



Submission to the Review of Funding Arrangements  
for  
Chemotherapy Services

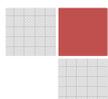
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**Contents**

- 1. Executive Summary ..... [3](#)
- 2. About UnitingCare Health..... [4](#)
- 3. Model of Care for the provision of chemotherapy infusions at The Wesley Hospital ( from the clinical decision to order an infusion to follow up after the course or cycle has been completed)..... [4](#)
- 4. Professional and administrative practices for the provision of chemotherapy and the business model that supports them: ..... 6
  - 4.1 Third party compounder business model ..... [6](#)
  - 4.2 Dispensing and script management services ..... 7
  - 4.3 Clinical pharmacy services ..... 10
- 5 Changes to the provision of chemotherapy medicine infusion services over recent years and there impact on consumer access to services **Error! Bookmark not defined.**
- 6 Other Matters Pertinent to funding for chemotherapy infusion preparation ..... 13



## 1. Executive Summary

Modern complex cancer therapies illustrate the progress made in recent years against advanced cancers that are resistant to traditional therapies. New targeted and immunotherapy drugs are emerging as viable strategies for halting the progression of these difficult diseases. Complex therapies demand multicomponent chemotherapy protocols incorporating chemotherapy agents (parenteral and/or oral), support therapies (i.e. anti-emetics, granulocyte-colony stimulating factor), and specific electrolyte replacements and hydration fluids. The clinical assessment of all pharmaceutical components prior to commencement of treatment as well as patients usual medications for their pre-existing medical conditions is critical to ensure safe delivery of the chemotherapy. The complexity of the modern chemo therapies necessitates complex business and service delivery models to support its safe, efficacious, and cost effective delivery resulting in optimal patient outcomes.

Current business rules and funding models neither reflect nor support the complexity of the cancer treatment delivered to Australians. Private hospital operators are entrenched in the rigid health insurers and Medicare Australia business rules in their daily battle of recovering costs associated with the provision of chemotherapy to the private hospital patients. Considering that more than 45% of chemotherapy patients are treated in private hospitals and day facilities, maintaining the viability of private chemotherapy service is of paramount importance to the Australian healthcare system. UnitingCare Health (UCH) therefore believes the funding for chemotherapy services and administrative processes should be revised to address the following issues:

### A) Payment model

It is imperative that the revised payment model is:

- consistent across all pharmacy sectors (Section 94, Section 90, and public hospitals)
- transparent in capturing the four component costs: cost of the chemotherapy medicine, cost of consumables/devices, preparation and reconstitution fee , pharmacy professional services fee

### B) Existing business rules for the claiming of PBS medicines via Medicare Australia are in terms of efficiency and equity across private and public sector

The Submissions prepared by the Australian Private Hospital Association (APHA) and The Society of Hospital Pharmacists of Australia (SHPA) in response to the Senate Inquiry in April 2013 detail the existing issues and provide logical and workable solutions. UnitingCare Health (UCH) supports the submissions of these two organisations, believing them to be adequately representative of both the interests of private healthcare providers and consumers' expectations of safe and efficient healthcare delivery. UCH has extensively consulted Haematologists – Oncologists practising at the day clinic located on The Wesley Hospital campus. The clinicians have voiced their concerns regarding the sustainability of cancer services provided by the hospital, specifically around the potential impact on their patients, endorsing the UCH's position on the matter.



## 2. About UnitingCare Health

UnitingCare Health (UCH) operates one of the largest not-for-profit private hospital groups in Australia, providing for over 1,000 licensed hospital beds spread across five facilities in South-East Queensland. A 'not for profit' organisation, owned entirely by the Uniting Church, UCH reinvests any financial surplus directly back into our hospitals and services including the provision of pastoral care services on behalf of the Uniting Church, not only in our own hospitals but also in most major public hospitals in Queensland.

The Wesley Hospital, one of UCH's largest private hospitals, proudly services over 115,000 patients from Australia and overseas annually. With 524 overnight beds, The Wesley is renowned for clinical excellence and positive patient outcomes, over more than 35 areas of clinical specialty including special clinical services such as: The Wesley Hospital Palliative Care Unit, The Wesley Hospital Pain Management, The Wesley Hospital Back Rehabilitation Program, The Wesley Hospital Cardiac Rehabilitation Program, The Wesley Hospital Kim Walters Choices Program and The Wesley Hospital Breast Clinic.

UnitingCare Health offers services to Australians diagnosed with cancer at The Wesley Hospital, Brisbane, The Sunshine Coast Private Hospital, Buderim, and St Stephen's Hospitals at Maryborough and Hervey Bay. This submission will primarily focus on cancer services provided at The Wesley Hospital.

## 3. Model of Care for the provision of chemotherapy infusions at The Wesley Hospital (from the clinical decision to order an infusion to follow up after the course or cycle has been completed)

The Wesley Hospital (TWH) offers a unique model of care for the provision of cancer services in the private healthcare sector. The hospital operates a 9 bed Bone Marrow Transplant Unit (BMTU), a 17 bed palliative care unit, 48 medical oncology and haematology beds, and 2 licenced children cancer beds. The Haematology Oncology Clinic of Australasia (HoCA), a day hospital also known as ICON, conveniently located on TWH campus, admits to the hospital day chemotherapy patients whose condition warrants additional monitoring of their treatment and any complications. The care of these patients requires input from a multidisciplinary team of doctors, nurses, pharmacists and other allied health personnel and careful coordination with third-party providers to assure safe and timely preparation of these often complex cytotoxic therapies.

Many of these therapies are individualised, requiring consideration of variables such as age, weight, sex, clearance organ function, immune status, and stage of medication cycle prior to preparation of the therapy. Additionally, expiry dating on the formulated product requires careful multidisciplinary planning to obviate wastage, often times warranting preparation and transport immediately prior to the intended infusion time. The clinical labour requirement is substantial.

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### Medical Team

The hospital works collaboratively with the team of experienced Haematologists-Oncologists Visiting Medical Practitioners (VMPs). In our system, there are no registrars or interns. Often times the primary mediums of communication are via fax or phone given there is no continued presence of the VMPs within the hospital due to their commitment to multiple hospitals or practices.

### Nursing Team

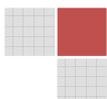
The Wesley Hospital has a dedicated chemotherapy nursing team, 'Chemo Service', tasked with the administration of parenteral chemotherapy to inpatients and day chemo patients admitted to the hospital. This nursing team consists of a Chemo Service Clinical Nurse Coordinator (CNC), and a number of chemotherapy competent support nurses. The Chemo service co-ordinates the scheduling and administration of chemotherapy to inpatients of The Wesley Hospital excluding BMTU. Patient bookings are made directly with these nurses by VMPs or the VMPs practice managers. Chemotherapy orders are obtained by the Chemo Service CNC and are emailed or faxed to pharmacy for clinical review and preparation. The 'Chemo Service CNC' and the Cancer Care pharmacist(s) work closely to ensure safe and efficient prescribing, dispensing and administration of chemotherapy is achieved.

**BMTU** is a high dependency unit with a nurse to patient ration of 1:2. The Stem Cell Transplant ward often accommodates high risk oncology patients in single rooms fitted with a specialised ventilation system designed to minimise the risk of infections. Myeloablative/non-myeloablative stem cell transplant conditioning protocols are commonly prescribed in this unit. Patients booking, admission, and chemotherapy orders are coordinated by the HOCA Transplant coordinator. For non-transplant patients chemotherapy protocols are provided to pharmacy by the nursing staff.

Intrathecal chemotherapy is routinely administered by an interventional radiologist in the X-Ray department. DC Bead therapy loaded with chemotherapy may also be administered here. The cancer services pharmacist is required to liaise directly with the nursing staff in X-ray to co-ordinate this treatment. All medication must be delivered to the X-Ray department by pharmacy staff.

### Pharmacy Team

The pharmacy cancer services team consists of two full time pharmacists with appropriate training in cancer services (completed accredited national and international courses), a dedicated technician, and a courier driver. The pharmacy cancer services team is working collaboratively with the medical, nursing, allied health and oncology ward pharmacist' teams towards enhancing the safety and quality of care provided to the cancer patients.



The key role of the cancer services team is to manage risk associated with the use of chemotherapy protocols. Every dose of every chemotherapy medicine (oral or parenteral) in every cycle must be:

- Calculated within the protocol being used and modified for weight, body surface area, renal or liver function and blood chemistry
- Reviewed for cumulative or acute toxicity the patient has experienced, the mode of delivery, the appropriate fluid and final product volume
- Confirmed as appropriate for that patient on that day considering their concurrent clinical status and concomitant use of other medications.
- Supported by the use of appropriate adjuvant therapies
- Independently checked by a second pharmacist as a quality control mechanism

After the completion of the chemo protocol review the verified order is sent to the third party compounding facility for reconstitution and preparation. A pharmacy courier is routing regularly to the compounding facility to collect prepared chemotherapies. Once the chemo therapy infusion is delivered to pharmacy, a final independent check and release step is completed by two pharmacists.

The pharmacy technician assembles any required adjuvant medications for a final check and release by a pharmacist. The technician is also responsible for processing orders for chemotherapy preparations, billing, and script management.

Pharmacists engage with patients and their families/carers to ensure adequate understanding of the received treatment, safety (or otherwise) of complementary medication usage when receiving an active chemotherapy treatment, and use of over the counter medications.

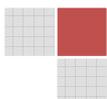
#### **4. Professional and administrative practices for the provision of chemotherapy and the business model that supports them.**

##### **4.1 Third party compounder business model**

UCH has elected to outsource the compounding to a third party provider for several reasons some of which are listed below:

- Lack of space for the establishment of an on-site compounding unit;
- The costs associated with running and maintaining an appropriate sterile facility are substantial;
- Training and validation of staff is expensive and not easily accessible; and
- Costs of quality assurance process (microbiological test etc.).

Whilst outsourcing of the compounding to a TGA approved third party manufacturing facility alleviated some of the outlined issues, it has presented a set of challenges. For example, some of the medications have an extremely short shelf life hence must be prepared immediately prior to administration. The time limiting factor becomes particularly critical in the case of melphalan, a drug with a 90 minutes shelf life following reconstitution. Administration of melphalan has several dependencies, i.e. timing is directly linked to stem cell collection and the availability of the transplantation team. This means that the timing of the reconstitution and delivery to the hospital ward must be aligned with the arrival of the transplantation team to the ward. It is not uncommon that melphalan arrives to ward 30 minutes prior to the product expiry. Melphalan containing protocols are routinely used at the hospital and



require enormous coordination by a multidisciplinary team. Last minute dose amendment is another challenge as the manufacturing facility can not modify previously prepared therapy. This results in a direct financial loss to pharmacy. The manufacturing facility business rules allow scheduled deliveries of compounded chemotherapy infusions to ordering pharmacies. At The Wesley Hospital, 30% of chemotherapy infusions are prepared on 'just in time' basis for a wide range of reasons, i.e. a turn around of 3 hours from the point of ordering by a VMP to the point of administering to patient is expected. To ensure timely administration of chemotherapies to the patients, a pharmacy courier was employed specifically to pick up compounded chemotherapies at short notice. Pre-ordered medications are delivered by the manufacturing facility at their scheduled delivery runs. The VMPs often commence new chemotherapy treatments on weekends in which case the hospital will pay the manufacturing facility a \$750 call out fee. The PBS revenue collected from Medicare Australia hardly covers unexpected administrative and logistic expenses both of which are critical elements in the delivery of chemotherapy to the patient.

#### **4.2 Dispensing and script management services**

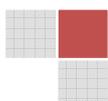
Dispensing and script management of cancer patients is complex and resource intensive. A dedicated pharmacy technician is allocated to billing and dispensing activities associated with the management of cancer patients. The dispensing includes chemotherapy agents, growth factors, anti-emetic medications, electrolytes, hydration etc. The pharmacy technician is also responsible for the management of PBS prescriptions in order to ensure that all required scripts are available at the time of supply of chemotherapy and ancillary medications. With the VMPs working off site most of the time, this chasing PBS scripts has become one of the most challenging tasks. Both VMPs and pharmacists are overwhelmed with the complexity of the current PBS model imposing additional administrative tasks and responsibilities and reducing clinical time with the patient (refer to Table 1).

Over the past decade a number of issues concerning the use of the Pharmaceutical Benefit Scheme (PBS) in acute care private hospitals have been identified. The problem essentially derives from a lack of integration between PBS prescribing requirements and hospital practice. PBS regulations specify the manner in which medical practitioners write prescriptions; restrict payment of benefits for some medicines to specified conditions and require prior Medicare Australia approval for other medicines on case by case basis. It is a requirement for pharmacists to receive the prescription in advance of supply, unless in cases of urgency.

The PBS works very well in the community care setting:

- Patient consults doctor
- Doctor determines need for medication
- Doctor provides prescription
- Patient takes prescription to pharmacy
- Pharmacist dispenses medication
- Patient pays co-payment
- Pharmacist claims Pharmaceutical Benefit from Medicare Australia on patient's behalf.

Medications in Australian private hospitals have always been subsidised by the PBS, on an individual patient basis. Private hospitals generally provide a limited amount of



ward stock for single and 'when required' orders, and drugs used in operating theatres. While PBS is a critically important source of funding for medications in private hospitals, the scheme is not well suited to hospital practice for a number of reasons.

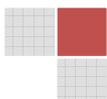
The key player in this process is effectively removed; that is, the patient is unable to fulfil their 'administrative' role (obtaining a prescription from a doctor and taking it to pharmacy) while lying in a hospital bed. Therefore, pharmacists and nurses become the patient's agents. The doctors caring for them do not always have the luxury of time and the necessary tools (office, computer, and prescription pad) to prescribe. However, the application of the PBS in hospitals must comply with the PBS regulations in order to have benefits paid on patient's behalf. The major obstacle to the efficient and timely provision of PBS medications to private hospital patients is the need for a valid PBS prescription prior to supply of the medication. This is in addition to the regulatory and organisational requirements for doctors to write medications orders on hospital charts. It is the duplication of written orders (charts and PBS prescriptions) which creates significant inefficiencies and confusion within private hospitals. Lack of integration between standard PBS operating procedures and the realities of hospital practice result in the 'outstanding owing scripts' problem that is faced by all private hospitals.

Whether for an increased quantity or for an Authority listed drug, the prescribing of Authority benefit items is particularly problematic. Authority prescriptions must be approved by Medicare Australia prior to supply of the drug by the pharmacist. Most Authority medications are used in the management of critical conditions or the treatment of severe illness and are expected to be supplied almost immediately. It is unlikely that a medical practitioner ordering an Authority item will have access to the appropriate PBS stationery or their computer in order to write or generate an Authority prescription prior to supply. Seeking approval in writing from Medicare Australia in this acute setting is not an option. The pharmacist has a professional obligation to dispense the drug to ensure patient's care is not compromised even though the approval may not have been received.

In an attempt to resolve the owing Authority scripts problem, some of the private hospital pharmacies have previously implemented 'no script, no drug' rule. However, to ensure the best interests of the patient remain central to our care, the acute nature of hospital treatment and the relationship between medical practitioners, UCH hospitals have not implemented such a general financial policy. Creating a pathway to allow the paperless claiming for chemotherapy drugs would significantly reduce the administrative burden in the planning, prescribing and supplying of cancer treatments in private hospitals.

The existence and success of the Paperless Claim Trial in selected private hospitals throughout Australia, which has been trialled since late 90's with no conclusion to the trial or expansion of the paperless system to other hospitals (it should be noted that UCH has written to Medicare on several occasions to request the inclusion of UCH hospitals in this trial) offers a pre-existing model on which to base a specific chemotherapy paperless PBS claim trial. This trial should reconsider the need for paper-based authority prescriptions (phone approval and streamlined).

It is worth noting that one of the greatest frustrations for VMPs in the writing of prescriptions for chemotherapy medications is this approval process whereby the VMP is required to phone Medicare to obtain authorisation. This administrative



authorisation is provided to VMPs by non-medical personnel, a distinction which does not escape these senior consultants.

*Table 1 Roles and Responsibilities*

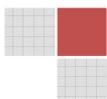
<b>Role</b>	<b>Current Responsibility</b>
VMP	<ul style="list-style-type: none"> <li>• Ordering chemotherapy treatment</li> <li>• Writing authority script (as required)</li> <li>• Writing medication requirements in the patient medical record</li> <li>• Obtaining phone authorisation from Medicare (as required)</li> <li>• Arranging for script to be delivered to pharmacy</li> </ul>
Pharmacist	<ul style="list-style-type: none"> <li>• Reviewing chemotherapy order sheet</li> <li>• Noting items that require scripts</li> <li>• Checking to see if a script currently exists</li> <li>• Noting items that require authority scripts</li> <li>• Checking to see if an authority script currently exists</li> <li>• Contacting VMP to arrange a script (as required)</li> <li>• Ordering and verifying the correct product is constituted</li> <li>• Dispensing authority scripts</li> <li>• Dispensing of non-authority scripts</li> <li>• The current system generates an administrative, paper based process requiring hospitals to ensure all required authorities are obtained prior to claiming reimbursement from Medicare.</li> </ul>

### Feasibility

The success of the Paperless Claim Trial currently in place at selected private hospitals in Australia sets precedent for broader paperless claim processes across the private hospital sector. The current Paperless Claim Trial also provides a basic framework that can be extended to include drugs currently requiring paper authority prescriptions. This framework includes:

- Legislative mechanisms defining prescribing and dispensing requirement
- Medicare claim process
- Dispensing software requirements

It is also worth noting that UCH is presently engaged in building an acute care facility at Hervey Bay, St Stephens Hospital (SSHB). This development is supported by the Federal Government's Health and Hospitals Fund (HHF) which will provide \$47 million towards the estimated \$92 million construction and e-Health costs of this 96-bed, not-for-profit private hospital. SSHB is expected to become the benchmark in automated patient care in Australia and aims to achieve Healthcare Information and Management Systems Society (HIMSS) Level Six and Seven, an international



measure of hospital clinical systems automation. Although extensively researched internationally, organisational, clinical and patient benefits of e-Health technologies and best practices when deployed in a HIMSS certified digital hospital will be monitored and measured independently of UCH using the e-Health Australian Research Centre, funded by the Commonwealth Scientific and Industrial Research Organisation (CSIRO). Unfortunately, UCH will not be able to obtain this Australian first achievement without moving to a paperless PBS prescription system and UCH continues to request this legislative change from the Pharmaceutical Benefits Division, Department of Health and Ageing. Attachment 2 provides an example of previous correspondence.

### **4.3 Clinical pharmacy services**

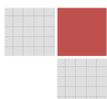
Modern complex cancer therapies illustrate the progress made in recent years against advanced cancers that are resistant to traditional therapies. New targeted and immunotherapy drugs are emerging as viable strategies for halting the progression of these difficult diseases. Complex therapies demand multicomponent chemotherapy protocols incorporating chemotherapy agents (parenteral and/or oral), support therapies (i.e. anti-emetics, granulocyte-colony stimulating factor), and specific electrolyte replacements and hydration fluids.

The clinical assessment of pharmaceutical components prior to commencement of a treatment is critical. Considering 40% of patients are treated in private hospitals, maintaining a viable private hospital pharmacy sector is a crucial facet of the Australian healthcare system. As of August 2012, more than 10.56 million Australians held private health insurance, and it is likely that private health insurance will play an expanded role in coming years.

Given the legislative changes that have occurred over the last decade specifically intended to ensure a greater number of Australians access private health insurance and thus reduce the cost to the public sector, then provision should be made to ensure that access to appropriate pharmaceutical services be equitable for both private and public hospital patients.

Health professionals including doctors, nurses and dentists all attract government remuneration for professional cognitive services provided by them. The value of clinical pharmacy services has recently been recognised by the Government in the 5<sup>th</sup> Community Pharmacy Agreement which provides a framework of Commonwealth funding for payments available to S90 pharmacies for professional services such as clinical interventions (to the total value of \$95 million over 5 years). Separate funding allocation is secured for the provision of Home Medicine Reviews.

These services have long been provided by private hospital pharmacies with no remuneration from the Commonwealth or recognition from health insurers. Yet there is an expectation that pharmacy clinical service will meet the requirements of the Standard 4, Medication Safety, National Standards in Quality and Safety in Healthcare. Interestingly, the National Standards requirements are specific to hospitals, i.e. there is no expectation for community pharmacies to comply. As the funding agreements between private health insurers and private hospitals are complex and subject to economic drivers such as the general cost of health insurance, it is highly unlikely that significant changes in private hospital pharmacy funding will occur in the foreseeable future to recognise the complexity of the services now provided by private hospitals. .



The creation of an appropriate Commonwealth funding mechanism for the provision of clinical pharmacy services in private hospitals is essential to maintain and expand the quality use of medications in private hospitals, and thus ensure that all Australians continue to benefit from the highest level of healthcare. Under current arrangements private hospital pharmacies will not be able to maintain clinical pharmacy services at current levels.

The provision of clinical pharmacy services is an integral component of patient care, both in the acute and community settings. Relating to cancer service provision, pharmacists are responsible for oversight of the clinical assessment of chemotherapy protocols with a focus on patient safety, and appropriate ordering, preparation and distribution of chemotherapy medicines.

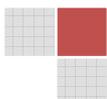
Economic analysis of chemotherapy services suggested that the percentage of time spent by the pharmacists on clinical activities in chemotherapy preparation practice area averaged 62%. A small qualitative and quantitative unpublished study undertaken in 2011 to evaluate ward-based clinical pharmacist activities in two private tertiary hospitals and two private secondary hospitals (1,351 beds) demonstrated the complexity of clinical tasks performed by cancer service pharmacists. Mean time to review a chemotherapy protocol was reported to be 30 minutes. As a part of this activity, pharmacists were making a clinical intervention (near miss prevention) in one in every ten protocols on average.

This clinical activity, which is critical to the safe and efficient administration of chemotherapy in the private sector, was formerly indirectly subsidised through a robust PBS remuneration framework. The current Chemotherapy reforms, compounded by progressive PBS price reductions, places the viability of these clinical services at risk.

It has been noted that a new clinical pharmacy attendance payment of \$233.67 has recently been announced as part of a national Activity Based Funding (ABF) mechanism for public hospitals. This payment recognises the pharmacist's time and expertise in delivering a service which includes the following functions:

- Review of medicine orders, new and repeat, for clinical appropriateness;
- Identification and resolution of medicine problems with the prescriber before processing the medication order;
- Counsel of patients or carers to ensure that the patient (or their carer) understands all information required for safe and proper use of the medicine; and
- Provision of consumer medicine information required for the safe and proper use of the medicine.

UCH strongly believes that this Activity Based Funding model provides a basis for a sustainable model for private sector chemotherapy services which will no longer be cross-subsidised by trading terms on chemotherapy drugs. A Clinical Services Fee was raised by the Guild and CPCSG during discussions in 2009 as an important element for a sustainable chemotherapy funding model. Clinical pharmacy is an essential component of the care of every cancer patient and encompasses all of the functions listed above.



As has been outlined in the earlier discussion, the business model that currently allows these services to be funded from generic trading terms no longer exists from 1 December 2012. That is, the previous margin made on product costs that was used to off-set the non-funded clinical services has been reduced significantly with no recognition of funding for the clinical service provision. It is now time for professional services provided by pharmacists in private hospitals to be recognised in the same way as services provided by community and public hospital pharmacists.

UCH supports both the APHA and SHPA position seeking fee-for-service payments of pharmacist's time allocated to clinical activities during chemotherapy production. An agreed fee per each chemotherapy protocol clinical pharmacy review could be one of the payment models. Such a payment model is transparent, auditable, and mirrors fee practices long established for other health professionals are recognised.

The above tasks are routinely performed by UCH pharmacists on a daily basis and are bundled into health fund recoveries. The inclusion of pharmacy costs within health fund contracts when they were initially rolled in at the then cost of service provision, has not kept pace with the increasing costs or change in clinical practice that has eventuated over the past decade. Essentially, the cost of pharmacy services included within health fund reimbursements is now well underfunded. The average number of medication management activities (excluding comprehensive discharge services and clinical intervention, i.e. near misses) reported at TWH is **6,500 activities or \$1.5 million per annum using the funding mechanism available to public hospitals.**

#### **5. Changes to the provision of chemotherapy medicine infusion services over recent years and there impact on consumer access to services**

The 1 December 2012 and 1 April 2013 Pharmaceutical Benefits Scheme (PBS) price reductions neglected to appreciate the services that pharmacy provides to ensure safe and timely supply of the individualised chemotherapy medication requirements of each of our patients. These price reductions come in the broader context of an on-going erosion of pharmacy margins arising from selective amendments to PBS remuneration for Section 94 pharmacies such as those operated by UCH.

The 1 December 2012 and 1 April 2013 Pharmaceutical Benefits Scheme (PBS) price reductions will negatively impact on the hospital's ability to satisfy the full range of chemotherapy medication supply requirements within their allotted means. Due to UCH's not-for-profit status and the mission and values that our service is based upon, The Wesley Hospital has already been supplying several chemotherapy infusions at a loss for a number of years (refer to a separate attachment titled "Chemo Costing Template' ). PBS reimbursement for the chemotherapy infusions is the primary recovery mechanisms of costs associated with their distribution. UCH are concerned that any further PBS price reductions will significantly reduce UCH's ability to sustain the delivery of optimal patient outcomes. Unfortunately, the increased costs of chemotherapy medication supply can not be compensated through health fund contracts as health insurers are not willing to consider additional recovery for the provision of chemotherapy infusions despite the fact that the hospitals are already running at a loss (Table 2).

The 'collateral damage' of increased costs associated with the supply of chemotherapy treatments eventually impact UCH's ability to invest in staff training,



hospital redevelopment and purchasing the latest technology required to maintain high standards of care delivered to the Australian community. Another indirect impact of a reduced capacity of private hospitals in the provision of chemotherapy services to Australians will be a shift of chemotherapy treatments to the already overloaded public health system.

*Table 2 FY13 Profit and Loss Statement for Chemotherapy Portfolio, The Wesley hospital*

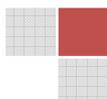
<b>FY2013 Summary</b>		
<b>Revenue</b>		
Total PBS Rebate	\$ 2,665,617.21	
Total Patient Charge	\$ 160,070.27	
	<u>\$ 2,825,687.48</u>	
Total Drug Costs (PBS)	-\$ 2,233,748.15	
Total Drug Costs (NON - PBS)	-\$ 33,000.00	
	<u><b>\$ 558,939.33</b></u>	
Associated Costs	-\$ 671,575.61	
Net Chemo Balance	<u><b>-\$ 112,636.28</b></u>	(loss position)

## **6. Other Matters Pertinent to funding for chemotherapy infusion preparation**

### **Private Health Insurance – Coverage Ancillary Tables**

The funding agreements between private health insurers and private hospitals are complex and subject to economic drivers such as the general cost of health insurance. Although some insurance companies make a reference to pharmacy services as a general rule any services provided by a pharmacy (distributive, clinical, administrative, or medication safety) are bundled into health fund recoveries. All funding arrangements with private health insurers will have specific clauses addressing the supply of PBS and non-PBS listed drugs. None of the arrangements recognise administrative pharmacy services associated with the administration of PBS in private hospitals. Administration of PBS in the private hospitals sector is complex and labour intensive as detailed in section 4.3.

Some General Cover or ancillary cover policies provide benefits in relation to non-PBS listed drugs or PBS listed drugs used for non-PBS approved indication. The cost of these drugs was partially recognised through the Exceptional Drug List (high cost drugs which are not routinely used for inpatient care, including oncology drugs) or special clauses referring to High Cost Drugs (HCD). The Exceptional Drug List has become abolished and no longer recognised, i.e. included within the contracted rebates hence absorbed by the health care provider, with no recognition by health insurers that separate funding arrangements previously existed to recognise the high cost of these drugs.



Health fund clauses on HCD are vague, open for interpretation and often include a disclaimer suggesting special consideration of additional funding for HCD is at the health fund's discretion. Essentially, any health fund may elect to decline additional funding for a HCD if they disagree with the clinician's choice of treatment or dosage regimen. As a general rule, health funds do not support use of drugs for non-TGA approved indications (medications used off label) often questioning the rational behind use of drugs for non-PBS approved indications.

Only a small percentage of HCDs used in the hospital are candidates for application for special consideration. UCH actual data indicates only 29% of HCDs used in the hospital are subject to application for special consideration for additional payment by health funds, i.e. 71% is a direct cost to hospital as the private health insurer expects the hospital to pay for the elected treatment. Table 3 is a summary of applications for special consideration for additional payment submitted to health funds in the past 7 months. Overall, the hospital submitted 79 applications from May 2010 to June 2013 to the total value of \$1,037,960 or on average \$27,314 per month. The total value of approved applications was \$233,927 (23%).

*Table 3 Health Funds Recovery (7 months Sample Data), TWH*

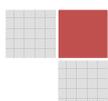
Fund	N of Claims	\$ of Claim	\$ of Recovery	Comments
Health Fund 1	17	\$ 146,291	\$ 36,182	25%
Health Fund 2	2	\$ 58,440	\$ 15,325	26%
Health Fund 3	1	\$ 13,928	\$ 6,976	50%
Health Fund 4	3	\$ 27,829	\$ -	declined
Total	23	\$ 246,488	\$ 58,483	

Breakdown of HCD prescribed at TWH as listed below:

- 50-55% are antimicrobials (antibiotics, antifungal and antiviral agents). Average spend per month is \$66K.
- 70% of high cost antibiotics and approximately 90% of antifungal agents are used in cancer (BMTU) patients for the treatment of opportunistic infections.
- 22% are chemotherapy related drugs (cytotoxics, stem cell stimulating agents and alike). Average spend per month is \$22K.

It is a common practice for haematologists to advocate innovative and aggressive treatments to combat resistant malignancies. The logic behind prescribers' choices is based on the most recent clinical trials or publications. As a general rule these choices involve well established drugs but new dosage regimens, new combinations, or new, non-PBS/non-TGA approved indications. Some of the examples are listed in Table 4. On rare occasions private health insurers would consider a partial contribution to these treatments however, in most instances the cost is shared between the hospital and the patient. For example, the total cost of chemotherapy agents used for non-PBS indications at The Wesley Hospital in FY13 amounted to approximately \$84K. 50% of these costs were absorbed by the hospital to ensure appropriate clinical treatment was provided to the patient.

In FY13 TWH treated 50 Bone Marrow Transplant patients and had 1,653 haematological malignancies admissions. The average length of stay was 26.9 and 10.19 days respectively. Several chemotherapy protocols for BMTU and haematological malignancies involve non-PBS listed parenteral chemo agents in combination with oral chemotherapy and adjuvant therapies. The top 5



chemotherapy agents commonly used at The Wesley Hospital are listed in Table 5. The cost of these agents has reduced over the past couple of years reflecting changes in prescribing patterns. TRETINOIN has been used in BMT protocols for many years. The cost of 100 tablets (8 days therapy) is \$781 or \$2,343 per episode of care (based on average length of stay for this DRG). This is usually absorbed by the hospital. It worth noting that in the recent years haematologists favoured a use of PLERIXAFOR in patients failed conventional G-CSF agent.

*Table 4 PBS listed chemotherapy agents prescribed for non-PBS indication  
July 2012-June 2013*

Chemotherapy agent	Cost \$
BORTEZOMIB 3.5mg INJ	\$ 7,438
CARBOPLATIN	\$ 135
CISPLATIN	\$ 87
CLADRIBINE 10mg/5ml vial	\$ 1,470
CYCLOPHOSPHAMIDE	\$ 474
CYTARABINE	\$ 489
DOCETAXEL	\$ 118
DOXORUBICIN	\$ 2,614
EPIRUBICIN	\$ 195
ETOPOSIDE	\$ 284
FLUDARABINE	\$ 21,867
FLUOROURACIL	\$ 29
IRINOTECAN	\$ 467
METHOTREXATE	\$ 18
MITOZANTRONE	\$ 561
OXALIPLATIN	\$ 1,648
PACLITAXEL	\$ 960
PACLITAXEL NAB	\$ 4,887
RITUXIMAB	\$ 29,087
TRASTUZUMAB	\$ 10,805
VINCRISTINE	\$ 77
VINORELBINE	\$ 181
<b>Grand Total</b>	<b>\$ 83,891</b>

*Table 5 Non PBS chemo therapies, TWH*

Chemotherapy agent	2011	2012	YTD2013	YTD 2013 extrapolated to 12 months
AMSACRINE 75mg/1.5mL INJ	\$ 9,282			
ANCESTIM 1.875mg INJ	\$ 7,200			
CARMUSTINE 100mg vial VIAL	\$ 38,853	\$ 36,687	\$ 8,252	\$ 16,504
DACARBAZINE 200mg INJ	\$ 2,129	\$ 3,308	\$ 1,431	\$ 2,862
MELPHALAN 50mg VIAL	\$ 26,834	\$ 20,074	\$ 6,817	\$ 13,635
<b>Total</b>	<b>\$ 86,309</b>	<b>\$ 62,080</b>	<b>\$ 16,500</b>	<b>\$ 33,000</b>

PLERIXAFOR 24mg/1.2mL INJ and TRETINOIN 10mg capsules were used in 19 patients diagnosed with leukaemia in 2010-2013. Total cost of these therapies was \$472K or \$24K per patient. Applications for additional funding resulted in 6%



reimbursement from the health insurers (\$23,982). The Wesley Hospital received 6% of the total costs in the form of a patients' contribution. The remaining \$423K was absorbed by the hospital. It is a fact that due to the inadequate funding of BMT patients from private health funds, no for profit hospital operator would provide this service with such patients and their associated costs, being transferred to the public setting.

Management of cancer patients receiving chemotherapy is complex and extends beyond preparation and administration of PBS listed chemotherapy medications. A holistic approach to both, the delivery of the chemotherapeutic regimens along with the associated supportive therapies is of paramount importance in securing positive outcomes for this vulnerable patient group.

