Better health outcomes through improved primary care: Optimising pharmacy’s contribution

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Foreword

Pharmacists are fundamental to improving primary health care and achieving better health outcomes across Australia.

PSA wants to ensure that all the initiatives in the forthcoming 6th Community Pharmacy Agreement (6CPA) meet community health needs whilst making best use of the skilled pharmacist workforce and the established community pharmacy infrastructure.

PSA’s overriding objective in the 6CPA is to ensure that consumer needs are met through a viable community pharmacy network to deliver high quality services across Australia. The options PSA offers are aligned with the Government’s policy objectives in rebuilding primary care, as our focus is on ensuring efficient use of health dollars through better utilisation of pharmacists and effective relationships between consumers, pharmacists, and GPs.

This document is a call for an evidence-informed policy framework for 6CPA, with commensurate increases in funding for pharmacist services. This represents a smarter investment for Government whilst delivering better health outcomes for consumers, particularly those with chronic diseases and on multiple medications.

The principles and options outlined in this document are informed by evidence from local and international programs and research, not only in pharmacy but the broader health domain. They are also informed by insights from PSA’s recent large survey of the profession and discussions with a broad range of stakeholders and organisations including those representing pharmacy, general practice and consumers.

The document builds on the Vision for the profession which positions pharmacists as critical contributors to Australia’s changing healthcare environment. Whilst community pharmacy is the most common setting in which pharmacists work and through which services are delivered, there are many other environments in which pharmacists can - and do – make a contribution to consumers’ health. This discussion paper positions 6CPA and the contribution of pharmacists within community pharmacy but also within this broader context.

Change is inevitable if we are to realise this Vision, and this document echoes its call for pharmacists to transition to a relationship-based, consumer-centric and collaborative model of care. The options PSA is suggesting for consideration represent evolutionary rather than revolutionary change, and we are committed to supporting pharmacists through the process.

I look forward to your engagement at this important time as we seek to progress these initiatives for the benefit of all Australians.
Executive summary

The 6CPA presents an opportunity to focus on the improvements in consumer health outcomes that can be achieved from the delivery of high quality pharmacist services, particularly for those with chronic diseases and on multiple medications.

The 6CPA needs to give appropriate recognition to the vital role that pharmacists and community pharmacies play in our primary healthcare system and, in doing so, help to ensure this well-established health infrastructure remains viable and sustainable into the future.

Whilst it is acknowledged that a number of the 5CPA professional programs are important contributors to maintaining and improving the health of the community, concerns have been expressed that some of the structural and governance arrangements of 5CPA may be limiting the effectiveness of these programs.

PSA wants to ensure that 6CPA can fulfil its potential to make a genuine difference to the health of the Australian community, as well as ensuring that pharmacies and pharmacists become more closely incorporated into the broader primary health care service environment. To do so, it is essential that 6CPA is built on an evidence-informed framework, so that increased investments in pharmacist services can deliver cost effective solutions for Government and better health outcomes for consumers, particularly those with chronic diseases who are taking multiple medications.

The full integration of pharmacists into a more collaborative, patient-centred model of care, is necessarily a long term (>10 year) objective, likely requiring different funding streams and significant changes within the health system as a whole. This doesn’t mean, however, that incremental steps towards this objective cannot be made within the context of 6CPA. A sound appraisal of what is achievable within the five-year CPA timeframe, from the perspective of all stakeholders, should be used to guide a pragmatic approach to improving current arrangements.

The transition period should be used to sharpen our focus on the key areas in which pharmacists can make a greater contribution to addressing gaps in the current health system and achieving Government health policy objectives through:

- better medication management, with a particular focus on chronic disease;
- public health and prevention initiatives;
- services to address shortages in rural and remote communities; and
- services to meet the needs of Aboriginal and Torres Strait Islander people.

PSA is strongly committed to the community pharmacy network as the preferred method of delivery of medicines made available through the Pharmaceutical Benefits Scheme (PBS), providing equitable community access to a range of cost effective pharmaceuticals.
All programs and services in 6CPA should make best use of both the pharmacist workforce and the established infrastructure of community pharmacy, and must be adequately funded to support their sustained delivery.

If the 5CPA professional programs are to continue in 6CPA, a significantly greater investment will be required to sustainably fund them. There are potentially smarter ways to make this investment, to allow a 6CPA that makes best use of community pharmacy in delivering optimal outcomes for consumers and the health system.

6CPA arrangements should reflect pharmacists as highly-trained healthcare clinicians who are accessible, responsible and accountable for their role in optimising medication outcomes in the community setting. The Agreement structure should be enhanced to give greater recognition to the numerous ways in which pharmacists can add value by ensuring access to health care for all Australians, in the supply of PBS medicines, and in improving the health outcomes of all Australians.

This discussion paper posits that a remuneration structure is needed which allows pharmacists to better utilise their clinical knowledge and ensures that clinical activities associated with medication supply are strengthened; removing incentives to operate in an environment which largely rewards volume – in many cases at the expense of high quality clinical service, and is focused on consumer need.

An option is proposed that would see 6CPA restructured to recognise the professional input of pharmacists along a professional services continuum from dispensing through to medication management and chronic disease monitoring.

This aligns with the key elements of Australia’s policy on Quality Use of Medicines, which the Agreements seek to deliver. In particular, it focuses on the safe and effective use of medicines to achieve the best possible results by: monitoring outcomes; minimising misuse, over-use and under-use; and improving people’s ability to solve problems related to medication, such as adverse effects or managing multiple medicines.

This approach is also focused on addressing the growing burden of chronic disease. Optimising the management of long-term conditions through quality use of medicines has been shown to reduce or delay the incidence of hospitalisation in patients with chronic diseases and to reduce the need for and spending on hospital admissions and medical services.

The options presented are likely to both reduce the burden on pharmacies attempting to implement multiple programs whilst also targeting services to populations most in need. Importantly, targeting these groups is likely to improve the cost-effectiveness of the programs, and it allows for a measured “scaling-up” approach to broader adoption of programs and services.

Not only do we need to take an evidence-informed approach to the services to be included in 6CPA, but the implementation must also be guided by evidence, if we are to collectively achieve the desired outcomes. Incentives and guidelines alone will not change practice. Evidence on effective implementation shows that investments are required in the following areas:

- Start-up costs (e.g. equipment, infrastructure);
- Purveyor support (e.g. forums, assessments, support for change);
- Funding for the services themselves; and
- Ongoing support of infrastructure for sustainability.

The 6CPA will be a significant driver for the pharmacy profession in terms of its contribution to the health of Australians. Realising the vision for 6CPA outlined herein requires pharmacy’s relevant professional bodies to work together. This will reduce unnecessary duplication of resources, and most importantly, will provide the profession with the best chance of successfully implementing existing and new professional practice programs, thereby delivering high quality health services to the Australian public.

There is no doubt that within the next five-year CPA cycle, there will be a greater demand for pharmacist services as a result of the ageing population, the increasing numbers of consumers with multiple chronic diseases, medical and technological advances, and the greater complexity created by these trends.

PSA's call for investing more health dollars in the community pharmacy system is bolstered by a recent report showing that health spending is at a 30-year low, with a large proportion of the reductions coming from the PBS, coupled with a recommendation that "What we can and should do is help people manage their illness in the community, to access the care they need where they live."4

Pharmacists and community pharmacies are ideally placed to help with the achievement of this goal but we need better mechanisms to ensure that they are used optimally. Greater engagement of PSA beyond being an “active participant” in Agreements can only be of benefit to this.

PSA acknowledges that real change is needed, not just for our profession’s future, but so that pharmacists can genuinely contribute to improvements in the health system, and ultimately, better outcomes for consumers.
Background

Since 1990, the Pharmacy Guild of Australia has negotiated five-year Community Pharmacy Agreements (CPAs) with the Australian Government, on behalf of its community pharmacy owner members.

These Agreements, which cover a large proportion of remuneration for community pharmacies, have been significant drivers of practice in community pharmacy in Australia. With the exception of Residential Medication Management Reviews in 2CPA (1995–2000), professional programs did not attract significant funding until the 3CPA (2000–2005), when Home Medicines Reviews (HMRs) were introduced. The funding allocated to professional pharmacy programs, as well as the range and focus of programs has increased with each subsequent Agreement, as summarised below.

The objectives of the Agreements have also evolved over time, moving from 3CPA which aimed to: provide consumers with reasonable equality of access to quality pharmacy services in their local community, to expand community pharmacy’s professional roles whilst providing a stable and predictable environment for community pharmacy and maximising taxpayer value; to the current Agreement (5CPA), which has sought to ensure that:

- pharmacists receive fair and adequate remuneration for pharmaceutical benefits supplied so that a stable environment is created for community pharmacy enabling it to remain viable and to participate in the continuity of care for all Australians;
- positive health outcomes are attained by the Australian community through the efficient delivery of patient-focused professional services and programs; and
- there is a network of accessible and viable community pharmacies throughout Australia including in rural and remote areas.

The extent to which each of the Agreements has achieved its objectives for each of the key stakeholders: Government, the pharmacy profession, and – ultimately – the consumer, has been a matter of some debate both within and outside of pharmacy circles. Concerns have been expressed about the current arrangements by a range of stakeholders, covering myriad issues from accountability to sustainability. There is general agreement, however, that development of, and advances in the arrangements for community pharmacy for the 6CPA are required; not only to address the challenges faced by the profession, but to deliver on objectives relating to effectiveness and health outcomes.
There is also a need to explore funding mechanisms that provide longevity and sustainability in service delivery, so that the contribution of the pharmacist can be truly integrated within the broader primary health care context.

**Challenges facing the profession**

Concern has been expressed that expenditure on health in Australia is reaching unmanageable levels. Annual spending on Medicare alone has increased by 125% over the past decade, from $8.6 billion in 2003-04 to $18.6 billion in 2013. And while Government outlays under the PBS are projected to remain stable at around 0.7% of GDP over the period to 2020, spending per person is projected to increase by 22% over the same timeframe.

The PBS remains an area of attention for the Federal Government, despite the savings made through recent reforms, and the latest AIHW report showing that health expenditure has reached its lowest level in 30 years.

The 2010 Intergenerational Report recommended that:

“It will be important to ensure that the health system provides value for money. This requires a health system that responds well to innovation, funding cost-effective improvements to health care while being able to adjust spending in areas where better value for money could be obtained.”

Minister Dutton has echoed this call, expressing a desire to find solutions now for a sustainable health system into the future, and foreshadowing the difficulty in finding money to pay for the services demanded by the increased burden of conditions such as dementia and diabetes.

Community pharmacy has and continues to feel the full force of efforts to rein in expenditure, through measures such as Accelerated Price Disclosure and Simplified Price Disclosure. At the same time, pharmacists are adjusting to changes in service delivery arrangements for programs such as Home Medicines Review (HMR).

The 6CPA presents an opportunity to focus on the value of pharmacists and community pharmacy to the Australian community. It is critical that the 6CPA gives due recognition to the vital role that pharmacists and community pharmacies play in our primary healthcare system and, in doing so, help to ensure this well-established health infrastructure remains viable and sustainable into the future.

The community pharmacy sector in Australia, encompassing more than 5,350 pharmacies across the country, is multifaceted and challenging, particularly as the health care needs of the Australian population are changing with an ageing population and advances in medical sciences and technology. The vital service that pharmacists play in dispensing and supplying essential medicines for the community, particularly consumers with chronic diseases, is a well-established part of the fabric of our society. Indeed, this has been the key role of pharmacists under the PBS since its inception in 1948. They have much more to contribute, however, as can be seen from the diagram below:

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**Pharmacists as part of the solution for a sustainable health system**

Community pharmacies are uniquely placed within Australian communities, and are increasingly being recognised as a hub for preventive health activities. The value of pharmacists and the community pharmacy network to patients and the health system is well documented, and many of the funded programs in the 4th and 5th Agreements were informed by trials demonstrating the benefits of pharmacist-delivered services.

Pharmacists are among the most trusted and accessible professionals in Australia. The 2014 annual Roy Morgan Image of Professions Survey found that 86% of respondents rate pharmacists highly on ethics and honesty, an increase on the 2013 result, placing pharmacists second overall behind nurses.

The community pharmacy sector in Australia, encompassing more than 5,350 pharmacies across the country, is multifaceted and challenging, particularly as the health care needs of the Australian population are changing with an ageing population and advances in medical sciences and technology. The vital service that pharmacists play in dispensing and supplying essential medicines for the community, particularly consumers with chronic diseases, is a well-established part of the fabric of our society. Indeed, this has been the key role of pharmacists under the PBS since its inception in 1948. They have much more to contribute, however, as can be seen from the diagram below:
The provision of medicines remains a core activity of pharmacists. This is not simply a supply function but is performed in the context of having the highest regard for patient safety and promoting judicious use of medicines, in line with Australia’s National Medicines Policy. That is, whether they are prescribed, recommended or self-selected, medicines should only be used when appropriate, with non-medicinal alternatives considered as needed. Pharmacists are also expanding and consolidating their role in promoting public health and safety, educating consumers and health professionals about QUM, and assisting consumers through health promotion activities and prevention of ill health.

Initial calls for savings to be made through the introduction of a co-payment for GP services, were denounced by health policy experts, with some suggesting that the Government look instead to the existing health workforce, noting for example that, “Overall, we use GPs to do work that could safely and more efficiently be done by nurses and other health professionals”.

General practitioners (GPs) and pharmacies are the most highly used health care services by consumers in Australia. Between July 2011 and July 2012, 94% of Australians aged 18 years and over reported using a pharmacy health care service. This proportion increases to 99% for Australians aged 65 years and over.

The recent Grattan Institute report on solutions for GP shortages in rural Australia highlighted the need for GPs to be better supported by pharmacists and other health professionals to deliver primary health care to the public. The report urged Government to “make much better use of pharmacists’ skills. Pharmacists are highly trained, have deep expertise in medicines, and are located in communities throughout Australia. But their role is far more limited in Australia than in many other countries.”

For most people the use of medicines is just one element of contribution to good or better health. This paper recognises the evidence behind a coordinated, team care approach where health professionals with different skills and expertise work in partnership to deliver care in a synergistic, cohesive and holistic manner. Such an approach was recommended by the National Health and Hospitals Reform Commission in its final report:

“We recommend improving the way in which general practitioners, primary health care professionals and medical and other specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting.”

Unfortunately, this goal will be challenged by the existing arrangements in place. For example, clinical pharmacy and education services are the missing link in most general practices and Aboriginal Health Services. There are opportunities in these settings for a non-dispensing pharmacist to work with other members of the health care team to improve medication use and reduce adverse events for consumers with chronic disease. This is a role that is complementary to programs being offered within community pharmacy, and ideally should be integrated within the broader suite of medication management services. The setting of a general practice with other primary care practitioners is a practical location for additional pharmacist services that can be tailored to the needs of consumers. However, this is only possible in very limited circumstances due to funding restrictions.

Currently a GP can call on the specialist skills of a nurse, physiotherapist or psychologist to help them meet the needs of consumers with chronic disease under programs nationally funded through the Medicare Benefits Schedule (MBS), yet a pharmacist can’t easily be included in the practice team to review and advise on the consumer’s medicines regimen.

A number of SCPA programs could and should complement these existing MBS programs, particularly those focused on improving the health of people with chronic disease, people with mental illness, Aboriginal and Torres Strait Islander people and people living in regional, rural and remote areas. Part of the challenge is that currently almost all funding for pharmacist-delivered services comes not from within the MBS where the other programs sit, but from the PBS as part of the Community Pharmacy Agreements. This leaves the pharmacy programs largely isolated from other programs administered by different sections within the Department of Health.

This separation could be adversely impacting the effectiveness and cost-effectiveness of all the programs. A recent review of England’s New Medicines Service found that pharmacists’ interventions around adherence delivered benefits for both consumers and the NHS, but that these could be improved by better integration within primary care.

Given the central role of medicines in the care and treatment of consumers with chronic disease, it doesn’t make sense not to foster linkages between programs. Without collaborative and integrated arrangements, a large number of consumers with chronic diseases are missing out, and an opportunity to improve their health is being lost.

Within the CPA itself, there is also scope to improve arrangements to remove impediments to the fuller involvement of pharmacists in primary health care. These issues and potential solutions are outlined in the following section.
Challenges presented by current 5CPA arrangements

Dispensing is wrongly perceived as an administrative task

Currently, remuneration for pharmacies is largely through the volume of dispensing and generic substitution. The Australian Government has invested some $15.4 billion over the five-year (2010-2015) term of 5CPA. These funds are directed primarily towards assuring the supply of medicines to the Australian community (“Part A”) and with approximately 4% ($663 million) allocated to a range of professional programs, workforce support and research and development initiatives (“Part B”).

Whilst the central element of the legislation underpinning the CPAs is to remunerate pharmacies for the supply of pharmaceutical benefits to the community, over time the Agreements have had an increasing focus on professional pharmacy services, as outlined earlier in this document.

Of significance is the fact that although in dollar terms the professional programs funding has steadily increased, as a proportion of total CPA funds it has actually declined for 5CPA. For example, in 3CPA, the funding accounted for 4.7%, in 4CPA it was 4.9%, but in 5CPA, it represents 4.1%.

The declining proportion of funding is also reflected in the arrangements for the professional programs, which in some way appear to be viewed as “add-ons” to the dispensing aspects rather than having been developed as an integral element of a strategic approach to improving the health of the community and changing pharmacists’ practice. This issue was articulated in a review of arrangements for 4CPA which found that “there was no overarching plan for rollout of programs and consideration of how projects and programs interrelate and how this might be better managed from the perspective of pharmacists participating in the programs.”

PSA is concerned that continuing to frame Agreements without such a plan has the potential to diminish the impact of both parts of the Agreement. Whilst it is acknowledged that a number of the 5CPA professional programs are important contributors to maintaining and improving the health of the community, concerns have been expressed that some of the structural and governance arrangements of 5CPA may be inhibiting the effectiveness of these programs.

Clarity of desired outcomes and impact

One of the challenges inherent in designing solutions for 6CPA is the difficulty of assessing the impact of 5CPA programs, particularly on aspects relating to achievements of the Agreement’s objectives on the quality use of medicines.

It is of course expected, based on the initial research that led to these funded programs, that 5CPA programs will have a positive impact on consumers and the health system. Optimising the management of long-term conditions through quality use of medicines has been shown to reduce or delay the incidence of hospitalisation in patients...
with chronic diseases and to reduce the need for and spending on hospital admissions and medical services. Furthermore, there is increasing evidence of the impact that pharmacists can have on medication safety and adherence, and the resulting savings to the health system.

The paucity of outcomes data from the specific programs, however, makes it challenging to identify areas for improvement when planning for 6CPA. For example, available data on the SCPA Pharmacy Practice Incentive programs including Primary Health Care, Working with Others and Community Services Support, do not indicate what services are being provided by pharmacists within each program category nor whether any or all of these services are meeting the health care needs of the community.

Similarly, the Clinical Interventions program guidelines only stipulate a requirement that pharmacies report numbers of interventions, and not the type of interventions made; making an evaluation of the impact of the program difficult. This is due in part to the absence of a data repository, which was a critical element of the design of the PROMISe research project (funded under 3CPA and 4CPA) on which the Clinical Interventions program is modelled.

Some of this may be addressed in the SCPA Evaluation, the final results of which will likely not be made available until April 2015, by which time it is anticipated that negotiations for the 6CPA will be well underway (some preliminary findings are anticipated in the 3rd and 4th quarters of 2014). However, as previously expressed concerns have highlighted, the SCPA Evaluation is largely focused on indicators of process rather than consumer outcomes, and may not provide the important insights needed to inform improvements and amendments for 6CPA.

By contrast, in the UK, where the NHS has imposed a strong emphasis on quality and outcomes, significant efforts have been made to evaluate the impact of pharmacist-delivered services beyond research trials, allowing issues to be identified and improvements to be made.

Integration between medication management programs

The medication management section of SCPA is perhaps most illustrative of the aforementioned concerns about a lack of integration between programs. This section contains programs with an obvious interconnection: Home Medicine Reviews (HMR), Residential Medication Management Reviews (RMMR) and MedsCheck/Diabetes MedsCheck.

In a policy sense, the three programs appear to have been regarded as distinct and unrelated rather than forming an integrated suite of medication management reviews that can be deployed on the basis of the needs of the individual consumer. This approach is reflected in separate program-specific rules and accompanying administrative arrangements as well as separate Professional Guidelines also applying to each program.

Funding for medication management programs has increased in dollar terms with each Agreement, as can be seen in the figure below.

A fundamental challenge from a budgetary perspective, however, is the fact that HMR referrals and follow-up by GPs come from an uncapped budget in the MBS, but the actual medication review services delivered by pharmacists sit within a capped budget environment of the PBS and five-year Agreements.

Funding of $164 million was allocated to these programs over the term of SCPA, and the year-on-year funding allocated to the programs does appear to have a relationship, in that funding allocated to the HMR program in 2012-13 was much lower than in preceding and subsequent years, presumably due to the introduction of the in-pharmacy MedsCheck program in 2011-12, but despite the projections for HMR growth.

During 2012-13, anecdotal reports of questionable business practices, increased demand, and inadequate funding led to a large cost overrun in the HMR program. This led to the development and administration of a new system of prior approvals for HMRs that need to be conducted outside the consumer’s home and further, to the introduction of caps in the number of services per provider to contain costs.

The budgetary challenges with the HMR program may also have slowed the introduction of the hospital-initiated HMR, as part of SCPA. It was to be introduced in response to research undertaken as part of 4CPA, and recognises the benefit an HMR service may offer to patients who are at high-risk of medication misadventure in the immediate post-discharge period, where they do not have access, or timely access, to a GP.
It is disappointing to note that because of the current financial constraints, it will be difficult for the 5CPA HMR program to be able to address the consumer access gaps identified in the 4CPA evaluation, which found that “Overall the research confirmed that those in greatest need of a HMR are the least likely to receive one and the greatest gap in access to HMRs is for those at highest risk of medication misadventure including:

- certain patients in the period after hospital discharge
- Indigenous consumers
- culturally and linguistically diverse consumers
- palliative care patients; and
- non-compliant or non-adherent consumers.”

Moreover, anecdotal reports provided to PSA suggest that the newly introduced prior-approval requirements for HMRs done outside the home are further disadvantaging the very groups that HMRs need to target, such as those from Indigenous and culturally and linguistically diverse communities.

This is compounded by the challenges faced by pharmacists delivering HMRs in rural and remote Australia. The $125 travel allowance falls far short of costs incurred when most rural HMRs are conducted. Many providers attempt to contain costs by combining 4-5 HMRs in the same region, but this may require an overnight stay, and the costs of accommodation are not covered by the HMR allowance.

Many Aboriginal and Torres Strait Islander people do not want a pharmacist to visit them at home, and want to have their HMR organised by the Aboriginal Health Service. Often HMRs for Aboriginal patients may be opportunistic rather than by appointment, in which case a 14 day time frame for prior-approval is not practicable.

All of this highlights the need for flexible delivery models for medication management programs which are tailored to the clinical needs of the consumer and are adequately funded to support their delivery. The identified target populations, who have the most to benefit from HMRs, must remain a priority for smoother access to medication management services in 6CPA, along with mechanisms to sustainably fund these important services. Importantly, targeting these groups is also likely to improve the cost-effectiveness of the programs.

Rural and remote pharmacy services

More research and data are needed about rural pharmacy workforce and rural pharmacists’ needs to inform decision making for 6CPA. Feedback provided to PSA by members indicates that many rural and remote communities cannot sustain a viable community pharmacy, despite 5CPA incentives such as the Rural Pharmacy Maintenance Allowance. Rural pharmacies can have a higher cost to income ratio than urban pharmacies, due in part to the higher wages needed to attract pharmacists, higher stock levels (fewer deliveries), greater transport costs and sometimes more expensive rent and accommodation (e.g. mining towns). The lower socio-economic status of rural populations is also a contributing factor to pharmacy income.

It also appears that current rural pharmacy workforce programs do not fully take into account the shortage of pharmacists in rural areas and regional towns, classified as PhARIA 1. Health Workforce Australia (HWA) statistics show that not only is there is a shortage of pharmacists in these regional areas, but pharmacists, interns and students located there have high travel costs whilst being ineligible for current allowances. Pharmacists are often unable to access/afford CPD events due to costs associated with travel, time and locums.

Thirty per cent of respondents to the Rural Pharmacy Survey conducted in June 2014, indicated that changes to rural program rules and the pharmacy rural classification system (PhARIA) under 5CPA had negatively affected them. The main concerns were the lack of ability to claim CPD and intern allowances. The capped HMR travel allowance also resulted in about 50% of HMR providers stating that they are doing fewer HMRs.
Aboriginal and Torres Strait Islander initiatives

The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) program focuses on improving QUM through a range of support services provided by participating Aboriginal Community Controlled Health Services (ACCHS) and community pharmacies in rural and urban Australia. However, only ACCHS registered for QUMAX are eligible to receive QUMAX funding, and therefore many Aboriginal patients are not receiving the benefits of QUMAX funding. A model that was linked to the consumer, rather than the setting, may see fewer people missing out.

The SCPA Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship scheme aims to increase the number of Aboriginal and Torres Strait Islander pharmacy assistants in community pharmacies and establish alternative pathways for Aboriginal and/or Torres Strait Islander students to enter a pharmacy career. However, currently only three scholarships are offered and the Australian Tertiary Admission Rank (ATAR) remains prohibitive for most students in the absence of university articulation pathways. Concerns have also been expressed that the scheme does not support trainees to complete training, and there is no incentive for pharmacists to employ Aboriginal pharmacy assistants once the allowance has finished.

Inter-professional engagement

There appears to have been little administrative focus on engaging other health professionals, particularly GPs, in an effort to ensure that the SCPA medication management reviews are considered as part of the regular cycle of care, particularly for consumers with a chronic disease such as diabetes. The unacceptably high and growing rate of avoidable hospital admissions as a result of medication-related problems provides compelling evidence of why such engagement is necessary.

As indicated previously, there is a need to link community pharmacy medication management programs to those offered by other health professionals such as GPs. Examples such as the diabetes cycle of care, or chronic disease management plans and team care arrangements could be formally linked and be part of the necessary requirements for some of the medication management programs for community pharmacy.

Beyond simply linking programs from the general practice and community pharmacy settings, there is an increasing body of evidence and support for the role of pharmacists co-located in general practice, providing both consumer and practice-focused services. Australian and international research found favourable results in various areas of chronic disease management and quality use of medicines, with positive outcomes in the management of diabetes and cardiovascular disease.

Furthermore, a recent survey conducted by PSA and the AMA found that both GPs and pharmacists welcome the opportunity to work more closely together, and there is agreement on the services that pharmacists can provide within a general practice.

Yet, as indicated earlier, important SCPA programs remain largely siloed from other programs administered by the Department of Health and Department of Human Services, and funded under the MBS. These programs, which could be amended to accommodate pharmacist participation, include Chronic Disease Management - Individual Allied Health Services, the Practice Nurse Incentive Program, the Quality Prescribing Incentive and the Mental Health Nurse Incentive Program.
Program implementation

The approach to program implementation in successive Agreements has also been the subject of ongoing discussion, with concerns expressed by pharmacy practice academics that implementation needs to be informed by the evidence and be underpinned by a change management framework. The importance of taking a broader view of the operations of a community pharmacy, highlighting the fact that ‘services cannot just be added as the next ‘retail category’...everything from philosophy of practice and vision, to customer service and staffing, will need to be built from the ground up…A new approach, developing understanding of the service business model, is urgently required.”

The absence of such a framework, despite recommendations from research funded through 3CPA and 4CPA R&D programs that not only did each program needed an implementation strategy, but that they should all be part of a broader change management strategy, led to what appeared at times to be a somewhat piecemeal approach to implementation during 5CPA.

Providing pharmacists with guidelines and an incentive (in the form of payments), along with the option to utilise software, is potentially an overly-simplistic approach for achieving widespread implementation of the programs. It appears to ignore the evidence showing a more holistic approach to change is required, well-articulated in a review of implementation research which stated that “implementation of programs and practices should not be viewed as “plug and play” where, somehow, new practices can be successfully added to ongoing operations without impacting those operations in any significant way.”

Pharmacy is not alone in these challenges. A recent NHMRC Report found that many clinical guidelines fail to document a dissemination and/or implementation strategy, impacting adoption rates across a range of practice areas and ultimately wasting investment in guideline development.

PSA has also expressed concern about the success measures being used, which relate to uptake and total volume of services delivered, rather than the spread and reach of service delivery to consumers across Australia. Clinical outcomes and cost effectiveness do not seem to be part of the evaluation parameters. This is evident in the pharmacy media, with an article stating how pharmacy had “exceeded expectations” by having 90% of all pharmacies registered to deliver PPIs. Another reported that there had been a 200% increase in the number of clinical interventions recorded. By reporting the uptake and volume alone, this commentary is silent on how many pharmacies are actively participating, where the pharmacies are located, to what level they are participating (i.e. no. of clinical interventions/pharmacy), or, importantly, the types of interventions that were made.

Reports that pharmacy participation rates for programs such as MedsChecks sit at lower than 50%, suggests only the innovative practitioners have been able to genuinely take up the program in the absence of any support. This is in keeping with change theory, but leaves a lot of consumers missing out. Moreover, as indicated earlier in this document, using indicators of uptake or participation alone leave us – collectively – with little insight on the impact of programs or how they might be improved for future Agreements.

“Implementation of programs and practices should not be viewed as ‘plug and play’ where, somehow, new practices can be successfully added to ongoing operations without impacting those operations in any significant way.”
Finding solutions

PSA wants to ensure that 6CPA can fulfil its potential to make a genuine difference to the health outcomes of the Australian community, and deliver on objectives such as those articulated in 5CPA (see page 8), as well as ensuring that pharmacies and pharmacists become more closely integrated into the broader primary health care service environment.

If the SCPA professional programs are to continue in 6CPA, a significant investment will be required to sustainably fund them. There are potentially smarter ways to make this investment, however, to allow a 6CPA that makes best use of community pharmacy, and truly delivers value to consumers and the health system.

The following sections set out broad principles to guide the design and implementation of 6CPA, followed by exploring potential arrangements to transition the profession from the current platform to one which allows a greater level of responsiveness to consumer needs, and better utilisation of pharmacists’ knowledge and skills.
Guiding principles for 6CPA professional programs

PSA’s position is framed within the context of the central objectives of Australia’s National Medicines Policy, and is built upon the central principle of cementing 6CPA as the cornerstone of pharmacy’s contribution to the provision of a comprehensive suite of primary health care services for the community.

This requires a transition from the concept of the CPA as simply remuneration for the supply of medicines, with some pharmacy services added on.

PSA believes that 6CPA should be underpinned by the following key principles:

1. Professional programs must focus on the consumer and be funded and delivered on the basis of clinical need.

PSA believes that:
- arrangements must be put in place to support a community pharmacy model which promotes the delivery of quality primary health care services to meet consumers’ health care needs.
- each professional program is a unique, cost-effective response to identified health care needs in the community and as such should be considered on its own merits for inclusion in or exclusion from 6CPA.
- it is inappropriate to design funding and structural arrangements for any programs under consideration for 6CPA on the basis of trade-offs or compensation received for reduced funding in other parts of the CPA.

2. Maintaining a viable community pharmacy network is essential.

PSA is strongly committed to the existing community pharmacy network which serves the needs of Australians well. This network is the preferred method of delivery of medicines made available through the PBS which provides equitable access to a range of cost effective subsidised pharmaceuticals to the community. All programs and services should make best use of both the pharmacist workforce and the established infrastructure of community pharmacy.

3. Dispensing and supply of medicines is a key consumer entry point into community pharmacy services.

The dispensing and supply of medicines encompass multiple components of professional activities and should be recognised and remunerated as a health service and not a retail transaction.

Reflecting these principles, PSA’s approach to the 6CPA is outlined in the logic model at Appendix A, and described in the following sections.
Transitioning from 5CPA

The full integration of pharmacists into a more collaborative, patient-centred model of care, is necessarily a long term (>10 year) objective, likely requiring multiple funding streams and significant changes within the health system as a whole. This doesn’t mean, however, that incremental steps towards this objective cannot be made within the context of 6CPA. A sound appraisal of what is achievable within the five-year CPA timeframe, from the perspective of all stakeholders, should be used to guide a pragmatic approach to improving current arrangements.

A remuneration structure which allows pharmacists to better utilise their clinical knowledge and ensures that clinical activities associated with medication supply are strengthened removes incentives to operate in an environment which largely rewards volume – in many cases at the expense of high quality clinical service, focused on consumer need.

PSA therefore offers for consideration a model for 6CPA which:
- acknowledges the complexity of dispensing beyond “supply”;
- recognises the contribution of the pharmacist as a clinician to consumers’ health care;
- simplifies claiming for programs linked to dispensing e.g. CIs, DAAs, staged supply;
- is informed by international models e.g. Scotland, New Zealand, UK, Canada; and
- aligns with Government health policy objectives to reduce the burden of chronic disease.

This model, which is focused on the needs of consumers, may mean that not all pharmacies deliver all services. This is aligned with international experience and is likely to both reduce the burden on pharmacies attempting to implement multiple programs whilst also targeting services to populations most in need. It also allows for a measured “scaling-up” approach to broader adoption of programs and services.

It will of course be essential in this transition stage to focus attention on the implementation process, utilising evidence-based models to guide pharmacists and their teams through the course of change, and setting a solid foundation for future initiatives.

The transition period should be used to sharpen the profession’s focus on the key areas in which pharmacists can make a greater contribution to addressing gaps in the current health system and achieving Government health policy objectives through:
- better medication management, with a particular focus on chronic disease;
- public health and prevention initiatives;
- services to address shortages in rural and remote communities; and
- services to meet the needs of Aboriginal and Torres Strait Islander people.

These areas, along with mechanisms to ensure a viable pharmacy network, are explored in the following sections.

Better medication management

Most Australians will at some stage of their lives need to take prescription and other medicines, and by the time they are 65, many people will be regularly taking five or more medicines. For those with a chronic disease or mental illness, the number can be even higher.

In 2010 an estimated 271 million prescriptions were dispensed and millions more medicines prescribed by pharmacists for minor ailments and conditions. Pharmacists play a key role in ensuring that all Australians have ready access to supplies of their essential medicines, especially those 7 million people with chronic disease.

Recognising the impact that medicines have on the health and safety of Australians, medication safety is a high priority for national health organisations including the Australian Commission on Safety and Quality in Health Care, the Australian Council on Healthcare Standards and the National Prescribing Service. Each of these organisations outline goals, set standards or deliver programs for achieving better medication safety for all Australians.

All medicines have the potential for side effects and can interact with other medicines. Each year 230,000 people are admitted to hospital, and many more people experience reduced quality of life, as a result of side effects of their medicines. This comes at a cost to the system of more than $1.2 billion. The COAG Reform Council’s recent report documented increases in potentially preventable hospital admissions. Significantly, medication-related admissions account for 20-30% of all hospital admissions for people over 65. Much of this personal and financial burden is preventable, with increasing evidence of the impact that pharmacists can have on medication safety.
and adherence, and the resulting savings to the health system.\textsuperscript{25,26}

PSA offers for consideration options which align with the key elements of Australia’s policy on Quality Use of Medicines, which the Agreements seek to deliver. In particular, it focuses on the safe and effective use of medicines to achieve the best possible results by: monitoring outcomes; minimising misuse, over-use and under-use; and improving people’s ability to solve problems related to medication, such as adverse effects or managing multiple medicines.

It acknowledges the important role and significant impact that pharmacists can have on issues relating to health literacy and medication adherence. It is also in keeping with recommendations from stakeholders and a large survey of pharmacists who deliver medication management services, which identified a range of areas for improvement in the existing MHR program.\textsuperscript{29} These were mainly focused on reducing the administrative burden and complexity of claiming and prior-approval processes, but also identified suggestions including:

- recognition of pharmacists as providers under the MBS;
- different levels of medication review based on time and complexity;
- follow-up MedsChecks requested by either the GP or pharmacist;
- the ability to establish a program of MedsCheck consultations to structure medication management services based on the consumer’s needs; and
- incentives for community pharmacies to employ additional pharmacists – especially those accredited for medication reviews – to support the provision of professional services.

This approach is also focused on addressing the growing burden of chronic disease.\textsuperscript{30} Optimising the management of long-term conditions through quality use of medicines has been shown to reduce or delay the incidence of hospitalisation in patients with chronic diseases\textsuperscript{31} and to reduce the need for and spending on hospital admissions and medical services.\textsuperscript{32}

Furthermore, it ensures that the populations identified as most in need of these services are the primary recipients.

Potential future arrangements

PSA puts forward two possible options for consideration, the first of which – a consultation model – represents a dramatic shift from the way in which pharmacy services have been funded thus far. The second involves a more evolutionary approach, as potentially an intermediate step towards ultimately implementing the full suite of changes required in a consultation model.

In line with the current thinking in the broader primary health care environment, consideration also needs to be given to models outside of the fee-for service paradigm, for example, funding based on outcomes and/or an agreed set of services to be delivered, articulated in a service agreement or contract.

\textit{Consultation model – the medication management continuum}

The model outlined below separates the administrative tasks that are performed as part of the process of dispensing a prescription from those that contribute to quality use of medicines and require a pharmacist’s unique expertise. It also recognises the role of the pharmacist in applying clinical reasoning to a decision about the need for additional services, including, for example, a follow-up MedsCheck.

The ‘consultation model’ would comprise a reallocation of funding based on the following principles:

1. The administrative component of dispensing comprises data entry, picking of medication and claiming.
2. When a medication is supplied to a consumer a consultation should occur between the pharmacist and the consumer and this consultation should be recognised and remunerated as a professional consultation.

This model would see pharmacists paid based on the consultation between the pharmacist and the consumer and should include the clinical aspects of a pharmacist involvement in ensuring the medicine is safe and appropriate for the consumer. The remuneration for this activity should be based on the time spent with the consumer during the consultation as well as the time taken in preparing for the consultation.

This element would see pharmacists’ remuneration becoming consistent with that of GPs and allied health providers, who are reimbursed by the MBS in a manner which reflects the time and/or complexity involved in each consultation.\textsuperscript{25,26,74} It addresses the need to reflect the various services pharmacists can and do provide, across a continuum of care needs based on the individual consumer (\textit{see Figure on page 20}). A robust documentation and audit system, with reporting linked to clear outcome measures, would need to be applied to such a model.

The consultation model represents a significant change in not only community pharmacy practice, but also in remuneration structure.
The primary difference being, pharmacies would be remunerated for the number of professional consultations undertaken by each pharmacist, as opposed to solely the number prescriptions dispensed. The number of prescriptions dispensed each year (approximately 271 million) is therefore not an appropriate basis on which to base the consultation model, nor is the number of individual patient visits to pharmacy per year (approximately 300 million). Further modelling work, with access to relevant data, will need to be undertaken to ascertain the cost of this option. Fees applicable to GP professional consultations and Allied Health Provider consultations could be used for comparative purposes.\textsuperscript{75,76}

**Transitional model**

The PSA recognises that the consultation model outlined above would take some time to implement, as pharmacists transition their professional practice to a consultation-style approach. There would also need to be significant changes made to dispensing/claiming software and the corresponding payment arrangements by Government. In that context, PSA envisages that an intermediate step towards the consultation model could incorporate the following components:

- Dispensing fee;
- Enhanced dispensing fee (e.g. complex patient/ significant clinical issue identified); and
- Professional consultation fee (incorporating fees at various levels or tiers which could cover services such as a New Medicines Service and MedsCheck).

Rather than being based purely on the pharmacist’s time, this transitional model would be a first step towards this and would recognise and pay the pharmacist based on the complexity of the presenting consumer’s situation and/or service provided.

**Funding**

In putting forward the options above, PSA is acknowledging that maintaining the status quo will not adequately deliver value for consumers or Government.

The SCPA acknowledges that “community pharmacy is an integral part of the infrastructure of the health care system...”, that pharmacists should “receive fair and adequate remuneration” for the supply PBS items to the community and that “positive health outcomes are attained by the Australian community through the efficient delivery of patient-focused professional services and programs”. PSA posits that these objectives have been challenging to deliver over the term of the SCPA and that this may have had a direct and detrimental impact on services provided to some consumers.

PSA strongly believes that a significant increase in the level of pharmacy remuneration is required, regardless of the funding model. CPA funding is a critical investment in Australia’s health system, not a mechanism to drive Budget savings.

Both the consultation model and transition model options outlined above would require a significantly increased investment in pharmacy remuneration, but PSA believes both models will provide better outcomes for consumers and better value for the Government in addressing medication management issues within the Australian population.
Medication Management Review Programs

PSA considers that one of the options available to ensure the sustainability of MMR programs is the removal of HMR and RMMR from 6CPA.

This consideration is based on an analysis of the existing situation, review of research evidence in this area, and feedback from members and other stakeholders. It would address identified issues such as the fact that a capped, five-year funding agreement is generally inappropriate for a fee for service payment model which is intended to meet specified consumer health needs. Moreover, the referral side is a MBS item (GP Item 900) and uncapped.

There may be long term benefits in allowing the service to grow and adapt if the service (and funding) is removed from the CPA arrangement. Furthermore, it would allow better targeting of the service to the groups identified in the 4CPA research whilst reducing the potentially unnecessary HMRs by tighter eligibility criteria to focus on where there has been evidence of most benefit. Links to community pharmacy could be maintained through referral/reporting requirements.

For the pharmacy profession and the health care sector as a whole, it would represent the first step of pharmacist recognition as health care providers through listing pharmacist items on the MBS.

Implementation of payment models

As outlined in earlier sections, PSA believes the CPA could be restructured to recognise the professional input of pharmacists along a continuum from dispensing through to medication management and chronic disease monitoring based on clinical need. As this represents a fundamental shift in the way pharmacists and pharmacies are remunerated for both dispensing and services, its implementation may realistically need to be delayed until the second or third year of 6CPA, or through implementation of the transition model as outlined above.

In the interim, amendments to the existing payment mechanisms and ‘business rules’ could be made to overcome the administrative barriers to effective delivery of medication management services by pharmacists. Such amendments, as suggested by a range of stakeholders, include:

- Extending the claiming window to 60 days;
- Allowing pharmacists to perform real-time database queries regarding the timing of previous reviews and confirmation of Medicare numbers;
- Increased clarity on reasons for claim rejections;
- Amended requirements for service caps and pre-approvals for providers servicing very remote areas;
- Rural loading to cover actual expenses per km travelled and accommodation costs;
- HMRs for Aboriginal and Torres Strait Islander patients to be conducted at location of patients’ choosing with removal of the need for prior approval for this population;
- MedsChecks being able to be conducted in Aboriginal Health Services; and
- Nurse practitioners being permitted to write HMR and RMMR referrals.

Although these represent interim measures, PSA believes that the opportunity exists with 6CPA to set a clear principle that arrangements are made with the needs of the community, not the size of the funding pool in mind. Whilst still suggesting a fiscally responsible approach, PSA considers that the removal of current caps, with the introduction of mechanisms to ensure better targeting of services, could achieve the desired outcomes for individual consumers and Government.

Funding

HMR and RMMR

At a cost of approximately $200 per HMR over the 5-year time frame of the Agreement, at least $102 million was needed in 5CPA to maintain the HMR services72, but the allocated budget was $52.11 million, which was even less than that allocated in 4CPA ($54 million). As outlined above, this may in part be explained by an assumption that the introduction of MedsCheck and Diabetes MedsCheck would go some way to reducing the need for a significant proportion of HMRs.

However, the data clearly show that the introduction of MedsCheck has had no discernible impact on the number of HMRs performed.

HMR data by quarter72

<table>
<thead>
<tr>
<th>Prior to the introduction of MedsCheck</th>
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<td>16,801</td>
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Since July 2007, an average of 18,210 HMRs have been undertaken each quarter. For the period 1 April 2013 to 31 March 2014, the average number of services per quarter increases to 27,513.

Even using the lower of the two averages, and...
assuming no further growth in service provision, a total of $81 million* would be required to fund all HMRs over the 6CPA period. There is a need for an increased investment in the HMR program in the 6CPA. With an appropriate level of funding, criteria can be implemented that ensure that those patients who would benefit from an HMR receive one.

Based on similar modelling, RMMR funding will need to increase to approximately $72 million in 6CPA (up from $70 million in 5CPA) just to maintain an average level of services at 32,335 per quarter.

Clearly, these figures are conservative, if for no other reason than the Australian Bureau of Statistics projects that the number of people 65 and over will double, from 3.2 million people (14% of the population) in 2012 to 6.8 million (20%) by 2040.29

Whatever the final funding allocation, consideration should be given to introducing a short/simple HMR and long/complex HMR, using the current fee level as the basis for the long/complex service. This would allow significantly more consumers to access HMR services over the Agreement period.

**MedsCheck/Diabetes MedsCheck**

The current program guidelines allow only one MedsCheck/Diabetes MedsCheck per patient per 12 months. Furthermore, the patient cannot have received an HMR or RMMR in the preceding 12 months. Finally, each pharmacy can only claim a maximum of 10 MedsChecks each month.

* Assumes no growth in average services per quarter and includes a 2.5% annual increase in the fee (based on current fee of $208.22)

If MedsCheck and Diabetes MedsCheck are to continue to be funded on a fee for service basis, then the provision of the service must be based on the clinical need of the patient and not an arbitrary number of services per month/per pharmacy.

Even using the existing program uptake as a guide, a significant funding increase would be required in 6CPA, e.g. $127 million for MedsCheck and $16 million for Diabetes MedsCheck ($29.6 million and $12.2 million in 5CPA respectively).

**Implementation of services**

Recognising the need to take a strategic approach to the implementation of these initiatives, whilst focusing on the areas requiring most attention, the model outlined below could be used to guide implementation of programs across the five years of the agreement (conditions are provided as examples only). It acknowledges the importance of meso-level interventions, a concept that has been used effectively in General Practice through the Australian Primary Care Collaboratives program.80

It allows for a more targeted and scalable approach rather than simply disseminating programs to all pharmacies across Australia.

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<td>• Engage local pharmacists, GPs and other health professionals in PHNs with highest diabetes burden</td>
<td>• Engage local pharmacists, GPs and other health professionals in PHNs with highest COPD and asthma burden</td>
<td>• Engage local pharmacists, GPs and other health professionals in PHNs with highest cancer burden</td>
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<td>• Work with pharmacies to plan, set goals, make changes and implement services</td>
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<td>• Pharmacies offer medication management and monitoring services focused on target population (diabetes) and especially:</td>
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<td>• Pharmacies offer medication management and monitoring services focused on target population (airways disease) and especially:</td>
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* Assumes no growth in average services per quarter and includes a 2.5% annual increase in the fee (based on current fee of $208.22)
Public health and prevention initiatives

The well-established network of over 5,350 community pharmacies and 27,000 pharmacists work to support equitable access for Australians to medicines, health information and professional advice, in most cases without the need to make an appointment. Pharmacists are often the first health professional that a consumer interacts with to discuss health issues. Again, however, there is increasing evidence of the under-utilisation of pharmacists in public health.81

Pharmacists have a significant role to play in addressing public health priorities such as immunisation, particularly as increases are being observed in vaccine-preventable conditions.82

Similarly, much more can be done in the area of chronic disease prevention. Overweight and obesity rates are rising, potentially leading to future peaks in type 2 diabetes and other chronic diseases.83 The Global Burden of Disease study 201084 showed that little progress has been made to reduce the overall effect of non-fatal disease and injury on population health, estimating that as life expectancy has increased, the number of healthy years lost to morbidities (disease sequelae and injury) has also increased.85 This means that globally we are living longer but the percentage of life lived without disability or disease has not been correspondingly extended.

Consumers receiving their seasonal influenza immunisations at community pharmacies is now commonplace in the US. In New Zealand, pharmacists with suitable credentials are also now engaged in the provision of immunisations. Yet in Australia, there remains a reluctance to devolve any primary care responsibility away from GPs, regardless of how well some functions could be performed by other suitably trained health professionals, with a key report noting that “Australia is one of the few countries where GPs give routine immunisations.”86

Prevention initiatives

Around Australia, State Governments are acknowledging the value pharmacists bring to public health and prevention. In NSW, community pharmacies have been engaged to act as awareness and referral points for consumers to access the Get Healthy Service, which is a free telephone-coaching service to assist adults to make lifestyle changes in relation to healthy eating, physical activity, and reaching and maintaining a healthy weight.

A trial conducted in 20 Perth community pharmacies allowed pharmacists to opportunistically offer chlamydia screening to women requesting emergency contraceptives (EC). The scheme was rated as highly convenient, and the time taken to offer a chlamydia test along with an EC consultation as highly appropriate, by consumers and pharmacists alike.

In Queensland, a trial which commenced in January 2014 has seen over 12,500 Influenza vaccines administered by nearly 80 participating community pharmacies without any issue. Notably, nearly 25% of services provided were opportunistic.

The public health benefits of community pharmacy immunisation are therefore quite significant. It is logical that pharmacists immunisation services could be considered for extension to other vaccines for adults in general travel medicine and repeated booster doses of diseases such as measles and whooping cough.

These are encouraging initiatives but lack a consistent, national approach, potentially limiting access for consumers most in need of the services.

Internationally, the UK’s Healthy Living Pharmacy (HLP) initiative commenced in 2009 with an initial investment by Portsmouth Primary Care Trust, with a goal for community pharmacies to become Healthy Living centres, promoting and supporting healthy living by offering healthy lifestyle advice and support on self-care and a range of pressing public health concerns.87

In the five years since, HLPs have been implemented across the UK, based on a framework aimed at achieving consistent delivery of a broad range of high quality public health services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. Interest in HLPs has been growing, not only in the UK, but around the world.

Services offered by HLPs include stop smoking, weight management, emergency hormonal contraception, chlamydia screening, advice on alcohol, inhaler technique, minor ailments and medicine use reviews.

Minor ailments services

Minor ailments are defined as conditions that are often self-limiting, with symptoms easily recognised and described by the patient and falling within the scope of pharmacist’s knowledge and training to treat. These conditions can usually be managed with the use of non-prescription products available to a pharmacist and through self-care.88

As part of their contribution to primary health care, pharmacists and pharmacies play an important role in the treatment and management of minor
ailments and illnesses. Pharmacists are one of the most easily accessible healthcare professionals, and in a recent study, 51% of consumers said they would consult a pharmacist/pharmacy staff about minor ailments in the first instance for advice. Minor ailment schemes operated through pharmacies have the potential to redirect care of minor ailments away from general practice and other high cost settings such as emergency departments as intended.

The Pharmacy First minor ailments scheme operated by Nottingham NHS for over a decade has been accessed by more than 250,000 consumers who would otherwise have added to the pressure on GP resources. Similar schemes operate in other parts of Britain, Scotland and Canada.

In England the schemes are authorised by the NHS and commissioned by the Clinical Commissioning Groups, depending on local need. Pharmacies are reimbursed the costs of the medicines, but the methods by which the consultation costs are paid vary among schemes, and include:

• a fee per consultation;
• banded fee structures, based on number of consultations; and
• an annual or one-off retainer.

Potential arrangements in 6CPA

An effective public health and prevention model for 6CPA would:

• recognise the contribution of the pharmacist as a clinician to consumers' health care;
• take advantage of community pharmacy's accessibility;
• align with emerging international models e.g. Scotland, UK;
• have clear goals that are aligned with Government health policy objectives around prevention and reduction in the burden of chronic disease; and
• align with the goals of the Primary Health Networks once established in July 2015.

Pharmacies could participate in programs at various levels (see diagram on following page) and be remunerated accordingly.

• Public awareness campaigns - aligned with national health priority areas for prevention e.g. tobacco, obesity and alcohol;
• Management of minor ailments, including triage and referral;
• Brief interventions e.g. smoking cessation;
• Screening and risk assessment – aligned with national health priority areas for prevention (tobacco, obesity, alcohol) and those where there is evidence supporting pharmacists’ role e.g. chlamydia screening; and
• Vaccination e.g. seasonal influenza.

Consideration should be given to linking a Minor Ailment Scheme (MAS) to the need for the documentation and recording of OTC medicines and interventions to the Electronic Health Record. Pharmacists could then receive a consultation and documentation fee for following appropriate processes and protocols surrounding the provision of the OTC medicine. This is in keeping with The Personally Controlled eHealth Record (PCeHR) Review, which recommended that the existing National Prescribing and Dispensing Repository (NPDR) should be widened to include the expanded set of over the counter (OTC) medicines, and that pharmacists should be responsible and accountable for the provision of information regarding OTC medicines use for the e-health record.

A consultation and documentation fee in line with the dispensing fee as outlined earlier, could ultimately be provided to pharmacies for provision of these services. As a transitional arrangement, however, pharmacies could receive an outcomes-based practice payment, with robust systems for audit and review.

The current funding for related services in 5CPA, through the PPIs, is $344 million over five years. It is likely that significantly greater investment would be required to fully optimise the pharmacist’s role in these key primary health care roles, but once again, with greater targeting and more effective systems in place, it would represent a smarter investment.
Pharmacy public health service continuum

Implementation of payment models

Pharmacies could be remunerated via a combination of practice payments and service payments for their participation at various levels of the public health programs and for the achievement of specific outcomes in each of the key areas outlined below. This could happen almost immediately as there is already a system in place for both practice payments and service payments. A robust documentation and audit system, with reporting linked to clear outcome measures, would need to be applied.

Implementation of services

Recognising the need to take a strategic approach to the implementation of these initiatives, whilst focusing on the areas requiring most attention, the following model could be used to guide implementation of programs across the five years of the agreement (conditions are provided as examples only). As with the medication management programs, this approach acknowledges the importance of meso-level interventions, a model that has been used effectively in General Practice through the Australian Primary Care Collaboratives program. It allows for a more targeted approach rather than expecting all pharmacies across Australia to offer all services, even in areas where there is limited consumer need for the services.
Services to address shortages in rural and remote communities

Effective primary and preventive health care is dependent upon locally accessible services. Chronic diseases such as diabetes and heart disease place a significant burden on most rural communities. Community pharmacies are ideally placed to play a more significant role in managing these conditions within the community and to identify those most at risk.

In 2012, 30% of the Australian population lived in rural and remote areas. Over 70% of pharmacists (approx. 16,000) were working in major cities, with less than 4,000 in rural and 300 in remote settings.96 People in rural, regional and remote Australia have worse health than people living in cities. They have higher rates of many diseases, more health risks and higher death rates in every age group.97 Compared with those who live in the major cities, people in Australia’s rural and remote areas have reduced access to prescribed and non-prescribed medicines, less advice about the use of medicines, and poorer access to professional pharmacy services. As with so many other issues in the rural and remote health sector, there is an increasing gradient of deficit with increasing remoteness.

To enable pharmacists to provide services to patients across vast distances, flexibility in service delivery models becomes necessary. In areas where GPs are scarce, rural pharmacists could be supported to take on expanded roles in prescribing and continued dispensing, and to be involved in such services as mental health referrals, cardiovascular and diabetes care, palliative care teams and immunisation.

The 2013 Grattan Institute report suggested that the pharmacists should be employed in rural areas of need to fill some gap where there are no or insufficient GPs.98 In many areas it is not viable to have a community pharmacy and other service models, such as employment of clinical pharmacists in GP surgeries and Aboriginal Health Services or by Primary Health Networks, need to be considered.

If multi-disciplinary healthcare teams, including pharmacists, are to deliver primary healthcare to under-served communities it is important that there is equity across the professions in the ability to claim for services provided. Pharmacists need to be remunerated, like all other health professionals, for the clinical services they provide.

Medications may be delivered to remote communities by bus or post or may be collected from a general store or service station. Many small rural hospitals have no pharmacist. Medications are often dispensed in these settings by nurses. In these communities patients get little or no medication management assistance or advice. Where there are no GPs, pharmacists often play important roles as primary healthcare professionals e.g. wound care, minor ailment diagnosis and treatment, chronic disease management. Current pharmacy legislation, which varies across Australia, does not allow pharmacists to dispense in premises other than approved community pharmacies or hospitals.99

In rural Australia, where health inequalities are greatest, tapping into the skills and accessibility of pharmacists, within a collaborative framework, can assist the Government to achieve community health goals.

Pharmacy has a plentiful workforce with a growing supply of well-trained graduates. Pharmacists are well placed to fill gaps in primary healthcare in areas currently underserved by GPs, if employment and remuneration strategies are developed which enable pharmacists to work in these rural and remote areas, just as they do for other health professionals.

Addressing the challenges of rural practice will undoubtedly require some amendments to the current arrangements to be made so that the contribution of pharmacists in these settings can be optimised, through mechanisms such as dispensing and provision of medication management services from clinical outposts, and provision of advice delivered by electronic media – Telehealth.

Potential arrangements in 6CPA

The following amendments should be considered for 6CPA:

- Comprehensive evaluation of rural and remote pharmacy services;
- Investigation of provisions for pharmacist dispensing at rural outposts;
- Reimbursement of rural pharmacists for a range of clinical services and telehealth, as per other health professionals; and
- Funding for salaried rural clinical pharmacy positions in areas of identified need.

For the Rural Pharmacy Workforce programs specifically, there are a number of options that could be considered to improve its utility and achieve desired outcomes:

- Aligning pharmacy with other workforce programs, using the GISCA rural classification system;
- Providing allowances for pharmacists, interns and students located in regional areas, currently classified as PhARIA 1;
- Remote areas to be eligible for more funding than inner regional;
- Pharmacy students to be encouraged and financially assisted to undertake rural placements.
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• Interns are given a financial incentive to practice rurally. It should be graded by remoteness;
• Rural scholarships are bonded i.e. scholarship recipient gives a commitment that they will practice rurally;
• CPE allowance includes all types of education and associated costs, and is capped to individual annually; and
• Increasing funding for the Rural Pharmacy Liaison Officer (RPLO) program to provide full-time roles which will allow more rural students, more regional CPD and research on rural workforce.

Services to meet the needs of Aboriginal and Torres Strait Islander people

Despite having two-to-three times higher levels of illness, underuse of medicines is evident in Australian Aboriginal and Torres Strait Islander populations. Poor adherence to prescribed medicines is well documented and associated with adverse health outcomes in all population groups. Social circumstances, deficiencies in health services and systems mean Aboriginal people often suffer even greater challenges in medicine management than non-Indigenous Australians. Social and emotional wellbeing issues may deeply pervade the lives of many Aboriginal people and may diminish the value that individuals place upon medicines and the potential of these medicines to improve their quality of life.

Over the last two decades, a number of programs have been initiated by the Australian Government to improve access to medicines for remote Aboriginal and Torres Strait Islander people. They also assist with financial burden of chronic disease medicines in urban and rural settings. The medicine access schemes for Aboriginal and Torres Strait Islander people vary according to geographical location. Program-specific rules can make navigation between programs difficult for both Aboriginal and Torres Strait Islander people and health professionals.

Complex medicine regimens may result in some Aboriginal and Torres Strait Islander patients finding medicines confusing and difficult to manage. Studies confirm that pharmacist interventions across population groups result in improved patient health outcomes, improved medicine adherence, reduced hospitalisations and reduced healthcare costs. Pharmacists need to partner with patients to establish realistic therapeutic goals and negotiate medicine adherence targets in order to improve Aboriginal and Torres Strait Islander peoples’ health outcomes.

There is often miscommunication between a non-Indigenous health professional and an Aboriginal and/or Torres Strait Islander patient. Miscommunication may be contributed to by language differences and differing belief systems regarding illness. More Aboriginal people are needed in the pharmacy workforce to assist in bridging these gaps.

Potential arrangements in 6CPA

A range of amendments may need to be made to existing arrangements to optimise the contribution of pharmacists to the care of Aboriginal and Torres Strait Islander people. These could include:

• Streamlining medication access programs so that Aboriginal and Torres Strait Islander people are eligible for subsidised medicines, regardless of the setting, i.e. eligibility is based on the consumer, not the location;
• Subsidising dose administration aids for Aboriginal and Torres Strait Islander people, regardless of the setting;
• Providing salaried positions for pharmacists in all Aboriginal Health services to oversee the supply process, provide QUM education to patients and staff and to assist patients with medication adherence;
• Continuing the allowance to employ Aboriginal pharmacy assistants through Cert II & III, and also to receive it for Certificate IV;
• Including face to face teaching and mentoring in pharmacy assistant courses (Cert II & III); and
• Increased number of Aboriginal and Torres Strait Islander pharmacy scholarships.

Currently funding for this area of 5CPA is $40.5 million (Rural workforce program $37 million and ATSI Workforce $3.5 million). Increased investment, likely more than $200 million, will be needed to effectively fund these arrangements across the period of 6CPA.

“PHARMACISTS NEED TO PARTNER WITH PATIENTS TO ESTABLISH REALISTIC THERAPEUTIC GOALS AND NEGOTIATE MEDICINE ADHERENCE TARGETS IN ORDER TO IMPROVE ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES’ HEALTH OUTCOMES.”
Research and development

The $10.6 million 5CPA R&D program has four stated outcomes:

- High quality and relevant research;
- Stronger knowledge base;
- Recognition of pharmacy role; and
- Supporting research capacity.

The R&D program is underpinned by a framework of themes developed under the 4CPA: “Quality Use of Medicines, Collaboration, Consumer Focus and Application”.

PSA believes the R&D program in 6CPA should be seen as the incubator of innovation, grown – to at least double or triple - from its current size to enable more focused research, more efficacy and effectiveness research, and most importantly, more service implementation studies in community pharmacies. However, to be more genuinely more effective, several enhancements to the R&D program are suggested.

1. The R&D program needs to be more strategic, and based on a longer-term agenda that improves patient outcomes.

Returns on the R&D investment could be enhanced, in terms of new services for consumers, improved QUM, if the program were based on a longer term, 10 year agenda connected with the above themes. From this agenda, the R&D program could identify research gaps within this longer term agenda, and progress a more targeted research plan. If used in 4CPA and 5CPA, such a strategic approach could have identified, for example, the impact of price disclosure on pharmacies in advance, and have funded research many years ago into timely solutions to enable pharmacies to improve QUM and at the same time proof them against the economic impact these reforms.

2. There needs to be a more robust evaluation of the impact and quality of the R&D investment.

There is currently little available evidence on how the CPA R&D program has actually achieved “Quality Use of Medicines, Collaboration, Consumer Focus and Application”. The evaluations of CPA R&D investments in the past appear to have been largely process-based (measuring how the program was implemented), rather than measuring how the program has actually improved or facilitated improvement in QUM, collaboration, consumer focus and application. There is significant work currently being undertaken at a national and international level with regard to measuring research impact and quality against international benchmarks. The CPA R&D program could benchmark impact and research quality using, for example, the Excellence in Research for Australia (ERA) process. Understanding research impact and quality is critical to ensure cost effectiveness, but is also in the long term interests of consumers and community pharmacy.

3. There needs to be much stronger focus on research into the efficacy, effectiveness and implementation of evidence based pharmacy services.

With greater investment there would be greater capacity for the CPA R&D program to undertake larger scale efficacy and effectiveness trials in community pharmacy. This evidence is critical to understanding how pharmacy services may improve QUM for consumers. But for this evidence to be used in practice, it needs to be coupled with strong evidence on how the practice is implemented in the real world. Without this – the evidence is rendered useless. The science of implementation has been slowing building, however the CPA R&D program seems to have been relatively slow at using it to “fast-track” evidence so it can be used in pharmacies and delivered to consumers.

Clinical placements

Given the large numbers of pharmacy students in undergraduate and postgraduate courses across the country there is a need to support their clinical training in a way which provides a supportive learning environment but also supports the community pharmacy setting in which the placement takes place.

Arrangements for 6CPA should consider allocating funding to support the clinical training of pharmacy students in the community pharmacy environment. As at June 2014, there were an estimated 1,846 students provisionally registered with the Pharmacy Board of Australia. The 6CPA could support student placements within community pharmacy by attaching funding to each student. Similar to other health professional placement programs, this funding could be administered by the Universities and allocated to clinical placements sites. These community pharmacy sites would require an approved training plan and be subject to audit as part of their accreditation. They would need to ensure they had appropriate staffing levels and facilities and a system of continuous improvement.

To effectively fund this program, $92 million over 5 years ($10,000 per student per annum) would need to be allocated.
Ensuring the pharmacy network and infrastructure across Australia

As indicated earlier in this document, these options represent a new way of working for most community pharmacies. Incentives and guidelines alone will not change practice. Evidence on effective implementation shows that investments are required in the following areas:

- Start-up costs (e.g. equipment, infrastructure);
- Purveyor support (e.g. forums, assessments, support for change);
- Funding for the services themselves; and
- Ongoing support of infrastructure for sustainability.

Evidence from the Australian Primary Care Collaboratives, used to effect change in General Practice, has shown that practices can be assisted to achieve incremental, rapid and locally relevant improvements across a broad range of clinical and practice business issues, and to sustain these changes.

A recent survey of pharmacists conducted by PSA (n=1013) found that whilst pharmacists are prepared to make changes, implementation of services remains a challenge. Although the majority responded that they are delivering professional services on a routine basis and have established systems for this, they were less positive about ongoing systems for monitoring and improvement.

The Pharmacy Guild has called for a change to the current community pharmacy model, to one in which services are better integrated, and PSA’s own Health Destination Pharmacy Trial reinforced evidence showing that practice facilitation through coaching can assist with cultural change, improve processes and service delivery.

The option for consideration below would remove the somewhat piecemeal approach currently in place for the various incentive programs, and provide a more transparent and accountable mechanism for supporting practice change.

Potential arrangements in 6CPA

**Quality Practice Incentive**

Pharmacies could receive a Quality Practice Incentive which is linked to specific goals and activities from a quality and outcomes framework. Payments would vary depending on the location and services provided by the pharmacy, and may include aspects such as:

- Maintenance of patient records
- E-health
- Accreditation
- After hours service
- Rural pharmacy maintenance allowance
- NDSS
- $100 support
- Harm minimisation
- Return Unwanted Medicines

**Implementation support program**

Implementation support will be required if the network of community pharmacies is to be supported to deliver services across Australia, especially to those most in need. This needs to be informed by evidence on change and must support pharmacies through the process, addressing aspects identified in research such as:

- Planning – financial & business performance;
- Staff – knowledge, skills & processes;
- Marketing/ communication; and
- Design/ layout & workflow.

Effective implementation arrangements will require at least $270 million across the five year period, which represents a modest investment equating to approximately $10,000 per pharmacy, per year.
Despite PSA’s role as the peak pharmacy body, with nearly 2,000 members who are owners of community pharmacies, since 3CPA, PSA’s role has been acknowledged only as “an active participant in those areas… related to professional practice” (Clause 1.2(c)).

PSA’s recent survey (n=1013) showed that an enhanced role for PSA in shaping the Agreements is supported by the profession. Without PSA, there is no voice for the many pharmacists employed within the community pharmacy sector, who in fact make up the largest proportion of the workforce. This was a strong theme in the comments from survey respondents including: “[PSA should] be our voice to the Government and the public” and “PSA needs to take a greater role in negotiating funding arrangements”.

PSA believes that if its advice and input are actively being sought to design the professional programs in 6CPA, then it is only fair and reasonable that PSA be considered as a joint signatory to the parts of the Agreement dealing with professional programs and services. Signatory status would of course need to be contingent on PSA being involved as an equal partner/participant in all discussions that relate to the proposed professional programs and services in 6CPA.

Greater transparency and consultation in the early phases of program design and planning, especially where collaborative services are proposed, should also be considered. Facilitating the engagement of consumers and other primary health care professionals (particularly general practitioners) in this process is a role that PSA could readily oversee, given its strong stakeholder relationships.

6CPA Governance

Realising the vision for 6CPA outlined above undoubtedly requires pharmacy’s relevant professional bodies to work together. This will assist in development of an evidence-informed Agreement, reduce unnecessary duplication of resources, and most importantly, will provide the profession with the best chance of successfully implementing existing and new professional practice programs, thereby delivering high quality health services to the Australian public.
Placing 6CPA in the broader context

Pharmacists’ contribution to health solutions for people living in their communities

Pharmacists are among the most accessible health professionals in Australia. As shown in the image below, pharmacists can be found in all of the settings where consumers may need assistance to prevent disease, maintain good health, and manage chronic conditions. Within each of these settings, pharmacists apply their unique knowledge and skills to provide medication management services according to the complexity of the consumer’s needs.

Optimising the management of long-term conditions through quality use of medicines has been shown to reduce or delay the incidence of hospitalisation in patients with chronic diseases and to reduce the need for and spending on expensive hospital admissions and medical services.

Whilst this document has necessarily focused largely on the community pharmacy setting for the 6CPA, it is important to consider services that meet the needs of consumers who are moving between settings. Furthermore, it is critical we acknowledge the broader contribution that pharmacists can make. As noted in the Grattan Institute report, “Pharmacists are highly trained, have deep expertise in medicines, and are located in communities throughout Australia. But their role is far more limited in Australia than in many other countries.”

Roles that pharmacists can fulfil beyond those delivered through a community pharmacy have been described in a range of publications, and can include but are not limited to the following:

1. Identifying, resolving, preventing, and monitoring medication use and safety problems;
2. Reducing poly-pharmacy and optimising medication regimens on the basis of evidence-based guidelines;
3. Recommending cost-effective therapies;
4. Designing tailored adherence and health literacy programs;
5. Developing consumer medication action plans with self-management goals; and
6. Communicating medication care plans to consumers, carers and other health care professionals in the team.

The breadth of locations in which pharmacists work, and their important contribution in each of these settings, is well aligned with the shift towards more collaborative and patient-centred models of health care designed to improve the efficiency and effectiveness of the health system, particularly for consumers with chronic disease. The 2010 Intergenerational Report, looking at the period to 2050, stated that “it will be important to encourage improvements in efficiency and quality, while being flexible enough to enable care to be provided by the most appropriate professionals in the most appropriate places.”

The role for Australian pharmacists in these collaborative, consumer-centred models has thus
far been described in very limited and peripheral terms, in contrast to international models. This unfortunately leaves Australia lagging behind in terms of applying the evidence; the models in which significant benefits have been demonstrated internationally are GP-led, but use an expanded staffing model in which nurses, pharmacists and others assume greater care management roles.

Pharmacists are accessible health practitioners who, by working within a collaborative framework, can assist Government to achieve fiscally sustainable, efficient and quality healthcare.

PSA recognises that this transition to a more collaborative, patient-centred approach by pharmacists, and indeed for the health system as a whole, is likely more than a decade in the making. It is also important to acknowledge that a focus solely on the community pharmacy setting through the Agreements will not be sufficient to optimise the contribution of pharmacists within the health system. Neither will it – without significant change – provide funding mechanisms that allow the ongoing and sustainable delivery of important pharmacist services.
Conclusion

There is little debate both within and outside of the pharmacy profession that the remuneration arrangements for community pharmacy will need to change for the 6CPA. Concerns have been expressed about the current arrangements by a range of stakeholders, covering myriad issues from accountability to sustainability.

We can no longer have the situation where the decisions about which programs are developed and funded are based on anything other than an objective assessment of the needs of the community and how best these needs can be met through the delivery of services that utilise the skills and knowledge of pharmacists.

As outlined in this document, PSA envisages “Part B” – the professional programs – as an integrated suite of pharmacy services that can become more explicitly linked with population health objectives and primary health care services delivered by other providers. In this way, 6CPA would offer solutions to the needs of the profession alongside those of the Government and consumers.

Whilst the options for consideration throughout this document involve greater investments, PSA argues that they represent smarter investments, coupled with the system changes required to ensure greater accountability and responsibility.

Emerging evidence suggests that ensuring the sustainability of the health system will be more about reducing wasteful spending than imposing cuts on critical elements of primary care – including pharmacists. There is room in the system to make these smarter investments if the right structural changes are made.

This document is a call for an evidence-informed policy framework for 6CPA, with commensurate increases in funding for pharmacist services. This represents a smarter investment for Government whilst delivering better health outcomes for consumers, particularly those with chronic diseases and on multiple medications.

In contributing to this discussion, PSA does not want to stand for defending the status quo. Although Australia ranks well on the world stage in terms of healthcare, we know that there are people in our communities who are missing out on this good fortune, and we want pharmacists to be part of the efforts to rectify this.

A recent report recommended that one of the requirements will be "structural changes, to improve seamlessness of care to ensure that a person with chronic illnesses has access to all the professional skills needed." Pharmacists can contribute some of those professional skills but we need better mechanisms to ensure that they are used optimally. Greater engagement of PSA beyond being an "active participant" in Agreements can only be of benefit to reaching these goals.

PSA acknowledges that real change is needed, not just for our profession’s future, but so that pharmacists can genuinely contribute to improvements in the health system, and ultimately, better outcomes for consumers.
Appendix A

6th Community Pharmacy Agreement – Logic model

**Situation**
- Community pharmacies face an uncertain future due to the ongoing impact of price disclosure
- Pharmacists are not being fully utilised as members of the primary health care team to improve consumer health outcomes
- Pharmacists want to deliver consumer-focused services as part of ensuring a sustainable future
- Providing SCPA professional programs funding as “compensation” for the effects of price disclosure has not resulted in greater financial stability nor shifted practice to consumer-focused models of care
- Providing SCPA professional programs funding as “compensation” for the effects of price disclosure has not resulted in greater financial stability nor shifted practice to consumer-focused models of care
- Current outcome measures focus largely on adoption/uptake by pharmacies and number of services delivered

**Priorities**
- Professional pharmacy programs focused on consumer needs
- Practice change to sustainably deliver quality, consumer-focused services
- Optimal use of the pharmacist workforce and community pharmacy infrastructure
- A viable community pharmacy network to allow cost-effective delivery of consumer-focused services
- Enhanced contribution by pharmacists to collaborative primary care services for consumers with chronic conditions

**Intended outcomes**
- Safe and quality dispensing
- Optimising medication management, especially for consumers with chronic disease/s
- Improving public health
- Additional Government focus on ensuring community pharmacy network and infrastructure

**Inputs**
- Investments to be made by Government
  - (Informed by evidence on effective implementation)
  - Start-up costs (e.g. equipment, infrastructure)
  - Training and support (e.g. forums, assessments, support for change)
  - Funding for the services themselves
  - Ongoing support of infrastructure for sustainability

**Outputs**
- Activities
  - What needs to be done
    - Programs to be developed as a cost-effective response to identified health needs in the community
    - Funding and structural arrangements to be outcomes-focused
    - Focus of pharmacy activities – and Government funding – to be in the following areas:
      - Safe and quality dispensing
      - Optimising medication management, especially for consumers with chronic disease/s
      - Improving public health
      - Additional Government focus on ensuring community pharmacy network and infrastructure

**Outputs**
- Participation
  - Who this will reach
    - Consumers
    - Pharmacists, including:
      - Pharmacy owners
      - Pharmacy managers
      - Consultant pharmacists
      - Pharmacy assistants
      - Other health professionals
      - Corporate pharmacy groups
      - Industry stakeholders
      - Primary Health Networks
      - State and Federal Governments
      - Government agencies
      - Peak bodies
      - Private health funds

**Short term results**
- Learning
  - Acknowledgment of the need to invest in change
  - Recognition of the public health platform provided by community pharmacies
  - Recognition of pharmacists’ contribution in primary care and prevention
  - Consumer understanding of what pharmacists and pharmacies can offer for their health and wellbeing

**Medium term results**
- Action
  - Pharmacies actively engaged and participating in 6CPA programs
  - Increased delivery of consumer-focused services
  - Improved health outcomes for consumers with chronic conditions
  - Shifts in pharmacist and pharmacy practice
  - Sustainable financial position of pharmacies

**Ultimate impact**
- Conditions
  - Pharmacy services are cost-effective and responsive to consumer needs
  - Viable community pharmacy network
  - Optimal use of pharmacist workforce
  - Pharmacists are recognised alongside other health professionals as true contributors to primary health care
  - Community pharmacies are the “go to” for advice on minor ailments

**Assumptions**
An overarching strategy guiding the introduction and implementation of community pharmacy programs during 6CPA, with shared goals and outcome measures

**External Factors**
Health system reforms, changes to state legislative arrangements, competitive environment – discount models

**Evaluation**
Programs need to be evaluated according to a framework with Economic, Clinical, and Humanistic outcome (ECHO) measures, and which considers aspects such as program reach (to individuals who are the target of services) and sustainability of service delivery by community pharmacies across Australia
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