CATAG
Council of Australian Therapeutic Advisory Groups

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
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Dear James,

Re: Pricing for Australian Public Hospital Services 2021-2022

The Council of Therapeutic Advisory Groups (CATAG) is an authoritative, expert, consensus-based collaboration of representatives from all Australian State and Territory Therapeutic Advisory Groups or their jurisdictional committee equivalents. CATAG aims to standardise and improve medicines use primarily (but not exclusively) in the hospital sector across Australia through: Information sharing, Advice and Advocacy activities.

Medicine related impacts due to COVID-19

COVID-19 has meant there have been challenging pharmaceutical chain supply issues. Medicine substitutes are usually more expensive, and it is likely the price of medicines will be not return to pre-pandemic levels even when supply returns normal. There have been significantly increased work and costs related to medicines delivery (often requiring courier delivery), which is unlikely to return to pre-pandemic activity in addition to significant levels of medication-related counselling via telephone and telehealth. Currently this activity and expenditure is not being captured.

Increased staffing to manage procurement processes have been required as supply issues have required more frequent ordering and changes in healthcare practice. Senior staff deployment to manage these non-businesses as usual activities impacts other activities, including staff training further compromising service delivery. There is no data capture of back of house pharmacy-only activities even though these activities support the activities of their facilities and importantly prevent shortages or outages having an impact of organisations and patients.

Furthermore, during COVID-19, fewer rural-based patients have been prepared to travel to the metropolitan or major regional hospitals. This has meant that patients have requested the administration of complex and/or high cost medicines nearer to home at smaller rural hospitals where there is no onsite pharmacy service and often nursing staff are not experienced or trained in the preparation or administration of these therapies. In some instances, nursing staff have had to be trained & supported remotely on these therapies to enable this treatment to proceed closer to the home. This has had significant impact on drug budgets, particularly when the medicines have been expensive non-S100 HSDs. This has been particularly problematic for those living near jurisdictional borders when their nearest major centre has been in another jurisdiction.

Costs associated with COVID-19 vaccine provision will need to be accounted for. This includes costs associated with preparedness, storage, administration by healthcare workers including pharmacists.

Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

CATAG considers the Pricing Guidelines relevant and they provide appropriate guidance to IHPA in pricing Australian public hospital services. However, the following considerations need to be included.

Emerging high cost medicines (HCM).
HCM information is not adequately captured as information for NWAU calculation is computed historically (3 year lag). HCMs are emerging more quickly than ever before, more quickly becoming reasonable options for care and improving survival often represents lifelong therapy.

Costs of HCMs may not have significant impact on expenditure when looked at in its entirety e.g. across jurisdiction; however, can they have significant impact on the drug budget of an individual hospital, especially in non-metropolitan or smaller metropolitan hospitals. This can lead to non-approval of use and inequity of access and/or budget blow-outs.

Immature/inadequate measurement of pharmacy and medicine-related activity costings.
The means to collect data to measure pharmacy activity is immature. In particular, data capture of intangible pharmacy-related activity is difficult and therefore absent leading to lower estimates regarding care per DRG. Intangible activity includes inpatient activities and clinical pharmacy cognitive services (included in NSQHS Standards) and it currently underfunds research and teaching. Pharmacy departments are not resourced adequately to capture activity (and costs) data. Furthermore the activity of district/hospital multidisciplinary Drug and Therapeutics Committees (see NSQHS Standard 1) are not adequately captured in ABF.

Incentivising quality – Home TPN example
The IHPA ABF formula recognises home TPN provision. However, given that ABF aims to drive quality, efficiency and safety, the TPN service, should include costs that improve care for these complex patients such as a clinical service that provides clinical nurse consultant resources in order to address the needs of these complex patients.

Increasing complex patients requiring high cost medicines in hospital, which are not captured by ABF
There is increasing frequency of complex patients requiring one dose of high cost PBS-eligible medicines during hospitalisation. This can be because some patients can get very ill with the first dose of a medicines e.g. cytokine release syndrome and it is unethical to shift them into the community. Alternatively, some patients having cancer or immunomodulatory therapy may be in a public hospital for another therapeutic intervention when this therapy is required. There are also medicines for which use needs to be instituted in hospital e.g. blinatumomab.

Under-recognition of clinical trials pharmacy service and pharmacist activity
Public hospitals are suitable relevant places for undertaking clinical trials and providing patients with rare and/or difficult to treat conditions with the opportunity to receive emerging therapy and developing an evidence base for treatments. However, such services particularly pharmacy services should not be provided to the detriment of other pharmacy services. Clinical trials are becoming more resource intensive and increasing in complexity.

Alternative funding (to that provided by ABF)
It is likely unrealistic to suggest the ABF model of funding can capture the provision of new emerging therapies, such as gene and gene modified organisms (GMO) therapies and personalised medicines

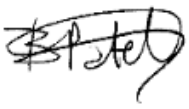
but alternate pathways of funding are required to harness therapeutic innovations that represent life-saving interventions and ensure equity of access to all Australians. Moreover, the expectations of clinicians and organisations to be innovative and be able to offer unique trials to patients is increasing. These emerging complex therapies require significant upfront investment to provide optimal care to patients receiving them. This investment includes upskilling of pharmacists and nurses, accreditation activities, and development and implementation of standards of practice and appropriate governance frameworks that include new expertise including relevant hospital-based biological safety committees. Such activity should be proactively recognised to promote innovation and uptake of appropriate practices.

Currently the provision of pharmacy services for these therapies is not recognised. There is increasing involvement of pharmacy departments regarding waste management, handling, governance and preparation of doses (which need for expensive compliant facilities and equipment such as PC2 laboratories within pharmacy departments or external organisations). Further challenges regarding these therapies include their classification: pharmaceutical, blood or other type products and the communication lines and committees required for optimal management. A national taskforce of relevant stakeholders including funders of hospital activity should be convened to address these issues.

Similar issues regarding funding may apply to the development of personalised medicines as they become a part of mainstream therapeutics e.g. tumour cell culturing and testing against a multitude of therapies as currently demonstrated in the Zero childhood cancer initiative.

Issues related to Hospital Acquired Complications (HACs)
The intent of measuring HACs is recognised; however, they require correct identification and coding in order that clinicians within the health care organisation address the care under which they occur.

I thank you for the opportunity to provide feedback and please do not hesitate to contact Jane Donnelly, National Coordinator for the Council of Australian Therapeutic Advisory Groups on catag@stvincents.com.au should you require any further information.



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Chairperson, Council of Australian Therapeutic Advisory Groups
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