PSA FEDERAL BUDGET SUBMISSION
2020/2021 FINANCIAL YEAR

ABOUT PSA

PSA is the only Australian Government-recognised peak national professional pharmacy organisation representing all of Australia's 31,000 pharmacists working in all sectors and across all locations.

PSA is committed to supporting pharmacists in helping Australians to access quality, safe, equitable, efficient and effective health care. PSA believes the expertise of pharmacists can be better utilised to address the healthcare needs of all Australians.

PSA works to identify, unlock and advance opportunities for pharmacists to realise their full potential, to be appropriately recognised and fairly remunerated.

PSA has a strong and engaged membership base that provides high-quality health care and are the custodians for safe and effective medicine use for the Australian community.

PSA leads and supports innovative and evidence-based healthcare service delivery by pharmacists. PSA provides high-quality practitioner development and practice support to pharmacists and is the custodian of the professional practice standards and guidelines to ensure quality and integrity in the practice of pharmacy.

PSA, in recognition of being the custodian of the Competency Standards for Pharmacists, Code of Ethics and Professional Practice Standards for Pharmacists, is a co-signatory to the 7th Community Pharmacy Agreement.

Above: Fredrik Hellqvist MPS, community pharmacist, Tasmania.

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EXECUTIVE SUMMARY

Commissioned by the Pharmaceutical Society of Australia (PSA), Medicine Safety: Take Care[1] released in early 2019 has shone a light on medicine safety in Australia. In response to this report, and other concerning data on medicine use, notably the Royal Commission into Aged Care Quality and Safety interim report,[2] the Australian Government has acted, working with state and territories to declare Medicine Safety and the Quality Use of Medicines Australia's 10th National Health Priority Area (NHPA).

PSA's submission to the 2020-21 Federal Budget aims to provide rational, innovative and cost-effective solutions addressing current health system challenges, particularly in relation to reducing the harm caused by medicine use in Australia.

PSA recommends the Australian Government, in its 2020-21 Budget, makes provision for the following:

1. Establish a Medicines Safety in Aged Care Resource and Support Program

Allocate $8.7 million over four years for the establishment of a Medicines Safety in Aged Care Resource and Support Program to support the safe and quality use of medicines within aged care.

2. Pilot a Rural Pharmacy Enhanced Services Program

Allocate $15.4 million to pilot a Rural Pharmacy Enhanced Services Program to support rural pharmacists deliver high-quality primary care that improves access to health care and addresses the disease burden challenges present in rural Australia.

3. Support a pilot opioid stewardship program through pharmacists working in general practices

Allocate $4 million for an 18 month pilot program of opioid stewardship pharmacists in general practices to reduce the harm caused by opioid medicines.

4. Increase the value of the tiers of the Workforce Incentive Program (WIP) per SWPE by 50% including lifting the limit to $187,500

Allocate additional funds to support more pharmacists within general practice; including increasing the value of the WIP funding per Standardised Whole Patient Equivalent (SWPE) by 50% and increasing the upper limit cap on the larger general practices by 50%.

This will improve management of chronic health conditions and improve medicine safety, particularly at transitions in care, for the Australian population.

5. Appoint a Commonwealth Chief Pharmacist

PSA calls on the Australian Government to allocate $400,000 annually to improve the Commonwealth Government's coordination and responsiveness to medicine safety and quality use of medicines in Australia's complex healthcare system.

Pooja Maru MPS, mental health community pharmacist, Perth.

RECOMMENDATION 1

Establishing a Medicine Safety in Aged Care Resource and Support Program

The challenge

The Royal Commission into Aged Care Quality and Safety interim report[2] (the Royal Commission) raised alarm at the manner in which medicines are used in Australia's residential aged care facilities. In particular, it identified systemic failures with regard to "widespread overprescribing, often without clear consent, of drugs which sedate residents, rendering them drowsy and unresponsive to visiting family and removing their ability to interact with people".

Of particular concern, nearly all (98%) of people living in aged care facilities have at least one medicine-related problem[1] and the rates of antipsychotic prescribing in residential aged care facilities[3,4] is unjustifiably high.

PSA contends there is no doubt that the absence of regular pharmacist services in aged care facilities is causing harm. The fundamental role of pharmacists is to keep people safe from medicine-related harm. When there is inadequate investment in pharmacist support in a care setting where medicines are used, the level of harm reported is not surprising.

Initial actions taken by the Government with respect to an additional $25.5 million investment in medication management programs, the declaration of Medicine Safety and the Quality Use of Medicines a National Health Priority Area (NHPA) and revised PBS Authority restrictions for risperidone represent a welcome initial response to the interim report's findings. However, significant additional resources and support are needed to achieve meaningful improvement in reducing use of chemical restraint, reducing preventable medicine-related hospital admissions from residential aged care facilities and improving quality of life for residents.

PSA maintains more pharmacists on the ground within aged care facilities are needed to identify, prevent, manage and resolve medicine-related problems and to adequately support health professionals and facility staff in improving the safe and quality use of medicines.

Antimicrobials

Substantial efforts to educate and support prescribers and facility staff to minimise inappropriate prescribing and use of antibiotics are warranted. The following data reported in antimicrobial prescribing and infections in Australian aged care homes: results of the 2017 Aged Care National Antimicrobial Prescribing Survey[5] are the basis of PSA's concerns.

- More than half (55.2%) of the antimicrobial prescriptions were for residents with no signs and/or symptoms of infection in the week prior to the start date
- For 26.9% of antimicrobial prescriptions, the start date was greater than six months prior to the survey date
- The indication for commencing an antimicrobial was not documented for 23.7% of prescriptions.

Sedative medicines

The Royal Commission heard startling testimony regarding the use of sedative medicines in aged care facilities, often as a form of chemical restraint. Presented research involving 150 residential aged care facilities described[2]:

- 61% of residents regularly given psychotropic agents
- 41% residents prescribed antidepressants
- 22% residents prescribed antipsychotics
- 22% residents prescribed benzodiazepines

Upon review, an Australian Department of Health's expert clinical advisory panel estimated that use of psychotropic medicines was only clearly justified in about 10% of cases in which they are prescribed in this setting.[2]

The proposed approach

PSA proposes that the Government allocate $8.7 million over 4 years to establish a Medicine Safety in Aged Care Resource and Support Program.

This program will provide for the establishment of a consortia to lead the development, dissemination, implementation and evaluation of evidence-based resources for aged care facilities. The resources will be used by health professionals, including pharmacists, general practitioners and nurses within aged care facilities to improve the safe and quality use of medicines.

The Medicine Safety in Aged Care Resource and Support Program would include:

- Development of evidence-based training resources for:
    - psychotropics, with a focus on their use as chemical restraint
    - antimicrobials
    - opioids
    - high risk medicines such as anticoagulants
    - deprescribing
- Practice change facilitation resources:
    - A train-the-trainer package will be developed to support practitioners including pharmacists, nurses and other health professionals to incorporate best-practice use of medicines within aged care

Under the program pharmacists, nurses and general practitioners will have access to the right evidence-based clinical resources and approaches to safer medicine use. Pharmacists, as part of their quality use of medicine (QUM) requirements, will be able to access appropriate tools to deliver better QUM programs, including education and training of aged care staff.

This proposal is separate and additional to addressing specific recommendations directed to PSA and other stakeholders within the Aged Care Royal Commission interim report regarding the negotiation of the 7CPA. PSA believes investment in pharmacist services through expanded medication management programs and increased investment in Quality Use of Medicines services should be addressed as part of the 7CPA.

Timeline

Establishment of the program commencing 1 July 2020

Budget

PSA estimates the budget allocation to support this proposal to be $8.7 million over the forward estimates, as outlined below:

FY	Budget impact
2020/21	$3.3 million
2021/22	$1.8 million
2022/23	$1.8 million
2023/24	$1.8 million

Why it will work

Supporting pharmacists, and other health professionals with the right tools and evidence-based information within residential aged care facilities has been shown to improve medicine safety, as well as communication and collaboration between members of the multidisciplinary team.[4]

Other Australian data shows pharmacists, in collaboration with doctors and nurses in aged care, can safely reduce the use of high-risk medicines. This includes reducing inappropriate use of antipsychotics and benzodiazepines through the delivery of structured programs led by pharmacists. These programs incorporate audit, feedback, and education of health professionals in the multidisciplinary team.[4]

Khanh Nguyen MPS, community pharmacist, Ascot Vale, Victoria.

A medicine safety resource development program would enable the national delivery of the highly successful RedUSe program, tackling sedative and antipsychotic medicine use in aged care facilities.[4,6,7] The educational components of this program were developed through a collaborative initiative involving the University of Tasmania, NPS MedicineWise and PSA.

RedUSe is a multi-strategic quality improvement intervention funded in aged care facilities, with three main components:

- audit and benchmarking of sedative and antipsychotic medicine use
- interactive and didactic education for aged care home staff about the benefits, risks, and guidelines for psychotropic use
- targeted multi-disciplinary sedative review for all residents taking regular doses of antipsychotics and/or benzodiazepines by a pharmacist in collaboration with nurses and prescribers.

Audit

Education

Review

Benefits identified included trends towards:

- improved agitation with both antipsychotic and benzodiazepine dose reduction
- reduced in occupational disruptiveness related to agitation with antipsychotic reduction
- reduced sleep disturbances with benzodiazepine reduction.

There were also savings with antipsychotic and/or benzodiazepine dose reduction, mainly driven by lower costs related to hospitalisations.

PSA calls for $8.7 million over 4 years to support the safe and quality use of medicines within aged care by establishing the Medicine Safety in Aged Care Resource and Support Program.

Benefits to Australians

- **Reduced inappropriate medicines use** in aged care as **measured** by:
  - Reduction in antipsychotic and sedative use
  - Reduction in medicines that increase or contribute to falls
  - Reduction in medicines which impair cognitive ability (anticholinergic medicines and sedatives)
  - Reduction in inappropriate antimicrobial and opioid use
  - Reduction of medicines inappropriately administered within aged care
  - Reduction in the number of elderly Australians receiving multiple medicines reporting adverse effects or problems with their medicines.
- **Improved clinical governance** of the safe and quality use of medicines within aged care, measured by:
  - Improved adherence to medicine management Aged Care Quality Standards
  - Improved staff education and training regarding safe and quality use of medicines.
- **Better quality of life for older Australians**, measured by:
  - Reduction in avoidable harm associated with medicine management in elderly Australians
  - Reduction in acute admissions to hospitals from aged care facilities for medication-related admissions
  - Reduction in admissions (to hospitals and residential aged care facilities) for elderly Australians receiving Home Medicines Reviews and follow-up
  - Deprescribing unnecessary medicines for aged care residents (polypharmacy), and associated reduction in PBS expenditure
  - Reduction in hospital admissions and injuries from falls

RECOMMENDATION 2

Pilot a Rural Pharmacy Enhanced Services Program

The challenge

The seven million Australians (approx. 29% of the population) living in rural and remote areas generally have a higher prevalence of chronic conditions, and often have poorer health and welfare outcomes compared to those who live in major cities.[8,9] They have higher rates of risk factors, such as daily smoking, excessive alcohol consumption, physical inactivity and overweight and obesity, especially in outer regional/remote areas.[9] They also have higher rates of preventable hospitalisations due to acute and chronic conditions, higher rates of potentially avoidable death and a lower median age at death, all trending worse as location becomes more remote.[9]

In many rural communities, the only health services available are from a general practice (if a general practice exists) and a community pharmacy. People living in rural and remote areas are less likely than those in cities to have a usual general practitioner (GP) or place of care, and more frequently report that there were times they needed to see a GP for a health care need, but could not because there was no GP available nearby.[9]

As the most accessible health care providers, pharmacists are well placed and willing to deliver a much greater role in Australia's health system. In regional, rural and remote Australia, where pharmacists may be the only health care provider in a community, this role in the health system is especially valued. Yet, recognition and integration of pharmacists into primary care in Australia remains generally poor. A recent international systematic review reported that improved integration of pharmacists into primary care resulted in reduced use of unnecessary GP appointments and reduced emergency department (ED) attendances.

Rural pharmacists working within community pharmacy in Australia have an opportunity to significantly address the breadth of disadvantage afflicting many people living in rural and remote Australia. It is PSA's view that innovative models of care, available to rural practitioners, should be adopted and implemented as a matter of urgency.

However, while ideally positioned to support their communities, community pharmacies in rural and remote Australia are on the brink of extinction as we know it. Without a specific focus on the rural pharmacist workforce in Australia we will see little improvement in complex and chronic disease management and will fail to deliver on the objectives of Australia's Long Term National Health Plan[10] and unique National Medicines Policy.[11]

The proposed approach

PSA proposes a **Rural Pharmacy Enhanced Services Program** to support the delivery of services that are required within rural communities due to lack of access to health care professionals and increased disease burden.

The program would provide support for provision of programs in a 'health hub' model, such as structured programs for:

- smoking cessation
- management of airways diseases (asthma and COPD)
- screening and risk assessment for chronic health conditions (e.g. cardiovascular disease and diabetes)
- wound care
- mental health triage and referral, including suicide prevention.

The programs would build on the existing evidence base for pharmacist-led services in its design, and include:

- Structured delivery protocols and documentation, which may be able to be uploaded into My Health Record
- Professional service fee
- Service-specific training and guidelines

PSA proposes the pilot program to be rolled out across 150 rural community pharmacies in PhARIA categories 3-6 over a three year period. This proposal is estimated to cost $15.4 million over the forward estimates.

Rural pharmacists should be supported to be better integrated with general practice, with appropriate training in providing primary health services (e.g. mental health support) and thereby more effectively address the primary health care and medication management needs of patients.

Timeline

Program development commencing 1 July 2020

Implementation three year period from 1 January 2021 to 31 December 2023

Budget

PSA estimates the budget allocation to support this proposal to be $15.4 million over the forward estimates: estimates, as outlined below:

FY	Budget impact
2020/21	$2.8 million
2021/22	$5 million
2022/23	$5 million
2023/24	$2.8 million*

* Six month implementation and evaluation

Why it will work

An adequate and appropriate Rural Pharmacy Enhanced Services Program is a vehicle to advance several priorities contained in Australia's Long Term National Health Plan,[10] including:

- Pillar One (supporting the role of pharmacists in primary health care and a CPA focus on greater use of pharmacists' scope of practice)
- Stronger rural health ("the Government is determined to ensure the seven million Australians who live in small towns or rural areas do not have to settle for second-class health services and health outcomes").

The Rural Pharmacy Enhanced Services Program will address the two major impediments to delivering equitable and accessible high-quality health care, that is:

- increased disease burden in rural Australia
- reduced access to health care providers in rural Australia.

PSA asks the Commonwealth to allocate $15.4 million over three years to pilot a Rural Pharmacy Enhanced Services Program to support rural pharmacists deliver high-quality primary care which improves access to health care and addresses the disease burden challenges present in rural Australia.

Benefits to Australians

- Improved health literacy support to improve understanding of health conditions and effective use of medicines
- Improved health of people living in rural and remote areas as pharmacists are empowered to apply their knowledge and skills in different ways to meet their health needs
- Reducing unfair disparities in access to health care in rural and remote areas
- More effective, cost-efficient care through innovative funding models to support a collaborative primary care rural workforce

RECOMMENDATION 3

Allocate $4 million for an 18-month pilot program of opioid stewardship pharmacists in general practices to reduce the harm caused by opioid medicines.

The challenge

The use of opioid medicines in the Australian community has increased dramatically in recent decades – associated with increasing use in the management of chronic pain and post-surgical pain.[12,13]

Associated with this increase has been a significant increase in the harm caused by opioid medicines.[13,14] Australian Government data on this issue is concerning:

- In 2016–17 there were 5,112 emergency department presentations and 9,636 hospitalisations due to opioid poisoning.
- Opioids led to greater than 3 deaths/day in 2018. The majority of these were unintentional overdoses in middle aged males involving the use of pharmaceutical opioids, often in the presence of other substances.[14]
- Pharmaceutical opioids are more likely to be involved in opioid deaths and opioid hospitalisations than heroin.[13]

The policy response to this challenge has included multifaceted harm reduction initiatives such as the introduction of real-time prescription monitoring (RTPM) systems, amendment to pack sizes of pharmaceutical opioids, improved community access to naloxone and revision of Consumer Medicines Information leaflets.[15] However, these initiatives can only achieve their objective to reduce harm with effective governance and implementation. Hospitals are increasingly engaging opioid stewardship pharmacists to fulfil this role in the hospital sector,[16] however, this role has not yet been explored in primary care where the majority of pharmaceutical opioids are prescribed.

The proposed approach

PSA, in collaboration with Pain Australia, proposes the Government commission a pilot project to support opioid stewardship pharmacists working within general practice. The proposal is for an 18 month pilot program consisting of:

- Grants to general practices to support the engagement of an opioid stewardship pharmacist for up to 15 hours per week (depending on SWPE) in up to 150 general practices across rural, regional and urban Australia
- Development of a primary care opioid-stewardship quality improvement program
- Pharmacist support and credentialing

The overall funding would be $4 million over 18 months.

Training

PSA offers the only online foundation training for pharmacists new to working in general practice which could be adapted to support pharmacists employed in this emerging stewardship role.

Guidelines

PSA has developed practice guidelines and a suite of practice support tools for pharmacists working in this setting. These can be customised to support the opioid stewardship program.

Timeline
From 1 July 2020 for 18 months to December 2021
Budget
PSA estimates the budget allocation to support this proposal to be $4 million for the duration of the 18 month pilot project.

Why it will work

There are currently over 200 pharmacists working in general practice in Australia. PSA has extensive experience in working with and supporting general practice pharmacists, including in three current Primary Health Network (PHN) trials. These trials have illustrated the benefits of pharmacists in general practice for medicine safety through individual patient care, clinical governance and staff education within practices in these trials **(see Attachment 1).**

These activities which general practice pharmacists are involved in align well with opioid stewardship activities. Opioid stewardship requires strong multidisciplinary support and involvement, clinician and consumer education, adequate communication across practice settings and review of prescribing patterns.[18] Pharmacists are recognised as the driving component of opioid stewardship programs.[18,19]

General practice pharmacists are best placed to increase safety and effectiveness of opioid use and pain management in primary care settings due to their unique expertise in medicines use, and ensuring patients attending general practices receive pain management that is safe, appropriate and evidence-based.

Patient-level activities	Clinical governance	Education and training
• Identify, resolve, prevent and monitor medication use and safety problems • Reduce polypharmacy and optimising medication regimens using evidence-based guidelines, recommending cost-effective therapies where appropriate • Support or lead chronic disease medication management consultations • Undertake assessment or referral in primary care • Medicine reconciliation through transition of care	• Deliver evaluation audits on best practice management for chronic disease (e.g. opioids) • Develop and lead clinical governance activities centred around the quality use of medicines • Collaboratively lead and develop systems, processes and communication strategies to reduce the risk of medicine misadventure • Improve the quality of prescribing, such as prescribing of high-risk medicines • Lead and undertake research which informs and improves medicine use.	• Develop and lead education and training processes related to quality use of medicines • Deliver education sessions (such as new evidence, guidelines and therapies) • Respond to medicine information queries from other health professionals regarding patients (e.g. switching anticoagulants, antidepressants, opioid equivalence)

Figure 1: *Roles of opioid stewardship general practice*[17]

PSA calls for the Government to commission an 18 month pharmacist-led opioid stewardship pilot program in general practice to reduce the harm caused by opioid medicines.

Benefits to Australians

- Reduction in risk of dependency and overdose in people prescribed opioid medicines
- Supports best-practice deprescribing of opioid medicines and appropriate dose titration to maximise effectiveness of pain management while managing the risks of dependence and sedation
- Increases individual consumer knowledge of opioid medicines, supporting safer and more effective use of opioid medicines at home.
- Increases quality of prescribing through prescriber education, drug audit and clinical governance

RECOMMENDATION 4

Increase the value of the tiers of the Workforce Incentive Program (WIP) per SWPE by 50% including lifting the limit to $187,500

The challenge

Data demonstrates the need to ensure general practice is more focussed on achieving improved health outcomes through a better approach to medicine safety and Quality Use of Medicines. For example:

- Each year, 36.4% (over $19 billion) of expenditure in the primary care sector is spent on medicines
- Medicine misadventure leads to 250,000 hospital admissions and 400,000 additional emergency department presentations. At least half of this harm and many of these preventable hospital admissions are preventable.[1]

Existing policies are helping to address this problem. In the 2018-19 Federal Budget, the Government announced the establishment of a new Workforce Incentive Program (WIP) that aims to strengthen multidisciplinary primary care through supporting general practices to engage allied health professionals including non-dispensing pharmacists. This is due to come into effect in February 2020.[20]

However, under this program, the overall capped budget allocation remains the same as what was in place under the Practice Nurse Incentive Program at $125,000 per general practice per annum, as described in **Figure 2**. This cap will limit the extent to which practices are able to engage a pharmacist through this initiative. Adjustment of this value/SWPE and the upper cap are needed to see appropriate engagement of pharmacists in general practice.

SWPE	Minimum number of practice nurse hours per week for full incentive payment	Incentive amount for a registered nurse or allied health professional
1000	12 hours 40 minutes	$25,000
2000	25 hours 20 minutes	$50,000
3000	38 hours	$75,000
4000	50 hours 40 minutes	$100,000
5000	63 hours 20 minutes	$125,000

Figure 2: Current annual incentive amounts based on Standardised Whole Patient Equivalent (SWPE) values[20]

There will be a rural loading (of up to 50% extra) allocated to general practices in acknowledgement of the higher costs of sourcing health professionals in rural Australia.

The proposed approach

PSA calls for allocation of additional funds to support more pharmacists to be engaged within general practice. This proposal consists of:

- Increasing the value of the WIP per SWPE by 50%
- Increasing the upper limit cap on the larger general practices by 50%

Revising these aspects of the WIP will facilitate capacity in general practice for clinically meaningful interaction between general practitioners and pharmacists including to improve medicine safety and rational medicine use. The role of GP pharmacists is further described in **Attachment 1**.

In particular, this proposal will improve safety at transitions in care for consumers between general practice and the community pharmacy, residential aged care, and hospital pharmacy settings.

Mina Naguib MPS, general practice pharmacist, Melbourne.

Timeline
From 1 July 2020

Budget
PSA recommends a 50% increase in the value of the WIP per SWPE by 50% and increasing the upper limit cap on the larger general practices by 50%.

Why it will work

The integration of pharmacists into general practice medical centres as a key member of the medical team and as a conduit between settings is an approach supported by evidence, health consumers and the wider medical and pharmacy community.

Australian experience

Two systematic reviews and one meta-analysis describe the benefits of integrating pharmacists into the general practice team. The results demonstrate significant improvements for consumers with chronic diseases such as diabetes, osteoporosis and cardiovascular disease. Further, individual studies have shown improvements in other outcomes including identification and reduction of medicine-related problems, process measures such as appropriateness of prescribing, and reduction in total number of medicines.

A 2015 report by Deloitte Access Economics examined the impact of embedding pharmacists in general practice. The report found the integration has the potential to generate $1.56 in health system savings for every $1 invested in the program.[21]

The 2015 report found integrating pharmacists in general practice is expected to yield a net saving of $544.87 million to the health system over four years. Specifically, these savings are expected to result from[21]:

- Hospital savings of $1.27 billion; due to reduced number of hospital admissions following a severe adverse drug event
- PBS savings of $180.6 million; due to the reduced number of prescriptions from better prescribing and medicine compliance
- Individual savings of $49.8 million; reduced co-payments for medical consultations and medicines
- Medicare Benefits Schedule (MBS) savings of $18.1 million; due to reduced number of GP attendances following a moderate or severe adverse drug event.

In addition to positively contributing to the Government's QUM objectives, this initiative will contribute to a more sustainable PBS and MBS as well as minimising upward pressure on patient co-payments, improving future access and affordability for Australians.

International evidence

International experience indicates the inclusion of a pharmacist within a general practice:

- represents value-based care, as it has the potential to generate significant savings across the primary health care sector
- achieves broader savings resulting from substantial reductions in Emergency Department presentations and hospitalisation.

There is evidence the general practice models in which significant benefits have been demonstrated, employ care teams that while led by GPs, use an expanded workforce model in which nurses, clinical pharmacists and others assume greater care management roles.

There has been significant investment by governments to support the development and integration of pharmacists into general practice.

- NHS England through the General Practice Forward View reforms have committed to invest over €140 million ($AU245 million) to support the employment of up to 2000 additional pharmacists within England by 2020. This funding supports pharmacist recruitment and employment costs, provides education and training for pharmacists transitioning into this role, and for organisational development programs to support the general practice setting to integrate the pharmacist into the team.
- New Zealand, Canada, USA, and other parts of the UK also have pharmacists providing services in general practice settings.

Benefits to Australians
• Reduced burden of illness for patients with chronic disease • Improved medicine use and reaching of treatment targets • Reduced adverse events and improved medication safety for patients with chronic disease • Improved coordination of care for patients with chronic disease

Jiamin Liau MPS, general practice pharmacist, Melbourne

RECOMMENDATION 5

Appoint a Commonwealth Chief Pharmacist

The challenge

The Australian health system provides support and advice to approximately 25 million people but is challenged by its complexity and fragmented nature. To deliver against key areas of health policy requires engagement with state, territory and federal stakeholders, often with conflicting priorities. Added to this is the ever-changing landscape of medicines and regulations in Australia, which require a collaborative and proactive approach to ensure health professionals and the public are kept aware of important updates.

This complexity is greater due to challenging reform in areas such as primary health care, digital health, preventive health, mental health and chronic disease prevention. Pharmacists, being the most accessible health professional, are suitably equipped to support and progress these reforms consistent with governments' objectives.

While the role of pharmacists in the logistical supply of medicines is well understood, the risk mitigation and case management value of pharmacists in health care are often unrecognised. As the recognised peak body for pharmacists, PSA plays a significant role in providing advice on matters relating to pharmacists to the Australian Government. However, there are no formal structures within Government to provide independent ongoing expert advice on pharmacy and quality use of medicines issues. Given the significance of the pharmacy workforce and the need for improved quality use of medicines policy settings, the appointment of a Chief Pharmacist means the Government would maximise the opportunity to more efficiently and effectively respond to Australia's health challenges and achieve desired reforms.

The proposed approach

PSA calls on the Government to fund and appoint a Chief Pharmacist to be embedded within the Department of Health to support the Government's coordination and implementation of policies relating to the prescribing, supply and administration of medicines, as well as policy settings relevant to the National Medicines Policy and the pharmacy workforce.

This role, similar to roles of the Chief Medical Officer and Chief Nursing and Midwifery Officer, would provide high-level advice on issues relating to the safe and quality use of medicines.[22] The position would serve as the Government's principal advisor on all matters related to the National Medicines Policy. The role would incorporate:

- Provision of high-level, high-calibre and independent advice on workforce and workforce issues, pharmacist practice advice, actual and potential contribution of pharmacists to address existing and emerging health priorities
- Clinical leadership across the Department and sector to support the design, planning, implementation and evaluation of health service delivery
- Leadership of strategies of national significance to pharmacists, such as the National Medicines Policy, Strategy for the Quality Use of Medicines, antimicrobial stewardship, opioid stewardship and digital health
- Participation in the formulation and implementation of policy, strategic direction and initiatives which support the delivery of care and achieving government health objectives.

The Chief Pharmacist would provide a link between regulation, programs, funding and infrastructure, with a clear responsibility for coordinating all relevant segments of the Department with the pharmacy community and fostering the collaboration of the pharmacy sector with other health professions within Australia. The Chief Pharmacist would liaise with all the contact points within the Government and/or Department of Health and provide advice to the Government and Ministers in support of policy development, planning and implementation of health service reform agendas.

Timeline
From 1 July 2020
Budget
PSA estimates the budget allocation to support this proposal to be $400,000 annually, including salary and on-costs.

Why it will work

This structure already exists in some state and territory jurisdictions, including New South Wales and the Australian Capital Territory where an appointed Chief Pharmacist provides coordinated advice and oversight to medicine-related matters within their health systems. These roles have become integral to the provision of high quality advice within government and facilitation of efficient operation of pharmacist-related regulations.

PSA calls on the Australian Government to allocate $400,000 annually to improve the Government's coordination and responsiveness to medicine safety and quality use of medicines in Australia's complex healthcare system.

Benefits to Australians

- Provides an expert advisory single point of contact between Australian Government agencies on pharmaceutical and pharmacy sector issues
- Delivers cross-departmental strategic advice and insights on how to best utilise the pharmacist workforce to achieve key health initiatives and outcomes
- Better coordination of government health policy and programs, particularly those relating to the use of medicines
- Provide high level insight and coordination of government programs that utilise pharmacists to improve the safe and quality use of medicines
- Provide advice to government on how to achieve the objectives of the National Medicines Policy

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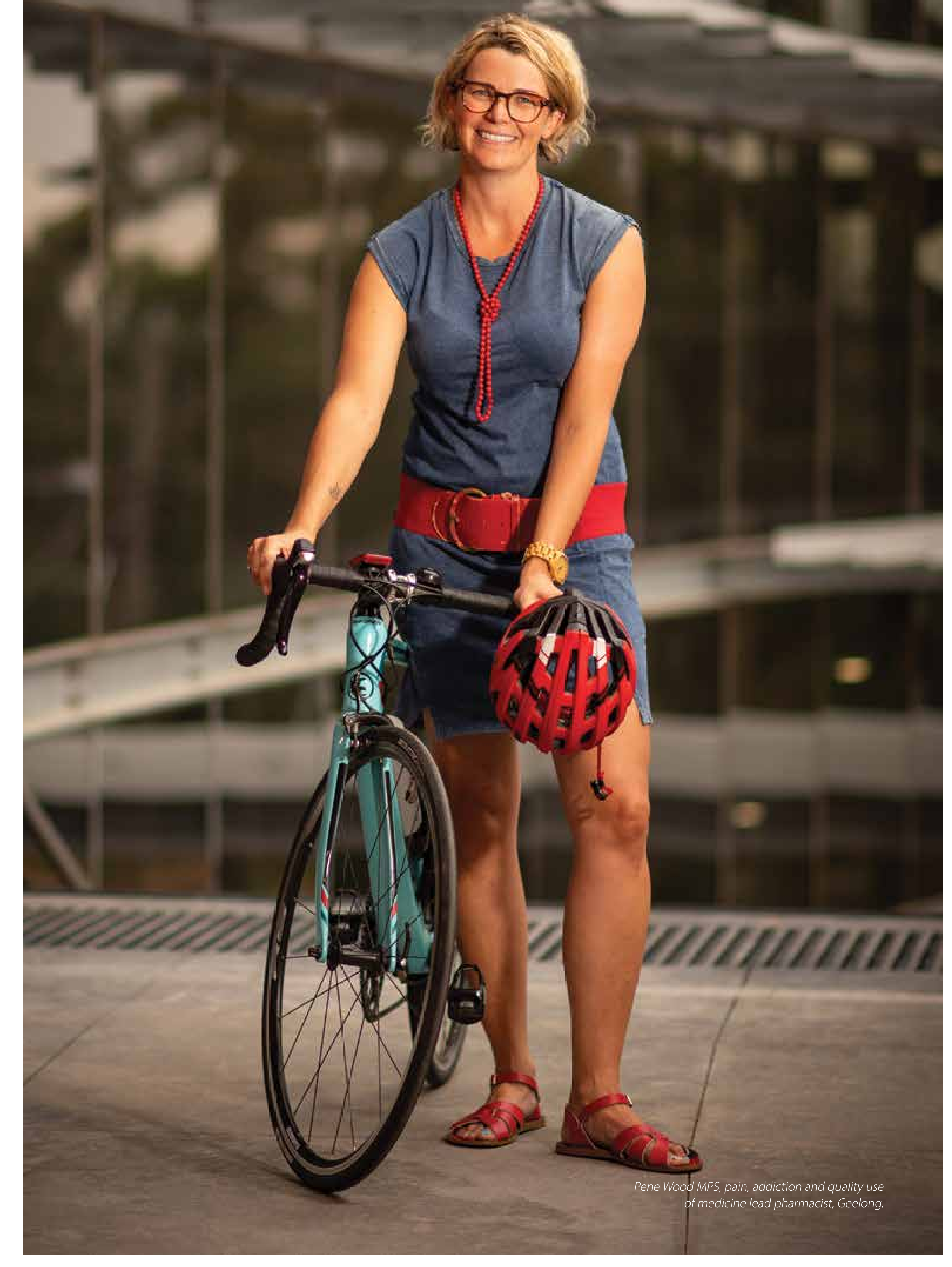

Pene Wood MPS, pain, addiction and quality use of medicine lead pharmacist, Geelong.

ATTACHMENT 1

GENERAL PRACTICE PHARMACIST

DESCRIPTION Pharmacist embedded within the primary care team at a general practice.[17]

ROLE	
CURRENT ROLE (2019)	
Supply of medicines	Not applicable – Dispensing medicines is not part of the role of general practice pharmacists.
Patient-level activities	• **Consultations**: Providing in-practice General Practitioner (GP) referred, patient requested or pharmacist-identified medicines consultations. These consultations can support activities described below, or be in response to specific patient or GP identified medicines related concerns. • **Medicine misadventure**: Identifying, documenting and following-up with patients regarding adverse drug events. Adverse events may be identified through review of patient records or referral by other practitioners within the practice. • **Medicine reconciliation**: Collaborating with community and hospital pharmacists to maximise medication reconciliation and management strategies. Though could include identifying missing or duplicate medicines, recommending ceasing unnecessary medicines or rationalising multiple medicines (e.g. opioids) into a simpler medicine regimen. • **Patient education**: Talking to patients about medicines related issues, including disease prevention, medicines adherence (e.g. appropriate dose times, inhaler techniques) • **Preventative care interventions**: Such as undertaking point-of-care tests (e.g. blood glucose, INR, blood pressure) to support medication management and smoking cessation counselling. • **Team-based collaboration:** Pharmacist participation in clinic activities that support team-based chronic disease care plans (case conferencing).
Clinical governance	• **Practice drug use evaluation audits**: Supports improvements in clinical practice by conducting Drug Utilisation Reviews (DURs) and Drug Use Evaluations (DUEs). • **Support RACGP standards and accreditation**: This may include audits of accuracy of data regarding medicines in software (i.e. medication reconciliation, medicines samples, disposal procedures for cytotoxic medicines etc.). • **Research**: Identify, initiate and conduct in-practice research activities.
Education and training	• **Group training**: Delivering education sessions (including new evidence, guidelines and therapies) to doctors and practice staff • **Individual training**: Providing tailored medication education sessions to medical students and general practice registrars. • **Medicine information resource to team**: Responding to medicine information queries including; questions relating to medication formulas, medication availability and specific medication concerns from GPs (e.g. switching anticoagulants, antidepressants, opioid equivalence).
Qualifications, skills and training	Requires the knowledge and skills developed in a Bachelor of Pharmacy or Masters of Pharmacy, intern training program and ongoing continual professional development post-initial registration. General pharmacist registration with AHPRA >2 years pharmacist experience (extremely desirable) Accreditation to undertake medication reviews desirable Holding or working towards postgraduate clinical pharmacy, advanced practice, diabetes educator or asthma educator credentials advantageous
Responsibility and accountability	Medicine safety and medicine regimens of consumers accessing care from the general practice

FUTURE ROLE (2023)	
Changes to role by 2023	Maturation of role as normative within general practices nationally, particularly in case conferencing. This will be accelerated through pharmacist access to the Medicare Benefits Schedule for chronic disease management plans, direct commissioning and other practice changes. Closer collaboration with doctors and an associated increase in autonomy through collaborative prescribing arrangements, increasing accountability for actioning medicine related recommendations (e.g. deprescribing, dose adjustment etc.).
Development pathway required for evolved role	Prescribing Schedule 4 medicines: collaborative prescribing endorsement via recognised certification pathway Advanced practice credentialing provides pathways to mastery of clinical skills and outcome Ongoing continual professional development
RECOGNITION	
Value to consumers	Pharmacists working in general practice work within a team that puts the patient at the centre. This teamwork directly benefits patients though: • Deprescribing of unnecessary medicines, medicines that have questionable risk versus benefit, and medicines that may cause adverse effects and reduced quality of life • Higher quality doctor prescribing from access to high quality medicines information at the time of prescribing • Reduced underuse of medicines that impact the risk of health events such as heart attack and stroke • Improved consumer understanding though more time to talk to a professional within a general practice about medicines, helping increasing consumer confidence in medicine use and providing a more patient-centred approach to care • Increased consumer knowledge of health conditions and medicines, leading to improved medicine adherence.
REMUNERATION	
Indicative salary in 2023 (ex. super)	• Foundation $80 000 to $100 000 • Advanced practice Level I (transition) $100 000 to $120 000 • Advanced practice Level II (consolidation) $120 000 to $140 000 • Advanced practice Level III (advanced) $140 000 and above

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