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AMA submission – Pharmacy Remuneration and Regulation Review

The AMA welcomes the opportunity to provide its views in writing to the Review Panel and respond to the discussion paper released for public comment in July 2016. We are pleased that the discussion paper reflects many of the concerns raised by the AMA's representative at a meeting with the Review Panel in February this year.

The AMA's submission focuses on the issues and questions raised in the discussion paper which impact on the quality of care provided to patients.

General comments

The AMA supports the review's focus on identifying future funding arrangements that support reliable, equitable and affordable access to medicines by the Australian community; quality use of medicines; and an equitable and sustainable PBS.

The AMA also values the professional role and expertise of pharmacists and the contribution they make to improving the health of patients.

Pharmacists' role and scope of practice

The AMA recognises the valuable contribution pharmacists make in improving the quality use of medicines. Pharmacists working with doctors and patients can help ensure medication adherence, improve medication management, and provide education about medication safety.

The AMA agrees that pharmacists' expertise and training are underutilised in a commercial pharmacy environment where they are distracted by retail imperatives including the sale of complementary medicines that have no basis in evidence. It would be difficult for anyone to argue that there is no inherent conflict of interest in this situation.

The AMA is therefore open to alternate models of funding that would encourage and reward a focus on professional, evidence-based interactions with patients.

Pharmacists working in general practices

With this objective in mind, the AMA made a proposal to the Government in 2015 to make non-dispensing pharmacists a key part of the future general practice health care team, supporting GPs to deliver high quality care for their patients.

The proposal calls on the Government to establish a funding program to support general practices to employ pharmacists - the Pharmacist in General Practice Incentive Program (PGPIP).

Under the AMA plan, pharmacists working in general practices would assist in areas such as medication management, patient education, and by supporting GP prescribing with advice on medication interactions and newly available medications.

Evidence shows that the AMA plan would reduce fragmentation of patient care, improve prescribing and use of medicines, reduce hospital admissions from adverse drug events (ADEs) and deliver better health outcomes for patients.

The proposal is backed by an independent analysis by Deloitte Access Economics. It shows that the AMA's proposal delivers a benefit-cost ratio of 1.56 – for every $1 invested in the program it generates $1.56 in savings to the health system.

Deloitte Access Economics estimate that if 3,100 general practices take up the PGPIP, it would cost the Federal Government $969.5 million over four years. However, this would be more than offset through broader savings to the health system in the following areas:

- hospital savings of $1.266 billion – due to reduced number of hospital admissions following a severe ADEs;
- PBS savings of $180.6 million – due to the reduced number of prescriptions from better prescribing and medication compliance;
- individual patient savings of $49.8 million – reduced co-payments for medical consultations and medicines; and
- MBS savings of $18.1 million – due to reduced number of GP attendances following a moderate or severe ADE.

The Pharmaceutical Society of Australia provided advice on the proposal's development and has given its full backing.

The full proposal as well as the Deloitte Access Economics report have already been provided to the Review panel and are publicly available on the AMA's website at:
https://ama.com.au/article/general-practice-pharmacists-improving-patient-care

Pharmacy programs funded under the CPA

Consistent with the above, the AMA supports many of the programs funded under the previous and the current Community Pharmacy Agreement (CPA) that support medication management and adherence such as Home Medicine Reviews and Dose Administration Aids. The AMA also supports ongoing programs to improve health outcomes for people living in rural and remote Australia, and Aboriginal and Torres Strait Islanders.

However, the AMA agrees it is important that these, together with other existing programs are evaluated for effectiveness and cost effectiveness to ensure the expenditure provides tax payers with value for money. The findings from these evaluations will help improve and strengthen the programs.

Similarly, the AMA applauds the requirement under the current CPA that all new programs undergo the same effectiveness and cost-benefit analysis. This introduces a level of accountability not previously present in the agreements negotiated solely between the Government and the Pharmacy Guild of Australia.

Pharmacy programs targeting Aboriginal and Torres Strait Islander people

Regarding the S100 Remote Area Aboriginal Health Services (RAAHS) program and the Closing the Gap (CTG) PBS Co-payment measure, the AMA agrees with the proposals in the discussion paper that these programs should be strengthened to improve the quality and continuity of care, and equal access, regardless of a patient's location or healthcare setting. These programs have had a positive influence in increasing access to medicines and improving health outcomes, but more could be done.

S100 RAAHS program

The AMA agrees pharmacists should have a stronger role under this program in the dispensing of medicines to individual patients to ensure quality, safe and efficient use of medicines. Without pharmacist involvement, there is an increased risk that the wrong medications, inappropriate or insufficient instructions and contraindicated medications are given to patients.

The physical presence of a pharmacist working in an Aboriginal Health Service would provide for direct advice to patients, avoidance of potential medication errors, better management of medicines dispensing history, as well as prompt advice and assistance to patients who need to cease taking a medicine, change their dose or change to a new medicine.

The AMA supports additional funding under the program to Aboriginal Health Services to employ or contract a pharmacist to provide quality use of medicines for its patients and for incentives to be created to attract suitable candidates for these roles in remote communities.

CTG PBS co-payment measure

While the impact of this measure has been encouraging, the AMA considers that access could still be improved. The AMA supports promoting the availability of the co-payment more widely to prescribers to increase awareness and uptake.

The AMA also agrees that access by eligible Aboriginal and Torres Strait Islander people should be improved by:

- allowing hospitals to issue patients on discharge with CTB PBS prescriptions, even if the patient is already registered for the co-payment;

- allowing Aboriginal Health Services in remote locations to provide CTG prescriptions and medicines under the S100 RAAHS program based on the needs of the patient; and

- linking eligibility to Medicare cards to allow residents living in remote locations who access medicines through the S100 RAAHS to automatically access CTG prescriptions when travelling in rural and urban locations.

Funding of health services outside pharmacists' scope of practice

The AMA fully supports programs that have been assessed as effective and cost-effective and which utilise pharmacists' training and expertise within their scopes of practice.

However, the AMA opposes expansions of pharmacists' scope of practice being funded under the Community Pharmacy Agreement.

Over the last few years, the Pharmacy Guild of Australia has pushed for a range of additional services to be funded under the framework of the Community Pharmacy Agreement to generate additional sources of income for pharmacies. These additional services represent an expansion of pharmacists' scope of practice beyond their core education and training.

This includes proposals that pharmacists undertake a range of new health care activities, such as: prescribing Schedule 4 medicines; early detection and intervention for mental illness; advice on nutrition, weight loss, smoking cessation, pregnancy and baby care; chronic disease management, e.g. asthma and diabetes; and so on.

Under the Health Practitioner Regulation National Law Act, which governs the practice of registered health practitioners, the national boards are responsible for setting the accreditation standards for education and training for the knowledge, skills and professional attributes to practise the profession.

By lobbying for these types of services to be funded under the Community Pharmacy Agreement, the Pharmacy Guild of Australia, representing for-profit business owners, is trying to drive the scope of practice of a health profession. The Pharmacy Board of Australia has not been involved in any way.

This is not an appropriate way to design a health care system to meet the future needs of the community.

To ensure patient safety and cost-effectiveness for the health care system, any expanded scopes of practice by non-medical health practitioners should be underpinned by a process that ensures:

- there are no new safety risks for patients;
- the change to scope of practice is rationally related to the practice of the profession and to core qualifications and competencies of their profession;
- the change in scope of practice is consistent with the evolution of the healthcare system and the dynamics between health professionals who work in collaborative care models;
- the training opportunities for other health practitioner groups is not diminished; and
- the cost to the health care system will be lower than the current service offering, taking account of supervision costs.

In addition, processes for expanding scopes of practice should also ensure that:

- the required competencies are predetermined, and accredited training and education programs are available to deliver those competencies; and
- there are documented protocols for collaboration with other health practitioners.

If in the future pharmacists' core education and training covers medical services, and pharmacists wish to have those services reimbursed by the Government, then those services should be assessed for safety, efficacy and cost effectiveness in the same way as other health practitioners' services – that is, evaluated and funded under the Medicare framework.

The Guild argues that pharmacists can meet an unmet need in the community because people cannot get in to see their doctor. However the pharmacist services quoted in this argument by the Guild, such as blood pressure checks, are the very services that people can plan for and make an appointment to visit their doctor at time convenient to them.

Many of the proposed services are also health screening services for which pharmacists are not trained to treat, for example, early detection and management of mental illness. So even in rural and remote areas, the patient's needs will be unmet.

Pharmacies in the community play an important role in providing medicines information to the public and ensuring that all Australians have access to medicines in a timely and safe manner.

However, medical practitioners are the only health professionals trained to fully assess a person, initiate further investigations, make a diagnosis, and understand and recommend the full range of clinically appropriate treatments for a given condition.

Hiving off certain aspects of health care, such as screening or prescribing, will only duplicate effort and fragment care.

Pharmacy location rules

The AMA supports high quality primary health care services that are convenient to patients, enhance patient access and improve collaboration between health care professionals. Co-location of medical and pharmacy services would clearly facilitate this.

The AMA supports changes to pharmacy regulation which would allow more pharmacies and medical practices to be co-located. The current restrictions are inflexible and are difficult to justify in terms of public benefit.

The current regulations require that for a pharmacy to be located within a medical centre, there must be at least 8 full-time prescribers. This does not recognise that the general practice workforce is increasingly made up of part-time medical practitioners, particularly those with family responsibilities who still wish to practise.

The regulations also require that any new pharmacy must be at least 500 metres from the nearest pharmacy. However with an ageing population, more patients are elderly and/or with chronic illnesses that impact on their mobility.

Restricting co-location of pharmacies and medical practices also reduces the opportunities of increased collaboration and communication provided by close proximity of doctors and pharmacists.

State legislation ensures there is a clear separation between prescribing and dispensing, with registered pharmacists responsible for medicines dispensing at all times.

Regarding the location of pharmacy premises within or adjacent to supermarkets, the AMA has no concerns as long as regulations continue to ensure a registered pharmacist remains responsible for dispensing.

Several independent reviews of pharmacy location rules (the most recent the Commonwealth Government's 2014 Competition Policy Review) have concluded that there is no evidence that relaxing current restrictions would negatively impact on patient health.

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