The peak national body for pharmacists, the Pharmaceutical Society of Australia (PSA) has strongly advocated and led calls for the integration of pharmacists in general practice clinics to boost healthcare outcomes for all Australians.

Evidence suggests there is an acknowledgement that pharmacists are currently underutilised in the Australian healthcare system and that consumers miss out as a result. Pharmacists are now integrated into General Practice teams in many other countries such as the UK, USA, Canada and New Zealand. The role of pharmacists working in general practice is just one of many strategies PSA is working on to ensure pharmacists can practise to their full scope, ensuring their unique skills and expertise can be optimised in consumer-focused, cost-effective, collaborative models of care. This model is good for consumers and good for the whole profession, including pharmacies. Despite these positive elements, there are some who have expressed concern about the model, with misinformation being published and promulgated to both the pharmacy and medical professions.

This PSA Fact Check document addresses some of the claims made about pharmacists working in general practices and their impact on the wider profession and health system.
CLAIM 1: The concept of a pharmacist working in General Practice does not have widespread support/appeal

The GP Pharmacist model does, in fact, have widespread support across the healthcare community. Research exploring the views of Australian consumers, pharmacists, and GPs has reported support for this model of practice. The Consumers Health Forum and Australian Medical Association (AMA) have both endorsed and called for investment in this model, including through inclusion in respective submissions. The Federal Health Minister The Hon. Sussan Ley has also spoken publicly of her support for the model, a number of Primary Health Networks have funded trials of practice pharmacists, and the current president of the RACGP has taken the step of employing a pharmacist in his own practice. PSA members have also spoken, with over 300 expressions of interest for a database of pharmacists who want to work in general practice.

Internationally, this model is well established in most developed countries, including in the USA, Canada, UK and Europe. Earlier this year the NHS England invested £31 million to facilitate the integration of pharmacists into general practices to support over 7 million patients.

CLAIM 2: There is no strong evidence of the benefits of practice pharmacists

A 2012 systematic review (a review of all current evidence) found integration of pharmacists in General Practice clinics resulted in a wide range of positive health outcomes including significant improved blood pressure, glycosylated haemoglobin (diabetes), cholesterol, osteoporosis management and reduced cardiovascular risk. Patient consultations by a GP pharmacist resulted in significant reductions in medication-related problems, improvements in medication adherence, improvement in process measures such as timeliness of services, and improvements in the appropriateness of prescribing. The large-scale PINCER trial found that a practice pharmacist-led intervention to reduce clinically important medicine-related problems was cost effective. Australian studies have also reported cost savings ranging from $44–$100 per patient. Co-location also enabled greater communication, collaboration and relationship building among the health professionals. Australian studies have found that pharmacists, consumers, and GPs all perceive benefits.

CLAIM 3: The GP pharmacist model will see community pharmacies reduced to a supply function with limited opportunities for professional services

There is absolutely no evidence whatsoever to support this claim, neither from the extensive experience with the practice pharmacist roles already in place in the UK, Canada and New Zealand, nor from the 30+ areas in Australia with pharmacists currently working in general practices or participating in trials. The GP pharmacist model PSA supports will actually ensure greater integration of pharmacists and community pharmacies within the primary healthcare setting to ensure alignment and coordination of services, including those funded through the 6CPA. The GP pharmacist model involves a strong focus of the practice pharmacist helping doctors and practice staff engage the surrounding community pharmacies to see enhanced uptake of services undertaken by community pharmacies, and to help identify for the GP which patients may benefit from these services.

As the Grattan Institute has noted, pharmacists’ roles are far more limited in Australia than in many other countries, including community pharmacy provision of continued dispensing, treatment for minor ailments, wound care, disease screening with referral, clinical interventions, point of care testing, New Medicines Service, MedsChecks, patient education and counselling, and vaccination. PSA supports these roles for pharmacies in Australia. The resources PSA has developed to support pharmacists and general practices promote awareness of and referral to local community pharmacies for these sorts of services, and clearly define the scope and focus of the practice pharmacist role. Anecdotal evidence supports the fact that community pharmacy services such as MedsChecks, DAAs and HMRs are in fact increased through referrals from the practice pharmacist.
CLAIM 4: PSA supports practice pharmacist payment through the CPA

PSA has always advocated that in the long-term, we would like to see funds external to 6CPA being used for the purpose of funding such a model. PSA has undertaken significant public advocacy in this regard – including two Federal Budget submissions, responses to the MBS Review and Primary Health Care Advisory Group consultations and others – with a view to securing an appropriate, sustainable funding source for practice pharmacists, given the weight of evidence behind the model and its impact on the broader health budget. PSA reiterates that we would like to see such a model ultimately funded, ideally through the MBS with a direct payment to pharmacists akin to other allied health professionals. Practice pharmacists have demonstrated positive outcomes on conditions which may impact MBS and hospital budgets (e.g. lowered CHD risk, reduced BP and better diabetes control) – funding sources to which community pharmacy currently does not have widespread access. Gathering further evidence for a practice pharmacist model in Australia provides perhaps one of the best opportunities the profession has had to demonstrate evidence to justify access to MBS and other funding, including Private Health Insurers.

CLAIM 5: General practice pharmacists will be paid $25 per hour

In their Federal Budget submission, the AMA called for pharmacists in general practice through the establishment of a funding model structured similar to existing incentive payments provided for nurses in general practice. The modelling undertaken by Deloitte Access Economics to support the AMA budget submission relied on available pharmacist wages data, which significantly undervalues a pharmacist’s expertise. PSA has actively and publicly rejected this sort of payment, instead arguing for a payment of $100,000 FTE and above. PSA has also been active in its call for an improvement in pharmacists’ remuneration across all settings.

CLAIM 6: The General Practice Pharmacist model would involve pharmacists paid directly by the surgery, through a Practice Incentive Program (PIP)

There are multiple options available for how a practice pharmacist could be paid. PSA’s preferred option is through a direct MBS item for pharmacists that would bring them into line with other allied health providers. Pharmacists are currently the only AHPRA registered health professionals not eligible for funding through the MBS, an inequity that needs to be addressed. A PIP, akin to the Practice Nurse Incentive Program, is another model that could be used. The Pharmacy Guild of Australia have advocated for a pharmacist outreach model, with funding through a single community pharmacy servicing multiple practices – a model which has not been tested and could place other surrounding pharmacies at a significant commercial disadvantage. Testing the best payment models and communication pathways is something that could be investigated in a trial and the Health Minister has previously stated that she would like to see this explored through the 6CPA Pharmacy Trial Programme.

CLAIM 7: PSA supports delivery of 6CPA-funded professional services by general practice pharmacists

PSA does not support the delivery of any 6CPA-funded professional services outside of the business rules and approved payment models for each service. Currently, the 30+ general practice pharmacists within Australia are funded through a variety of means, with some accessing 6CPA funding. PSA believes a trial could provide strong evidence for payment outside of the 6CPA – a payment model for which PSA has been strongly advocating. A media release clarifying this position was published in October 2015.
CLAIM 8: The GP Pharmacist model will duplicate services currently delivered through community pharmacies

The opposite is true. The GP Pharmacist model advocated by PSA will ensure the practice pharmacist refers patients through to local pharmacies for services not offered within the surgery, and would promote access to 6CPA funded services where appropriate. The PSA has ensured that the practice pharmacist job description has a clear delineation of roles – the model is about optimising the contribution of pharmacists and pharmacies, for the benefit of consumers. If a trial of this model were to proceed, the PSA would develop standards and guidelines to ensure the roles complement, not duplicate local services.

CLAIM 9: General practice pharmacists should be prescribers

There has been some suggestion that pharmacists working in a general practice should have prescribing rights, like their UK colleagues. While some international models for pharmacists in general practice do include pharmacist prescribing, it is important to acknowledge the different economic, policy and workforce issues in these settings. The conditions that exist in the UK make pharmacist prescribing both an appropriate response to health workforce issues and a role that is acceptable to GPs.

PSA has been a contributor to and a supporter of Health Workforce Australia’s work on health professional prescribing and acknowledges that there may be circumstances in which pharmacist prescribing may be appropriate. However, there are many important Quality Use of Medicines activities that a pharmacist may undertake within the general practice setting that do not require the pharmacist to be a prescriber and are possible within a pharmacist’s current approved scope of practice. As PSA has stated previously, pharmacists working within this environment need to value-add, filling current gaps in the provision of care to consumers.

CLAIM 10: Pharmacists working in a general practice need HMR credentialing

While accreditation for medication review may assist a pharmacist in this role, all of the documented functions of a practice pharmacist are possible under the current scope of practice of all pharmacists, with HMR credentialing not required. PSA does not agree with assertions from some organisations that a pharmacist’s practice setting determines their clinical skills and abilities. We know that those who have taken on practice pharmacist roles thus far have a wide variety of backgrounds and experience. PSA has recognised that pharmacists can benefit from support in relation to general practice orientation and has developed a course and resources in consultation with experts in the field. These tools and training meet the recommendations of the recent evaluation of the WentWest PHN trial of practice pharmacists.
CLAIM 11: The model will lead to doctor dispensing

The supply of medicines by doctors is not part of any general practice pharmacist model that PSA is aware of. The documented benefits (see above) have been achieved in models with an integrated, non-dispensing pharmacist. The 2010 UK PINCER and PRACtICE studies\textsuperscript{36,37} found that pharmacists play a critical role in reducing medicine errors in general practice. PSA strongly supports the separation of prescribing and supply roles as a safeguard for patient safety and is underpinned by the NMP. PSA’s views on the importance of separation of prescribing and dispensing are informed by evidence and have been articulated in a number of position statements.\textsuperscript{38,39}

CLAIM 12: The general practice pharmacist will be a ‘handmaiden’ to the GP

The documented benefits of a practice pharmacist have been achieved in models with an integrated pharmacist who is a professional colleague with the ability to independently exercise his/her own clinical judgement, not in a role which places them as subservient to a GP. Whilst there are some GPs who have promulgated the view that a pharmacist employed in a general practice must be under the supervision of or the instruction of the GPs, this is not a model with any support from PSA. Furthermore, the 30+ practices around Australia who already employ or contract pharmacists do not operate under this assumption.

CLAIM 13: PSA is pursuing a model of GP pharmacists that will have negative consequences for community pharmacies

PSA believes that based on international and local experience, a trial of GP pharmacists will demonstrate positive impact on community pharmacies. Some of the benefits that we would expect to see include:

- Increased uptake of 6CPA-funded services in local community pharmacies e.g. MedsChecks, DAAs and HMRs, as the practice pharmacist raises awareness of, and creates referral pathways for these services.
- Increased medication adherence and new medications dispensed through local community pharmacies for prevention and management of chronic disease. This is enabled through the practice pharmacist identifying at-risk patients.
- Increased referral and communication between local GP surgeries and pharmacies – for services not provided by practice pharmacists (e.g. for minor ailments etc.).

If a trial were to show unintended consequences or a negative impact on pharmacies, then we would re-evaluate our position and support for such a model.

In summary, PSA believes that a viable and robust community pharmacy network is necessary to achieve quality use of medicines for consumers, but quality healthcare does not happen in isolation.

If we put up barriers to progress and innovation then we may miss opportunities for pharmacists to play a role in the broader health reform being progressed by Government – opportunities that are critical to pharmacists being utilised to their full potential and more appropriately remunerated.

For more information about the practice pharmacist model or to find out more about any of these facts and the evidence quoted, please contact practicepharmacists@psa.org.au
REFERENCES


8. Tan EC et al. Pharmacist services provided in general practice clinics: A systematic review and meta-analysis. Research in social & administrative pharmacy. RSAP Published Online First: 22 Oct 2013


28. Comments by Health Minister at 6CPA PTP Stakeholder consultation forum held 26 October 2015

29. Comments by Health Minister at 6CPA PTP Stakeholder consultation forum held 26 October 2015


32. Comments by Health Minister at 6CPA PTP Stakeholder consultation forum held 26 October 2015


36. Comments by Health Minister at 6CPA PTP Stakeholder consultation forum held 26 October 2015


38. Comments by Health Minister at 6CPA PTP Stakeholder consultation forum held 26 October 2015


40. Comments by Health Minister at 6CPA PTP Stakeholder consultation forum held 26 October 2015