more complex.

In this context the clinical role of the pharmacist is becoming more and more important. Pharmacists can identify errors or contra-indications in medication charts. They can raise considerations of which the treating doctor may be unaware.

Pharmacists within hospitals are becoming increasingly specialised particularly in the areas of:

- Oncology – private hospitals provide a third of all chemotherapy services.
- Cardiology – private hospitals provide around half of all cardio-vascular procedures.
- Intensive care – private hospitals provide 35 percent of all intensive care beds.
- Psychiatry – private hospitals provide 45 percent of all acute adult general psychiatric beds and every year treat more than 40,000 people living with a serious psychiatric condition.

Within a hospital environment, the judicious use of pharmaceuticals is critical for patient safety and for avoidance of waste.

There are many specific services that are provided by pharmacists. With the right incentives and funding models, these could be provided on a wider and more consistent basis. Although all patients discharged from hospital are supposed to receive a discharge summary, only one in five discharge summaries is provided in a timely manner. Furthermore, 3 in 5 hospital discharge summaries where pharmacists are not involved in their preparation have at least one medication error.[1]

***Workforce planning***

The NMP should include consideration of workforce planning to ensure that there is an adequate and appropriately skilled workforce in place to fulfil the goals of the policy.

Pharmacy has been included as an area of national skill shortage for some time. Workforce projections and provisioning for future workforce training need to take account of the impact of COVID-19 on workforce demands, skilled migration and the attraction of international students to Australia in both the immediate and longer term.

[1] https://www.psa.org.au/wp-content/uploads/2019/01/PSA-Medicine-Safety-Report.pdf

***Making sure that all clinicians are aware***
Recognising that contemporary care models are interdisciplinary, it is important that all clinicians are aware of the NMP and understand its implications for their practice and responsibilities.

## ToR 2: Consider the definition of medicines and whether the NMP needs to be expanded to include health technologies.

APHA agrees in principle to ToR2. The definition of medicine should take account of a broader definition of medicines and associated technologies. It is important to recognise the emergence of hybrid technologies that combine pharmaceuticals with other technologies. These hybrid technologies widen the scope of issues which must be addressed in ensuring medication safety. It is also important to recognise the widening contexts of care, therapies and models provided by the private hospitals and other health care providers. Further work should be undertaken to support this widened scope by developing more comprehensive mechanisms for stakeholder engagement.

## ToR 3: Assess the NMP's utility in the context of rapidly evolving treatments options, population changes, interconnected relationships and system-wide capacities.

The NMP needs to recognise that treatment options are rapidly evolving. In particular, treatments that were once only available to admitted in-patients can now be provided in a variety of settings including "hospital-in-the-home". These new settings present new challenges:

- Specific safety protocols.
- Use of remote monitoring, self-administration and other technologies.
- Team based models of care and closer collaboration between hospitals, other health service providers, aged care and community care services, consumers and carers.

Regulatory arrangements and system infrastructure need to support these new more flexible arrangements while at the same time ensuring strong clinical governance. Examples of areas for further improvement are detailed below.

***PBS Authority processes***
Some authority processes have been streamlined but this work needs to continue. Authority processes need to be integrated with electronic systems and hospital medication charts. Arrangements for Complex Authority Required Highly Specialised Drugs (CAR HSD) also need to be streamlined.

***Support for MyHealth Record***
MyHealth Record could potentially assist pharmacists and clinicians by providing ready access to medication summaries, prescription records, allergies and contraindications. While significant progress has been made in this regard there is still further work to be done.

Although registration to access MyHealth Record is well established across many pharmacies, registration amongst private hospitals and specialists continues to lag. As at 30 June 2020, 67% of private hospitals and 16% of day hospitals were registered for the My Health Record system, with 53% and 5% respectively actively using the My Health Record system. [2]

***Interoperability***

Interoperability between hospital, pharmacy and community is a goal that has considerable advantages to offer in improving medication management for both clinicians and consumers. However, it is not a goal that is attainable using current infrastructure. Investment and closer collaboration will be required across both government and non-government sectors.

## ToR4: Consider the centricity of the consumer within the NMP and whether it captures the diversity of consumers' needs and expectations.

To achieve ToR 4, patient centric continuity of care must be ensured. There are a number of areas where additional reform will be needed to achieve this goal.

***Access to expert advice from a pharmacist***

Consumers depend on a multiplicity of services and professions to provide them with the care and support they need.

Under current PBS funding arrangements, pharmacists working in the private hospital sector must strictly ration their time with the result that only the most complex patients receive the opportunity to directly interact with a clinical pharmacist. As a result many opportunities are missed to identify and respond to potential risks, provide education and support medication compliance.

As pharmacy becomes more specialised there may be occasions when the consumer needs access to specialist pharmacy expertise which may be difficult to find outside a hospital setting.

***Script transferability***

Complex distinctions between types of script and the circumstances/places in which they can be dispensed create complexity and inconvenience to patients. There may even be patient safety concerns if consumers cannot access medications promptly.

Consumers need to be able to access medications without having to contend with unnecessary administrative barriers.

[2] https://www.myhealthrecord.gov.au/about/who-is-using-digital-health/private-hospitals-using-my-health-record-system

***Continuity of care - ability for hospital pharmacies to dispense to non-patients***
True continuity of care should mean that patients have access to the appropriate support and expertise as they move between care settings. Too often there is an abrupt disconnect between the care patients receive during a hospital admission and the care they receive post-discharge.

While in hospital patients are likely to experience changes to their medications – changes which may be complex to understand. They may receive specialised medications while in hospital and they will likely be required to follow specific regimens post-discharge. Currently the expertise and support available during a hospital admission is no longer available to the patient post-discharge. This sharp distinction exposes the consumer to a multitude of risks:

- Timely, accurate and comprehensive exchange of information between the hospital and primary sector services may not take place.
- The consumer may not be able to easily access primary care services.
- Primary care services may not necessarily have the expertise or background information needed to address complications that arise.

Changes in technology mean that it is often possible to discharge patients more quickly or facilitate their on-going treatment in the home. Sometimes patients require a sequence of admissions – eg cancer patients receiving chemotherapy or patients receiving rehabilitation. For such patients it may be both more convenient and more clinically appropriate to access pharmacy services from the hospital.

Consumers, both patients and carers, would also benefit from the convenience of being able to collect medications during visits to a private hospital (or adjacent medical services) at a time when due to illness or carer responsibilities, they may be coping with additional stress, complexity and time constraints.

***Efficient and seamless transfer of information***
Using MyHeathRecord and interoperable systems could potentially enable the efficient and seamless transfer of medication related information to the consumer and all members of their care team as they move between treatment settings.

At every point in the care pathway, consumers and clinicians can struggle to obtain a complete and accurate picture of the patient's medication history and current medications.

## ToR 5. Identify options to improve the NMP's governance, communications, implementation (including enablers) and evaluation.

Further work should be undertaken to identify options to improve the NMP's engagement with stakeholders. For example, the NMP should promote better sharing of data held by the Department of Health and linkage with other data systems such as those held by the Australian Institute of Health and Welfare. These initiatives will increase data access and use. In turn better access to data will drive awareness of the goals of the NMP and encourage accountability across all stakeholders.

## ToR 6. Review the NMP partners and provide options for building greater accountability including addressing conflicts of interest.

APHA supports a strong focus on accountability under the NMP but also cautions that new frameworks should not duplicate arrangements already in place.

Private hospitals are already required to demonstrate their accountability for medication safety through accreditation against the National Safety and Quality Health Service Standards which include a specific standard on medication safety. [3] In addition, the Australian Commission on Safety and Quality in Health Care (ACSQHC) has been charged with establishing a national portal through which all hospitals, public and private, will be required to report against a number of safety and quality indicators. These indicators will include accreditation outcomes and in the longer term a wider range of indicators will be added. Through this portal consumers will be able to view information about specific facilities.

One of the challenges in building frameworks for increased accountability is that the collection and validation of data can be very expensive. Some of the methodological issues involved are outlined in the publication National Quality Use of Medicines Indicators for Australian Hospitals (ACSQHC 2014). Many smaller private hospitals and day hospitals, lack the infrastructure required for sophisticated inhouse monitoring. Care is needed to ensure that accountability arrangements support improvement without drawing already scarce resources away from service level initiatives to support quality decision making. The NMP can best do this by promoting national consistency in reporting arrangements while at the same time providing flexible opportunities for the full range of health service providers, large and small, to be involved. [4]

[3] https://www.safetyandquality.gov.au/standards/nsqhs-standards/medication-safety-standard

[4] https://www.safetyandquality.gov.au/sites/default/files/migrated/SAQ127_National_QUM_Indicators_V14-FINAL-D14-39602.pdf

# Private hospitals in Australia

The private hospital sector makes a significant contribution to health care in Australia, providing a large number of services and taking the pressure off the already stretched public hospital system.

The private hospital sector treats:

- 4.4 million hospitalisations a year.

In 2019-20 it delivered:

- 58% of all surgery
- 72% of eye procedures
- Almost half of all heart procedures
- 76% of procedures on the brain, spine and nerves.
- 60% of all musculoskeletal procedures
- At least 30% of all chemotherapy

Australian private hospitals by the numbers:

- In 2021, almost half (49%) of all Australian hospitals are private
- In 2021, 642 private hospitals made up of:
    - 292 overnight hospitals
    - 350 day hospitals
- In 2016-17 (the most recent data available), that amounts to: 34,339 beds and chairs (31,029 in overnight hospitals and 3,310 in free-standing day surgeries)
- Employs more than 69,000 full-time equivalent staff.

## The Australian Private Hospitals Association

The Australian Private Hospitals Association (APHA) is the largest peak industry body representing the private hospital and day surgery sector.