



11 June 2004

**COPY of letter sent to all Health Ministers**

Dear Health Minister

**SHPA response to: Pharmaceutical Reforms in Victorian Public Hospitals  
- Evaluation of Impacts on Service Providers and Patients**

*Final Report 11 May 2004 by Healthcare Management Advisers (HMA)*

The Society of Hospital Pharmacists of Australia (SHPA) is the professional body representing pharmacists working in hospitals (public and private) and many other pharmacy practice settings across the health system. Safe and effective medicine use is the core business of hospital pharmacists, with a focus on quality use of medicines and reducing adverse medicine events.

SHPA welcomes the recent release of the Evaluation Report of the Pharmaceutical Reforms in Victoria. **The Society takes this opportunity to commend the Report to Health Ministers and urges all key stakeholders to take up its recommendations.** Continuous quality improvement is essential to ensure that solutions to the identified shortcomings are developed as soon as possible. In so doing, the positive goals of the reforms that we all share may be attained in a more effective manner and be nationally consistent.

The Report's authors acknowledge the limitations of their review as being *qualitative* and undertaken to assess stakeholders *impressions* of the impacts. Whilst this may limit the conclusions that can be drawn, the Report highlights a number of areas for improvement, many of which were anticipated. The independent review process has provided all stakeholders with a firmer base from which to move forward.

SHPA will limit comments on the detail of the findings here, but it welcomes further discussion with individual jurisdictions. The need for a more streamlined administrative and prescribing process has already been noted by Health Ministers. This is vital for the better overall use of hospital staff time and the elimination of any adverse impacts on existing service delivery due to the administrative impost of current processes.

Changes to medicines access or the delivery of pharmacy services should be designed to enhance the time available for clinical pharmacy services, rather than to reduce it, as mentioned in the Report. A holistic decision making process is essential in the context of an ongoing shortage of pharmacists and the pressure on the whole health workforce.

**The SHPA comments in the attached table relate to the six main Report recommendations with some suggested actions for the consideration of Health Ministers.** Such changes are needed to ensure that improvements flow from the first step in the reform process that has been undertaken in Victoria.

In addition to the specific comments in the table, the Society makes three further comments.

**1. That future Australian Health Care Agreements should use the heading “National Medicines Policy” to replace the section entitled “pharmaceutical reforms”.**

This would allow policies on any of the four arms of the National Medicines Policy to be properly grouped, so that policy changes on access and equity (funding) policies e.g. what is currently termed the pharmaceutical reforms, can be linked with policies promoting judicious, appropriate, safe and effective use of medicines (or quality use of medicines).

**2. That as the community-based Pharmaceutical Benefits Scheme (PBS) is now being used in both private and public hospitals that the jurisdictions and bodies such as SHPA should have input into all decision-making at Australian government level about the PBS. This also includes input into policy development for linked professional pharmacy services via the PBS negotiations that result in the Community Pharmacy Agreement arrangements.** Briefly, the main reasons are:

- Our current dual health funding system challenges providers to provide “seamless care” and it can create unintended “service gaps.” Changes to medicines access and/or payment for pharmacist professional (cognitive) services in the community sector that are funded via PBS negotiations need to be aligned with services in hospitals in both private and public sectors. **Linked funding systems need to be developed for these professional pharmacy services to emanate from the hospital sector, via PBS negotiations, in all jurisdictions.**
- The genesis of many pharmacist professional (cognitive) services, with some now being funded via PBS negotiations in the community sector, was the acute teaching hospital sector. Service examples are medicine management reviews, clinical pharmacist interventions, use of medicine dose administration aids, hospital in the home, post acute care pharmacy services, community liaison pharmacists, outreach and medication liaison pharmacist services at discharge and medicine management services for patient “at high risk” in the immediate post discharge period. This is a cogent reason to ensure that the knowledge from hospital practice is brought into discussion for new community-based services to ensure that they are linked and integrated across the continuum of care and also to draw on the wealth of more than 30 years of clinical pharmacy service experience.
- Research funding provided under the Third Community Pharmacy Agreement is linked to overall PBS negotiations. It is vital that a fund for research in hospitals is also established in the context of the PBS negotiations related to hospital medicine management services e.g. to fund medicine utilization reviews, continuum of care services, post discharge medicine management review services etc., in all jurisdictions.
- The business rules for new or changed professional services such as residential medication management review should be developed with the involvement of all professional players, including SHPA. In many jurisdictions, hospitals have associations with aged care and other facilities and should be able to provide them with cognitive pharmacy services, under PBS-related negotiated arrangements. **In particular, in rural and regional areas the current arrangements are a major barrier to being able to use the skills of hospital pharmacists more widely to support the community and this requires change as a priority.**

**3. SHPA commends the undertaking by Health Ministers to explore the implementation of a single national system for subsidizing medicines across the continuum of care and notes that discussions have now commenced.** The identification of the needs of consumers in public and private hospitals will be important to inform policy development.

SHPA has given consideration to the issues and has produced a discussion paper to highlight some of the complexity and to describe some high level key principles which may be useful as the development commences. A copy of the discussion paper has been enclosed for your information.

In summary, SHPA considers that it can provide timely independent advice to governments on pharmacy professional issues and on how to deliver better outcomes from medicines, for all Australians.

This aligns with our mission statement “*Committed to promoting quality use of medicines through leading edge pharmacy practice*”.

SHPA awaits feedback from Health Ministers and stands ready to constructively assist governments on the following:

1. The adoption of changes flowing from the recent Evaluation Report on the Pharmaceutical Reforms in Victoria.
2. The development of the Fourth Community Pharmacy Agreement and the ongoing management of professional practice areas which flow from the Agreement, as part of the overall PBS negotiations.
3. The development of the single national system for subsidizing medicines now that intergovernmental discussions have commenced. SHPA has in-depth knowledge of the complexity within both the public and private hospital sectors and seeks to develop workable solutions that take this into account, yet still integrate across the continuum of care.

Further information on any of these issues may be obtained from SHPA Executive Director, Yvonne Allinson on 03-9690 6733.

On behalf of the Society and its membership, I look forward to working with you on these issues into the future.

Yours sincerely



Helen Matthews  
Federal President

- cc. Mr Allan Rennie, Assistant Secretary, Pharmaceutical Access and Quality Branch  
Ms Joan Corbett, Assistant Secretary, Pharmaceutical Benefits Branch  
Prof Lloyd Sansom, Chair, Pharmaceutical Benefits Advisory Committee  
Dr John Aloizos, Chair, Australian Pharmaceutical Advisory Council  
Prof Ric Day, Chair, Pharmaceutical Health and Rational Use of Medicines Committee  
Dr Stephen Phillips, Chair, National Prescribing Service  
Prof Bruce Barraclough, Chair, Australian Council for Safety and Quality in Health Care

<b>HMA Recommendation</b> (from page 9 of Report)	<b>SHPA's comment and additional facts</b>	<b>SHPA recommends the following continuous quality improvement actions for the consideration of Health Ministers</b>
1. Streamline the administrative rules that apply to the operation of the PBS in hospitals.	<ul style="list-style-type: none"> <li>▪ <b>SHPA strongly supports this recommendation</b></li> <li>▪ The underlying reason for this recommendation is that the community based PBS and associated HIC procedures are designed for ambulatory patients, not the cohort that use hospitals, especially public hospital services. The reforms require a large effort by many staff “to make them work in the hospital setting”. By streamlining the administrative processes, the community will be better served because the time savings can be re-directed to core patient care.</li> <li>▪ Recognition of the main administrative and prescribing issues can lead to change to meet the needs of hospital patients and thus also correct many current problem areas.</li> <li>▪ The 2003 average national vacancy rate for funded pharmacist’s positions in public hospitals was 10%. Victoria (the first State to take on the PBS reforms) has a much lower vacancy rate (6%) compared to States such as NSW and QLD. Therefore the workforce implications of policies must be taken into account. Moreover, whilst some hospitals in Victoria have been successful in taking on extra pharmacist staff, this is unlikely to be achievable nationwide given the national workforce situation.</li> <li>▪ The opportunity cost of any policies which require an increase in hospital pharmacist time spent on purely administrative tasks will be the reduced ability in that hospital (or others) to work on improving medication safety. The 2003 SHPA Snapshot survey showed that there is currently a demand for an additional 10% more hospital pharmacists for these activities.</li> <li>▪ Hospital doctors work under great pressure. The streamlining of administrative procedures that do not “value-add” will also allow them to concentrate on their core patient care functions.</li> <li>▪ Hospital pharmacists are well used to administrative processes and undertake them on a daily basis to support the quality use of medicines and hospital medicine policies such as antibiotic prescribing to reduce antibiotic resistance etc. These processes do “value-add” as distinct from the PBS requirements which are administrative only.</li> </ul>	<p><b>That Health Ministers, as a matter of urgency, direct that solutions be developed for the identified administrative and prescribing issues to overcome current problems. Solutions will likely include the delegation of some authority processes to the hospitals, whilst maintaining the ability of the HIC to audit these delegations at hospital level.</b></p> <p>Examples cases:</p> <ul style="list-style-type: none"> <li>▪ Compliance with an approved hospital protocol should be an alternate method to authorize an antibiotic course of 8 weeks for the diagnosis of osteomyelitis.</li> <li>▪ Compliance with an approved hospital protocol should be able to be an alternate method to authorize a larger quantity of analgesics for patients, post-hospitalization.</li> </ul> <p><b>That Health Ministers encourage the HIC to adopt alternate processes for hospitals when necessary. These should provide “PBS equivalent outcomes”, be able to be audited and still be able to demonstrate judicious use of taxpayers funds.</b></p> <p><b>That Health Ministers direct the HIC to support processes that are consistent nationwide, so that a uniform national policy results. The Report has already noted variations between jurisdictions as to how the HIC deals with issues.</b></p>
2. Fully implement the APAC guidelines, especially improved communication of information on patients discharge to GPs.	<ul style="list-style-type: none"> <li>▪ <b>SHPA strongly supports adoption of the APAC guidelines regardless of the linkage with these reforms.</b></li> <li>▪ Hospital pharmacists surveyed were critical of the additional administrative processes and the impact on their ability to undertake cognitive clinical pharmacy services, which are recognized as a key way to improve medication safety for patients.</li> <li>▪ The Report states that the reforms had caused pharmacists at some hospitals to reduce some activities such as: preparation of medicine use protocols, less times on wards and less time spent with patients on admission. Others highlighted “short cuts” in doing clinical tasks, rather than dropping activities e.g. reduced time spent on patient medication counselling. If these services are not undertaken due to the administrative pressures of the reforms, then other important patient outcomes will suffer.</li> </ul>	<p><b>That Health Ministers ensure that any new policies relating to medicines or the delivery of pharmacy services are designed to enhance the time available for clinical pharmacy services, rather than to reduce it. A holistic decision making process is essential in the context of an ongoing shortage of pharmacists and the health professional workforce, in general.</b></p>

<b>HMA Recommendation</b> (from page 9 of Report)	<b>SHPA's comment and additional facts</b>	<b>SHPA recommends the following continuous quality improvement actions for the consideration of Health Ministers</b>
	<ul style="list-style-type: none"> <li>▪ Clinical pharmacists surveyed reported more time on continuum of care services because of the reforms, but this is not an “either/or” scenario. The increase in time for these activities was at the cost of other clinical pharmacy services which were reduced. With an under-resourced workforce, any activity that reduces time spent on clinical pharmacy services has an opportunity cost in reduced medication safety for patients.</li> </ul>	<p>The adoption of more streamlined methods as outlined above will provide a better overall use of hospital staff time and eliminate the adverse impact on service delivery due to the administrative imposts of the current processes.</p>
<p>3. Continued enhancement of the HIC's training of junior doctors on the use of PBS in hospitals</p>	<ul style="list-style-type: none"> <li>▪ <b>SHPA supports this recommendation.</b></li> <li>▪ The development of online training packages may be useful and these may be able to be coordinated with other curricula e.g. via the National Prescribing Service.</li> </ul>	
<p>4. Continue to promote hospital doctor awareness of PBS administrative requirements in order to reduce the administrative burden of hospital pharmacists</p>	<ul style="list-style-type: none"> <li>▪ <b>SHPA considers that this is addressing the “symptoms rather than the cure”.</b></li> <li>▪ The underlying reasons for the administrative issues is that the community based PBS is designed for ambulatory patients, not the cohort served by hospitals, especially public hospitals. However, by recognition and associated integration with the needs of hospital patients (public and private), many current problem areas can be corrected.</li> </ul>	<p><b>That Health Ministers direct the HIC to work with key stakeholders to develop systems that work with hospital patients and staff, yet still allow for HIC audit activities to maintain their confidence in the system. The HIC should note that some differences will be needed to integrate with the hospital system.</b></p>
<p>5. Promote GP awareness of the reforms and ensure they use the APAC guidelines as a tool to leverage access to better information from hospitals on discharge medication</p>	<ul style="list-style-type: none"> <li>▪ <b>SHPA strongly supports adoption of the APAC guidelines regardless of the linkage with these reforms.</b></li> <li>▪ SHPA cautions that the APAC guidelines stand independently as a patient care improvement strategy. There is a risk that hospitals and GPs could perceive that they only need to adopt them in the context of medicine funding reimbursement programs, such as hospitals using the PBS. The 1998 APAC guidelines pre-date the funding reforms and were developed independently and should be recognized as a distinct initiative in their own right.</li> </ul>	<p><b>That Health Ministers strongly support adoption of the APAC guidelines, regardless of the linkage with the PBS reforms.</b></p>
<p>6. Ensure hospital patients are aware of the reforms and their personal responsibility to effectively communicate with hospital staff about their medication usage to enhance quality use of medicines</p>	<ul style="list-style-type: none"> <li>▪ <b>SHPA notes this recommendation.</b></li> <li>▪ SHPA cautions that linkage of the “reforms” with this sensible recommendation could be confusing. Similar to the comments about the APAC guidelines, this recommendation stands independently as a patient care improvement strategy, regardless of medicine funding reimbursement programs, such as hospitals using the PBS.</li> </ul> <p><i>Key points which are <b>always</b> valid for consumers are:</i></p> <ol style="list-style-type: none"> <li>1. What is the medicine supposed to do?</li> <li>2. How do I take it?</li> <li>3. How long do I keep taking it?</li> <li>4. Are there foods, drinks or other medicines that I should avoid?</li> <li>5. What if I miss a dose?</li> <li>6. Are there any side effects and what should I do if they occur?</li> <li>7. How do I obtain ongoing supplies of my medicine?</li> </ol>	<p><b>That Health Ministers continue to support the main quality use of medicines (QUM) messages that consumers should always know about their medicines. These should encourage consumers to partner with health professionals to enhance outcomes from their medicines as a routine practice, regardless of how their medicines supply is being organized (via the PBS or otherwise).</b></p> <p>Messages about the hospital PBS reforms themselves may be more <b>simple if truncated to:</b>  “Your hospital can now provide a larger quantity at discharge. You will need to contribute a co-payment as you do at your community pharmacy”.</p>