Background

Community pharmacists offer a range of services in addition to the supply of prescription and non-prescription products and are an integral component of primary and preventative care. They offer advice and medication reviews as part of their service while working in partnership with primary care providers. The 2014 Inquiry into Community Pharmacy in Victoria found that “Pharmacies play a crucial role within our health system and have the potential to take pressure off GPs and emergency departments”1.

Through this submission, Victoria recommends arrangements to support reliable and affordable access to medicines and promote the quality use of medicines. Given that an estimated two to three per cent of Australian hospital admissions are medication related2, there are opportunities to better utilise pharmacists within the health system. Victoria’s submission pursues a number of reforms that will enhance pharmacists’ contribution to health care and create transformational change within the pharmacy sector.

Victoria is leading the way in the evolution of community pharmacy services with the introduction of a Pharmacist Chronic Disease Management Pilot, which will utilise appropriately trained pharmacists in collaboration with general practitioners, to help local consumers better manage their chronic diseases.

Community Pharmacy Agreement negotiation process

Every five years, the Commonwealth Government (the Commonwealth) negotiates the Community Pharmacy Agreement (the Agreement) with the Pharmacy Guild of Australia (the Guild), as set out in section 98BAA of the National Health Act 1953. A range of stakeholders have an interest in, and are affected by, the Agreement, though the Commonwealth has entered into successive agreements with the Guild only.

The Australian Government Guide to Regulation3 states that policy makers:

1. “…should consult in a genuine and timely way with affected businesses, community organisations and individuals.”; and
2. “…must consult with each other to avoid creating cumulative or overlapping regulatory burdens.”

Incorporating consultation with a broader range of stakeholders would be consistent with the Department of Prime Minister and Cabinet’s guidance on best practice consultation4.

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Including a broader range of stakeholders in the consultation process for the Agreement would provide an opportunity for states and territories to influence the design and implementation of programs, including those that may require legislative change at a jurisdictional level. The Fifth Community Pharmacy Agreement included two programs, the continued dispensing initiative and the residential aged care medication chart initiative, that required amendment to Victorian legislation. The design and implementation of these programs would have benefited from consultation with jurisdictions during the development phase and promoted timely and effective implementation of the programs.

Involving other relevant stakeholders has the potential to benefit the evolution of the pharmacy profession and the services they can provide. Stakeholders are able to provide a broader view of the range of clinical services that pharmacists could offer and provide insights that may not currently be represented in the negotiation and consultation process.

Given that the Review of Pharmacy Remuneration and Regulation is primarily consumer-focused and aims to identify which services and programs consumers value from pharmacy providers, the involvement of consumer groups is integral to any negotiation and consultation process.

Incorporating a wider range of stakeholder views in development of the Agreement would promote a more inclusive process and, ultimately, better access to care.

Recommendation:

1. It is recommended that a broader range of stakeholders, including state and territory governments, are included in consultation for, and development of, the Community Pharmacy Agreement. This approach is consistent with best practice principles for whole-of-government consultations, policy development and regulation. It would ensure that a greater range of interests are represented in negotiation of the Agreement, and would mean that the Agreement can be implemented more effectively and achieve better care for consumers.

Pharmacists’ access to Medicare Benefits Schedule claiming

In 2014, the Victorian Parliamentary Inquiry into Community Pharmacy in Victoria found that “…unlike many other health care providers, pharmacists do not charge for advice, do not have Medicare provider numbers and consumers cannot seek reimbursement for the cost of pharmacist services through private health insurance.”

Currently, Home Medicines Reviews, MedsChecks and Diabetes MedsChecks are funded through the Sixth Community Pharmacy Agreement. However, under Team Care Arrangements, pharmacists are not able to provide allied health services for people with chronic conditions and complex care needs. This means that pharmacists are not reimbursed for delivering an expanded range of professional services, adversely impacting their ability to sustainably offer these services to the public.

A recently published literature review states that approximately 230,000 hospital admissions in Australia each year are attributable to medication prescribing errors at a cost of around $1.2 billion each year. Estimates of patient rates of non-compliance with medications are as high as 33%. These are significant costs to the health care system that may be reduced through better utilisation of pharmacists. Table 1 provides examples of the range of clinical services offered by pharmacists in other countries, and related outcomes.

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New Zealand: A community pharmacist-led anticoagulation management service in New Zealand provided point-of-care International Normalised Ratio (or INR) testing and pharmacists adjusted warfarin doses with the aid of a decision support system. Using the therapeutic range as a marker for the quality of anticoagulation control, the study found that it is reasonable to postulate a reduction in potential adverse events and hospitalisations. The predicted budget impact of the service is a net reduction in anticoagulation-associated costs of approximately NZ$177 million over 5 years (for 80% of patients managed under the pilot) or approximately NZ$111 million over 5 years (for 50% of patients managed under the pilot).

Canada: The role of pharmacists in Canada has been expanded to include prescription renewal, therapeutic substitutions, initiating prescription drug therapy, prescribing for minor ailments, prescribing for smoking cessation, ordering and interpreting lab tests and administering drugs by injection. This has resulted in improvements in public health outcomes such as increases in the uptake of vaccinations, better access to services and better self-management for chronic conditions such as diabetes. There is also good evidence to support a more collaborative care model for pharmacy practice.

United States of America: A study in which clinical pharmacists implemented a physician-approved care plan, including managing lipid-lowering drug therapy and educating patients on cardiovascular risk, indicates the effectiveness of a collaborative approach to optimising the management of patients with coronary heart disease whose low-density lipoprotein levels (LDL) were not at goal. 72% of patients achieved goal LDL in the intervention group versus 18% in the control group.

Although expanding the range of clinical services available from pharmacists offers a number of benefits, there are currently significant financial disincentives for pharmacists to offer new models of care. The major barrier is related to the cost of the pharmacist's time while they are providing a clinical service without reimbursement.

A recent qualitative study conducted in New South Wales evaluated consumers' experiences with a pharmacist-led hypertension management service and found that consumer feedback was extremely positive. However, cost was a barrier as most consumers would not be able to afford to pay for the service themselves. Consumers believe that services of this nature should be covered under Medicare.

Other countries such as Canada, the United States of America and the United Kingdom have been expanding the role of pharmacists for many years and have developed funding schemes to make these services accessible to consumers. Examples include:

1. Scotland has introduced a plan for the Primary Care Fund, which funds pharmacists to work directly with general practitioners as independent prescribers relieving pressure on general practitioners and allowing them to focus on caring for consumers.

2. Under the National Health Scheme in the United Kingdom, all pharmacy contractors offer ‘essential services’ such as dispensing, promotion of healthy lifestyles, disposal of unwanted medications, and support for self-care (minor ailment management). In addition, pharmacists are reimbursed for ‘advanced services’, which include new medicine services, medicines use reviews, appliance use reviews, stoma appliance customisation, and flu vaccination.

3. In some Canadian provinces, scaled publicly-funded remuneration is accessible to pharmacists providing advanced services such as prescription renewal and extension, therapeutic substitutions, initiating prescription drug therapy, prescribing for minor ailments and smoking cessation, ordering and interpreting lab tests, and

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<sup>6</sup> Shaw J, Harrison J, Harrison J, 2011. Community pharmacist-led anticoagulation management service: final report: School of Pharmacy, Faculty of Medical and Health Sciences, University of Auckland, Auckland. Available at: http://www.nzdoctor.co.nz/media/151782/pharmacy_ams_final_report.pdf [29 September 2016].


administering drugs by injection. Expanded scopes of practice provide pharmacists with an incentive to upskill. In addition to these roles, pharmacists also provide core services, including chronic disease medication management, and provide medication care plans.

Australia provides some remuneration for pharmacist services through the Community Pharmacy Agreement, but these arrangements do not take account of the potential scope of clinical services that could be offered by pharmacists. Individual practitioner remuneration would ensure that appropriately trained pharmacists are being adequately reimbursed for the services they provide and the additional training they would be required to complete. It is proposed that pharmacists providing clinical services should have access to an appropriate mechanism for claiming under the Medicare Benefits Schedule. This approach would incentivise pharmacists to advance their practice and may contribute to workforce retention.

By granting pharmacists access to Medicare Benefits Schedule claiming, there is an opportunity to provide adequate compensation for the pharmacy workforce to help improve community access to health services and support consumers to better manage their health. Including pharmacists in the range of allied health services that are available under Team Care Arrangements would also ensure a genuinely multi-disciplinary approach to chronic disease management that recognises the importance of medication management as part of consumer care. Consideration should be given to how remunerated clinical services are delivered independently to the supply of medicines.

The current caps on Team Care Arrangements, Home Medicines Reviews, MedsChecks and Diabetes MedsChecks do not align with consumers’ needs. For example consumers with chronic diseases like Type II Diabetes usually have a range of comorbidities with complex polypharmacy requiring frequent changes and adjustments outside of the allowance for home medicines review. Increasing the number of occasions of service for people with chronic disease, and expanding the existing limits on Home Medicines Reviews, MedsChecks and Diabetes MedsChecks would recognise the complexity of chronic disease management and improve outcomes for consumers.

According to the Inquiry into Community Pharmacy in Victoria, “the necessary training, protocols and physical infrastructure needs to be put in place to ensure that safety and quality are maintained” if pharmacists are to provide an expanded range of clinical services. Involving appropriately trained pharmacists in a greater range of clinical services has the potential to improve access to care, reduce costs to the health system and deliver better clinical outcomes for consumers.

**Recommendation:**

2. It is recommended that the Commonwealth Government consider implementing the following changes:
   a. Allow appropriately trained pharmacists to access Medicare Benefits Schedule claiming for evidence-based services such as chronic disease management, smoking cessation and vaccination;
   b. Provide a significant increase in the number of episodes of care included for chronic disease management under Team Care Arrangements and include pharmacists in these arrangements; and
   c. Remove or revise the cap on Home Medicines Reviews, MedsChecks and Diabetes MedsChecks.

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Submission: Review of Pharmacy Remuneration and Regulation