Pharmaceutical Society of Australia

2021-22
BUDGET SUBMISSION
NSW

Cover image: Karen Carter FPS, accredited pharmacist and community pharmacist, Gunnedah and Narrabri NSW

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Pharmaceutical Society of Australia

About PSA

PSA is the only Australian Government-recognised peak national professional pharmacy organisation representing all of Australia's 33,000 pharmacists working in all sectors and across all locations.

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

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

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

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

In NSW, there are 9,772 registered pharmacists working in community pharmacies, hospital, general practice, aged care, NSW and federal governments and within other private sector organisations.

Peter Crothers FPS, community pharmacist, Bourke NSW

Executive Summary

Medicines are the most common intervention in health care.[1] Alarmingly, problems with the use of medicines is also common. In Australia, 250,000 hospital admission a year are a result of medicine-related problems. The annual cost of these admissions is $1.4 billion; 50% of this harm is preventable.[2] This burden of harm is felt in NSW, as it is throughout Australia.

This submission identifies five key areas for consideration as part of the 2021/2022 Financial Year NSW Government Budget. The PSA seeks to work in partnership with the NSW Government to achieve mutually beneficial goals of improving access to medicines and health care for the NSW population and individual patients, enabling provision of better health outcomes.

In light of this, the Pharmaceutical Society of Australia recommends five key areas of action:

1 **Improve access to vaccination to protect the community and fund selected vaccines currently administered by pharmacists in NSW**

PSA calls for regulatory change to enable pharmacists to administer additional vaccines to persons 10 years and over such as the COVID-19 vaccine and selected travel vaccines to support public health outcomes. PSA also calls for the funding of vaccines to eligible persons through the National Immunisation Program and state funded programs to be made available through community pharmacies to increase access and herd immunity.

2 **Facilitate and fund re-direction of non-urgent emergency presentations to community pharmacists**

PSA calls on the NSW Government to allocate $7.5 million to improve access to health care through community pharmacy and reduce the financial impact and burden of non-urgent presentations on hospital emergency departments.

3 **Support and fund pharmacist administration of injections for opioid agonist treatment in NSW**

PSA calls on the NSW Government to allocate $5 million to develop a model of care for pharmacist administration of injectable buprenorphine in community pharmacy to improve patient outcomes and increase patient access.

4 **Fund and embed pharmacists in state funded aged care facilities to support medicine safety**

PSA calls on the NSW Government to invest $1.2 million annually to employ pharmacists in state run Residential Aged Care Facilities (RACFs) to reduce the use of inappropriate chemical restraint and protect residents from harm caused by medicines.

5 **Fund public health initiatives by pharmacists that support positive health outcomes and patient self-care**

PSA calls on the NSW Government to allocate $1.5 million funding for a Hepatitis C public health initiative that raises awareness, facilitates detection and provides access to antiviral treatment by trained community pharmacists.

Ms Chelsea Felkai
NSW President

Recommendation One

Improve access to vaccination to protect the community and fund selected vaccines administered by pharmacists in NSW

PSA urges the NSW Government:

- to include COVID-19 vaccine(s) in the pharmacist vaccination schedule
- to provide funding for pharmacist immunisers to administer COVID-19 vaccine(s)
- to provide access to the NIP for seasonal influenza and state-funded vaccines (i.e. measles) administered by pharmacist immunisers.

The challenge

Immunisation is one of the most effective disease prevention methods. Vaccines are safe, efficacious and easy for competently trained health professionals to administer. They provide protection against both health and economic impacts of epidemics of vaccine preventable infectious diseases.[3, 4]

In the past 12 months, the NSW Government has facilitated greater access to vaccination by enabling pharmacists to vaccinate children aged 10 years and over for influenza and allowing pharmacist administered vaccination outside a community pharmacy.

Access to funded vaccines is the main barrier to uptake of vaccination by non-immunising parents which may relate to social disadvantage and logistical barriers[5]. Among health care workers in Australia, awareness, cost, and convenience have been identified as key barriers to vaccination with data suggesting that raising awareness of the benefits of influenza vaccination, along with improving access to affordable, convenient vaccination are likely to improve uptake[6].

Barriers still exist to accessing funded vaccines when administered by pharmacist immunisers. The National Immunisation Program (NIP) is specific to an individual who meets eligibility criteria, not the health care professional administering the vaccine.

The state's obligations as part of the National Partnership Agreement on Essential Vaccines (NPEV) is to purchase and distribute vaccines to immunisation providers, manage the efficient and effective delivery of the immunisation program and monitor and minimise vaccine wastage[7].

Given the value of vaccines, there is an onging need to monitor and continually reduce vaccine wastage[8]. Broadening access to NIP and state funded vaccines may minimise vaccine wastage due to expired stock and an increase in targeted populations receiving vaccination and the information itself.

With the impending availability of the COVID-19 vaccine in 2021, it is critical every skilled resource is used to maximise vaccination coverage.

COVID-19 vaccine

The Australian COVID-19 vaccination program aims to protect Australians from coronavirus SARS-CoV-2[9]. The Australian and Technical Advisory Group on Immunisation (ATAGI) preliminary advice on general principles to guide the prioritisation of target populations in a COVID-19 vaccination program in Australia[9] has indicated the program should seek to ensure equity of vaccine access and uptake.

The Australian Government has agreements for the supply of three candidate vaccines, with one being manufactured in Australia[10]. If the vaccines are shown to stop community transmission, a high rate of population vaccination will be needed to achieve herd immunity.

PSA strongly believes that a large scale rollout of this vaccine in New South Wales (NSW) can only be achieved by using pharmacist immunisers, including those who practice in community pharmacies, hospitals and residential aged care facilities.

Evidence pharmacists can reach a large proportion of the population is highlighted in this year's response to the pandemic, where over 3 million doses of influenza vaccine were administered in NSW, many through the existing community pharmacy network.

In addition, logistics, including cold chain and administration of the potential COVID-19 vaccines requires special attention. Community pharmacies are experienced in cold chain management and have a very robust, accredited procedure for cold chain maintenance. The special administration requirements for some candidate vaccines should factor in additional training of all immunisation service providers.

Providing access to funded vaccines when administered by pharmacist immunisers

The NIP was established by the Commonwealth and state and territory governments to increase national immunisation coverage in order to reduce the number of cases of diseases that are preventable by vaccination in Australia. The NIP provides free vaccines to eligible people to help reduce diseases that can be prevented by vaccination. Free influenza vaccine is available under the National Immunisation Program (NIP) for people in specific risk groups[11].

In addition, NSW Health funds measles mumps rubella vaccine (MMR) free in NSW for GP immunisation provider use only in all people born during or after 1966, who haven't had measles or two doses of measles vaccine[12]. Funded vaccination increases immunisation coverage[13]. NSW pharmacist administered vaccines are currently privately funded – that is, eligible patients cannot benefit from funded influenza vaccines through the NIP nor state funded MMR vaccines.

The proposed approach

PSA recommends using pharmacist immunisers for large scale rollout of the COVID-19 vaccine in NSW and ensuring the COVID-19 vaccine and service is funded when administered by any trained immuniser, including pharmacists.

Achieving these recommendations is a matter of regulatory change. Any additional training needs in relation to cold chain management, multi-dose vials and administration of the COVID-19 vaccine applies to all immunisers equally and pharmacists should be included in this training.

PSA also proposes equal consumer accessibility to NIP-funded influenza vaccines and state funded MMR vaccination programs for eligible patients through community pharmacy.

Why it will work

Australian pharmacists have been administering vaccines safely and effectively since 2014 and across all States and Territories since 2016.

Community pharmacists (through a well-established network of community pharmacies and extended operating hours) provide an accessible and convenient location for the delivery of vaccination services. By improving vaccination rates, pharmacies can help ease pressure on general practice and hospital emergency departments which can become overcrowded in the event of serious influenza outbreaks. The pharmacist workforce has contributed to a meaningful reduction in the severity of seasonal influenza[14].

Pharmacists in other countries have also been shown to safely administer these vaccinations[15].

Vaccines able to be administered by pharmacist immunisers

	NSW	Australia (other)	Argentina	Canada*	Portugal	South Africa	Switzerland	UK	USA*
Influenza	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pertussis, diphtheria, tetanus	✓	✓&	✓	✓	✓	✓	✓	✓	✓
MMR	✓	✓%	✓	✓	✗	✓	✓	✓	✓
Meningococcal	✗	✓*	✓	✓	✓	✓	✗	✓	✓
Hepatitis A	✗	✗%	✓	✓	✓	✓	✓	✓	✓
Hepatitis B	✗	✗	✓	✓	✓	✓	✓	✓	✓
Varicella	✗	✗	✓	✓	✓	✓	✗	✓	✓
Pneumococcal	✗	✗%	✓	✓	✓	✓	✗	✓	✓
Influenza type B	✗	✗%	✓	✓	nd	nd	nd	nd	nd

*** denotes jurisdictional variation**

% MMR: All except ACT; Hepatitis A, Influenza type B, pneumococcal: Queensland only

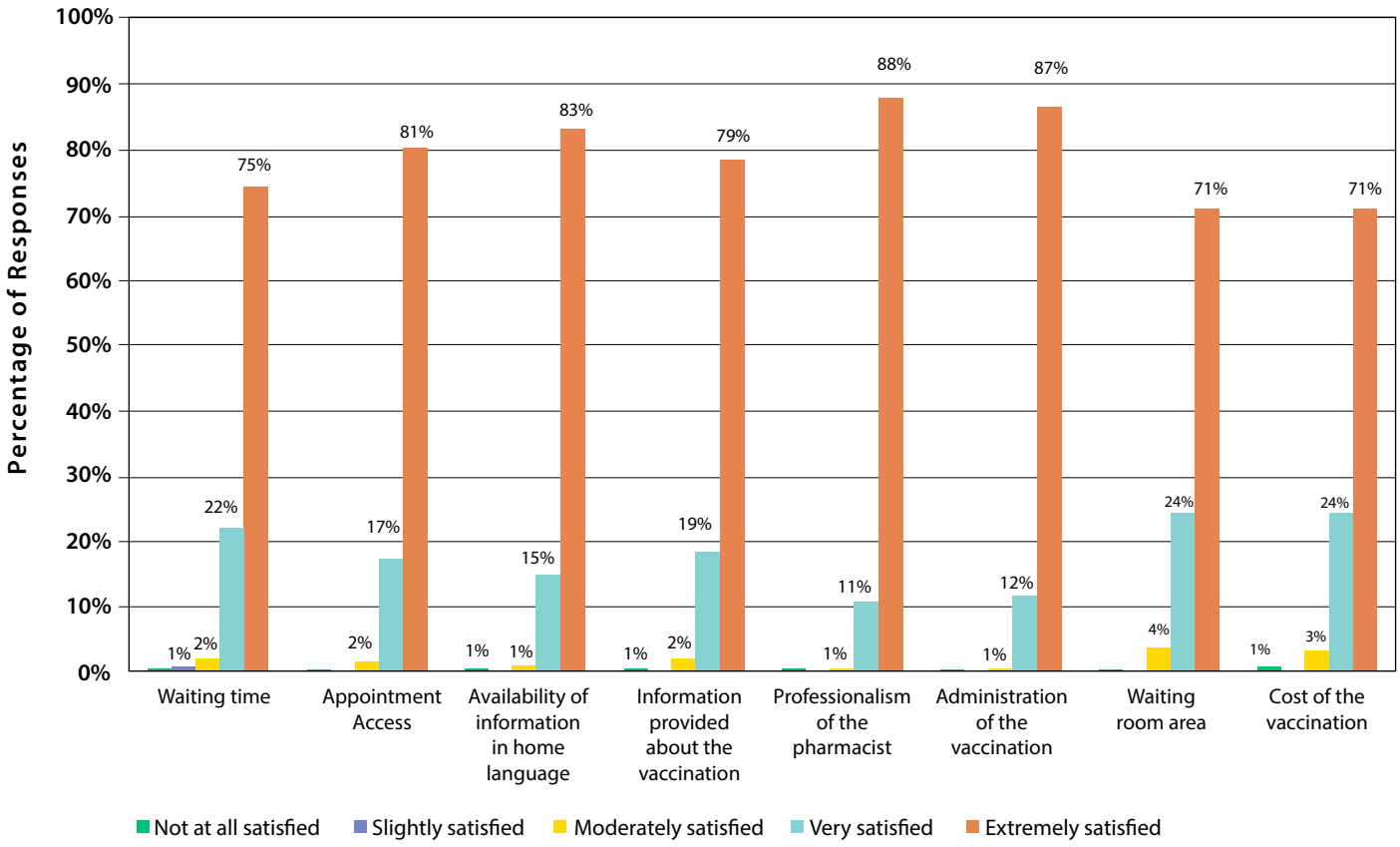
& only for purpose of pertussis immunity (most states) | nd: no data

In Victoria, pharmacist immunisers can administer government-funded vaccines under the NIP, the Victorian Government's Partner Whooping Cough Vaccine Program and MMR Adult Vaccine Program to eligible individuals aged 16 years and over.

Evaluation of the Victorian pharmacist administered vaccination program indicated that between June 2016 to September 2017, 47,525 Victorians received influenza and pertussis-containing vaccines while 10,420 Victorians received the vaccine for the first time[16].

Ninety-six per cent of consumers reported they were 'very satisfied' or 'extremely satisfied' with the pharmacist-administered vaccinations received[20].

Evaluation of the Victorian pharmacist administered vaccination program 2017 - patient satisfaction



The evaluation results suggest that the program had an impact on reducing and avoiding disease burden associated with influenza and pertussis[16]. With further expansion in the number of participating pharmacies and number of trained pharmacists, it is anticipated that this impact will continue to increase. In addition, consumers benefited from an increase in access to these vaccination services, a reduction in wait time and for some patients, a smaller fee[16].

Only 0.02% of cold-chain breaches were reported by community pharmacies compared with 0.85% for vaccination services provided in other provider settings[16], highlighting the high level of compliance to cold chain requirements in the community pharmacy environment.

WA Health provides NIP funded influenza vaccines to community pharmacies, including the high-strength vaccine for those aged 65 and over. The program has improved access for thousands of West Australians, particularly those who live without GP services or in rural remote areas in single pharmacy towns.

Similarly, ACT Health provides NIP funded influenza vaccines to ACT pharmacies as part of a pilot program. The costs of NIP and state funded vaccines are already accounted for in state and federal budgets based on eligibility criteria and population data. This means a marginal cost is involved for the redistribution of NIP and state funded vaccines to pharmacist immunisers in community pharmacies.

Research indicates the introduction of funded programs increases vaccination coverage[13]. Given the value of vaccines, there is an ongoing need to monitor and continually reduce vaccine wastage[8]. Broadening access to NIP and MMR vaccines may minimise vaccine wastage due to expired stock and a better ability by targeted populations to receive vaccination information and the vaccine itself.

Implementation

Trained pharmacist immunisers already have the skills and infrastructure to provide these services. Any additional training for the COVID-19 vaccine will be required across all health care groups involved in vaccination. Pharmacists should be included in this training. The wholesaler network provides an established distribution channel experienced in cold chain management. The NIP could be implemented as an allocation for targeted populations distributed via the wholesaler network. A rebate system based on report extraction from AIR for pharmacist administered vaccines to eligible NIP patients is also possible.

Cost

Administration fee for COVID-19 vaccines administered by pharmacists

Redistribution of current NIP-funded influenza vaccines and MMR state-funded vaccines to community pharmacy

Benefits to NSW

- Allows rapid vaccination of COVID-19 to priority groups followed by the whole population
- Increases access to vaccination, especially in rural and remote areas
- Reduce and avoid disease burden associated with vaccine preventable diseases (e.g. influenza and MMR)
- Improve efficient use of vaccines for the NIP and state funded MMR program
- Reduced wait time for patients
- Reduced cost (for some patients)

Recommendation Two

Facilitate and fund emergency presentations manageable by community pharmacists

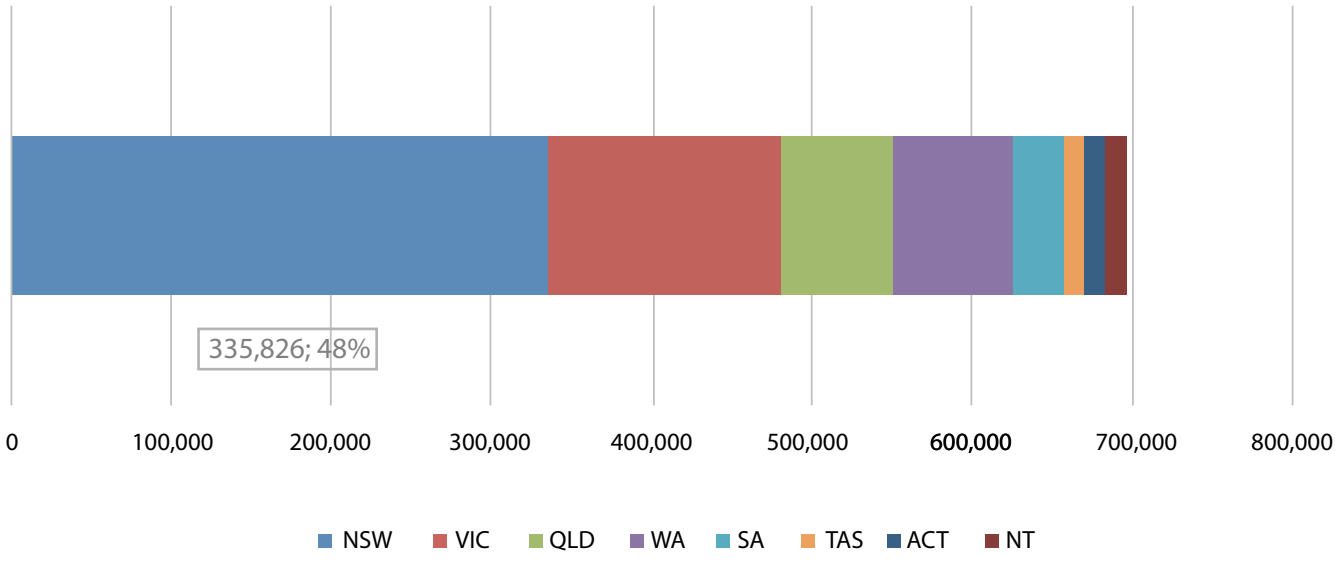
PSA recommends the NSW Government:

- to fund pharmacists for the management of non-urgent conditions through community pharmacy.
- to promote community pharmacy as a service provider for non-urgent conditions
- to fund PSA to support implementation through development of service protocols, support tools, practitioner education, training and delivery.

The challenge

In 2018-2019, there were 8.4 million presentations to Australian public hospital emergency departments - an average of about 23,000 presentations per day, a figure up 4.2% from 2017–1817. Of these, 2,976,532 emergency department presentations were in NSW, with 335,836 (11%) of these being considered as non-urgent. Seventy percent of non-urgent presentations to emergency departments occur between the hours of 9am and 7pm, during the typical business hours of a community pharmacy[17].

Emergency Department Presentations Non-Urgent
All states and territories (2018-2019)



The Australian Institute of Health and Welfare report *Use of emergency departments for lower urgency care: 2015-16 to 2017-18* highlighted that presentations to hospital emergency departments for lower urgency care may be avoidable through provision of other appropriate health services in the community[18].

Measures of non-urgent care were based on the 2018 National Health Agreement (NHA) indicator and were defined as presentations which[18]:

- did not involve arrival by ambulance
- were assessed upon arrival as needing semi or non-urgent care and
- were discharged without needing further hospital care

The report found that between 2017–2018, 37% (2.9 million) emergency department presentations were for non-urgent care. There was a higher rate of presentations from regional Primary Health Network (PHN) areas than urban PHN areas (152 versus 92 per 1000 people respectively), although within urban areas there were varied levels of presentations[18].

This will support the NSW Premier's priorities to reduce preventable visits to hospital by 5% through to 2023 by caring for people in the community.

The proposed approach

Action 6 in PSA's *Pharmacists in 2023* report states that building upon the established accessibility of community pharmacies in primary health care will improve the community's access to health services – lessening the burden on other healthcare providers such as hospitals. Improved access to healthcare across the country will reduce government costs associated with the delivery of care[19].

Patients seeking care from the emergency department for conditions such as headaches, coughs and colds, earaches and other non-urgent conditions are an inefficient use of resources[18]. Instead of going to emergency departments for non-urgent conditions, patients could instead visit their community pharmacist.

In addition, remuneration of pharmacist services in the assessment, triage and management of these patients will reduce state government expenditure and improve accessibility by providing timely treatment for patients with non-urgent medical conditions through the community pharmacy in both metropolitan and rural areas.

It is estimated that 2.9 to 11.5% of all emergency department services in Australia could be safely transferred to a community pharmacy[20]. Of the 2.88 million emergency department services provided in NSW annually, up to 331,233 presentations are potentially transferrable to community pharmacy[20].

The average cost of an emergency department attendance in NSW is $552.19, while an average cost per pharmacist consultation is $14.49 (a total of $26.88 including out-of-pocket patient costs for medicines). This results in a potential cost reduction of $525.31 per patient in NSW, if transferred from the hospital emergency department to community pharmacy[20].

Under this scenario, if pharmacists were paid through a consultation fee structure of $14.49 per consultation and if the patient paid for their non-prescription medicines, the NSW Government would save between $131 million and $439 million per annum[21].

Why it will work

There is strong evidence that the clinical advice provided by community pharmacists regarding symptoms of minor illness results in the same health outcomes as if the patient went to see their GP or attended the emergency department [22].

There is consistent evidence that pharmacy-based minor ailment schemes that manage non-urgent conditions or low urgency conditions, provide the right level of care, mitigate funding and system inefficiencies as patients access professional support for conditions that can be self-managed[23]. A total of 94 international schemes are identified in the literature, including the United Kingdom (England, Scotland, Northern Ireland and Wales) and regions of Canada (known as Minor Ailments Prescribing Services) [23, 24]. These initiatives were

implemented in Scotland in 1999, England since 2000, Northern Ireland since 2009, Wales in 2013 and in Canada since 2007 [25].

Internationally, pharmacies are paid a consultation fee for the delivery of minor ailment services[21]. In England, payment is made under the Community Pharmacy Consultation Service and is £14 ($25 AUD) per consultation to pharmacies. In some localities pharmacies are reimbursed for the cost of medicines supplied under a given formulary for certain minor ailments[26] Pharmacies may also receive a small annual retainer to assist with set-up costs[26].

Cost

$7.5 million per annum for the management of non-urgent medical conditions through community pharmacy.

An additional $1.5 million to implement a consumer awareness campaign to encourage people to visit a pharmacy instead of the hospital emergency department for non-urgent care.

Benefits to NSW

- Relieving pressure on existing emergency departments and urgent care services
- Reducing the number of non-urgent presentations and/or low urgency presentations to NSW emergency departments, reducing state budget expenditure
- Improving accessibility by providing timely treatment for patients with non-urgent medical conditions through the community pharmacy in both metropolitan and rural areas
- Empowering consumers to seek the appropriate level of care
- Increasing primary care capacity and availability of general practice for medical provision of chronic and complex patients through the transfer of common non-urgent medical consultations to community pharmacy

Todd Marion MPS, community pharmacist, Kiama NSW

Recommendation Three

Support and fund pharmacist administration of injections for opioid agonist treatment in NSW

PSA recommends the NSW Government:

- to make legislative changes and fund pharmacist-administered buprenorphine injections within the community pharmacies under direction of an authorised prescriber

The challenge

Opioid Agonist Therapy (OAT) with methadone or buprenorphine (BPN), has been demonstrated to be a safe and effective treatment approach for addressing opioid dependence[27]. The risks associated with methadone and BPN (such as diversion to others, injecting medicines, overdose risks with methadone) have resulted in a treatment model in Australia that is predicated on supervised dosing at a specialist clinic, community pharmacy or correctional health service, with take-away doses becoming available upon stabilisation according to a risk assessment and risk mitigation strategies [27].

The reliance on daily dosing impacts greatly upon the cost and inconvenience of treatment for patients and service providers, and has been cited as a barrier to engagement and retention for some patients in treatment. This is magnified in the rural and regional setting where patients travel further to access health services and medicines.

The introduction of depot BPN formulations into the Australian treatment system represents a significant development. The availability of BPN treatment with once-a-week and once-a-month depot injections is expected to be associated with several potential benefits [27]:

- Greater convenience for patients in that they will not have to attend dosing sites on a frequent basis for supervised dosing
- Reduced treatment costs for patients and service providers
- Less risk of diversion and non-medical use of the medicine, enhancing community safety
- Greater medicine adherence and better treatment outcomes for patients who struggle to attend regular dosing

Currently, injectable buprenorphine is administered in a specialist setting. These preparations must never be dispensed directly to or handed to the patient as there is a risk of serious harm or death if long-acting injectable buprenorphine is administered via the incorrect route or not injected subcutaneously[27]. This presents a challenge as to how patients can receive their treatment safely and effectively.

There are also specific storage requirements. Depot BPN is a Schedule 8 medicine (*Controlled Drug*) and thus requires storage in a safe, with one formulation also requiring refrigeration. Many primary care sites are not equipped to fulfill legal storage requirements when administering this medicine.

There is substantial patient interest in depot buprenorphine with advantages such as 'less service attendance', 'more time to do other things' and 'freedom to travel for work or holidays'.

This is coupled with the practical advantages of depot buprenorphine during the COVID-19 pandemic including a rapid reduction in the need for daily contact with a subsequent reduced risk of transmission of COVID-19.

The proposed approach

The availability and facilitation of drug and alcohol treatments through primary care is essential to supporting patient access for opioid agonist treatment (OAT) and take-home naloxone, withdrawal services, counselling and residential rehabilitation.

Pharmacists are increasingly more involved in the administration of medicines, as seen with the provision of vaccination services. The authority to administer medicines by injection is provided by jurisdictional legislation. In NSW, the *Poisons and Therapeutic Goods Act 1966* and *Poisons and Therapeutic Goods Regulation 2008* enable pharmacists to administer medicines by injections provided that, if the injection is a Schedule 4 (*Prescription Only Medicine*) or Schedule 8 (*Controlled Drug*), the supply has been made by, or the supply is directed/prescribed by, an authorised practitioner[28,29].

The *Poisons and Therapeutic Goods Regulation* provides authority for a pharmacist to supply and administer certain vaccinations under their own authority when certain conditions are met, which include training to ensure competency, including in injection technique.

Pharmacists are a skilled workforce with the infrastructure to support the supply and administration of injectable medicines, such as depot buprenorphine and provide access and flexibility to patients who are suitable for treatment.

Legislative change and funding is needed to establish a model of care for pharmacist administered buprenorphine in the community setting directed by an authorised practitioner. This will focus on community pharmacies currently involved in the NSW Opioid Treatment Program. A similar funding arrangement to the existing Pharmacy Incentive Scheme is proposed. The estimated cost is $5 million which includes community pharmacy service provisions, clinical governance and training.

Why it will work

Pharmacists have demonstrable experience in providing harm minimisation services in community pharmacy including the opioid treatment program. Pharmacists also have demonstrated experience in intramuscular and subcutaneous injections through vaccinations over recent years, including strong management of records, reporting and adverse event follow up. Pharmacists also have supply chain and inventory structures to manage administration of Controlled Drugs in a legally and professionally appropriate manner.

In 2019, under a pilot scheme in the UK, pharmacist administration of depot buprenorphine commenced. The pilot scheme involved patients who agreed with their doctor to being changed from oral buprenorphine to the injection, booking an appointment with a trained community pharmacist to administer the medicine [30].

The *PSA Injection Guidelines 2020*, outline the requirements for pharmacists to administer medicine by injection based on jurisdictional requirements including[31]:

- education and training minimum requirements
- resources such as equipment (including waste management), policies, procedures and protocols (including infection control), trained personnel, practice agreements (where relevant), documentation and indemnity insurance are required to conduct a medicine administration service
- quality assurance.

PSA has established training for pharmacist immunisers to learn to *Manage the delivery and administration of injections and immunisations (APPIMM806)*. PSA has also established the ***Administering medicines by injection course*** which is designed for ***trained and authorised pharmacist immunisers*** to upskill in administering medicines by injection. The course covers consultation, administration of injections and relevant state legislation and is designed to supplement the specific therapeutic area of the required injectable (in this instance buprenorphine).

Cost

$5 million to establish a model of care for pharmacist administered buprenorphine in community pharmacies.

Benefits to NSW

- greater convenience for patients in that they will not have to attend dosing sites on a frequent basis for supervised dosing
- reduced treatment costs for patients and service providers
- less risk of opioid diversion and non-medical use of the medicine, enhancing community safety
- greater medicine adherence and enhanced treatment outcomes for some patients who struggle to attend regular dosing
- ability of the service provider to focus on the broader health needs of the patient.

Recommendation Four

Fund and embed pharmacists in state-funded aged care facilities to support medicines safety

The challenge

Australia's population is aging, and currently 3.8 million people or 15% of the total population are aged 65 or over[32]. With this growth in the aging population, more and more, older Australians are entering residential care services [33]. As people are on average, older and frailer when they enter aged care facilities, the care and medicine management they require is becoming more and more complex [33]. The Royal Commission into Aged Care's interim report [34] was scathing in its criticisms of medicine management in Australia's aged care sector citing 'a surprisingly neglectful approach to the use and prolonged use of chemical restraint'. They further highlighted:

> *"widespread overprescribing, often without clear consent, of drugs which sedate residents, rendering them drowsy and unresponsive to visiting family and removing their ability to interact with people"*, and
>
> *"psychotropic medication is only clearly justified in about 10% of cases in which they are prescribed in residential aged care".*

These findings are consistent with those contained in PSA's *Medicine Safety: Take care* report (2019) and *Medicine safety: Aged care* (2020) which revealed:

- 98% of residents in aged-care facilities have at least one medicine related problem
- 80% are prescribed potentially inappropriate medicines[2]
- One in five unplanned hospital admissions of residents living in aged-care facilities are due to inappropriate medicine use.

There are approximately 81,000 residential aged care beds in NSW[34]. Residential aged care in NSW is provided by[35]:

- 881 non-government RACFs in NSW (March 2020), regulated by the Aged Care Quality and Safety Commission (ACQSC)
- 9 RACFs operated by NSW Health (regulated by ACQSC)
- 63 multipurpose services with residential aged care operated by NSW Health (regulated by ACQSC).

The range of geriatric and specialised clinical care services offered to RACF residents varies between LHD/SHNs. These facilities experience the same challenges with medicine safety which exist throughout the aged care sector in Australia.

The proposed approach

In order to achieve safe and best-possible use of medicines in residential aged care facilities, pharmacists, with their unique knowledge and medicines expertise, must have a greater role in the residential aged care sector [2,34,36,37].

PSA proposes incorporating a pharmacist on the ground in all NSW Health operated residential aged care facilities. This is supported by Recommendation 18 in the Royal Commission into Aged Care Quality and Safety – Counsel Assisting's proposed recommendations to require[38]:

> *"approved providers to engage at least one of each of the following allied health professionals: an oral health practitioner; a mental health practitioner; a podiatrist; a physiotherapist; an occupational therapist; a pharmacist; a speech pathologist; a dietitian; an exercise physiologist; a music or art therapist."*

The RACF pharmacist role complements the role of other pharmacists involved in the provision of care to residents, including community pharmacists who supply residents' medicines to the facilities in dose administration aids.

PSA recommends that in each of the 72 aged care facilities operated by NSW Health, 0.5 full-time equivalent (FTE) pharmacists should be dedicated per 100 aged care residents in order to perform the recommended activities.

What does a RACF pharmacist do?

A non-dispensing RACF pharmacist would be involved in undertaking medicine reviews, identifying and resolving actual and potential medicine related problems and providing medicine safety advice to prescribers, nursing staff, carers and residents. It would also enable greater communication and collaboration between members of the multidisciplinary team involved in resident care.

The role of a pharmacist employed in an aged care facility includes[19, 37]:

- **resident-level activities** including identifying, preventing and managing medicine-related problems, reducing polypharmacy and optimising medicines use
- **education and training** of other health professionals and facility staff in the quality use of medicines and medicines information
- **clinical governance activities** around using medicines appropriately including leading programs and systems to reduce use of high-risk medicines such as antipsychotics and benzodiazepines, providing stewardship of opioid and antimicrobial use, including monitoring and reporting
- supporting **achievement of accreditation standards** related to medicine management.

Why it will work

In 2018, an ACT residential aged care facility was the first in Australia to employ a pharmacist as part of a 6-month trial. The study found that 'including a pharmacist in a residential aged care home can improve medicine administration practices by reducing inappropriate dosage form modification and staff time spent on medicine administration rounds, and increasing the documentation of resident allergies, adverse drug reactions and medicine incidents[39]. Almost 80% of the pharmacist's activities were initiated by other stakeholders, demonstrating acceptance and demand of pharmacist activities in this environment.

The role of the pharmacist employed within the aged care facility was well received by residents, family members, care staff, doctors and other health care professionals involved in the care of residents. The facility now maintains an on-site pharmacist as a member of staff.

Cost

$1.5 million annually to employ pharmacists in state-run RACFs to reduce the use of inappropriate chemical restraint and protect residents from harm caused by medicines.

Benefits to NSW

- reduction in the use of psychotropic medicines/chemical restraints,
- improving the quality of life for residents through reduced side effects (e.g. sedation, weight gain, impaired cognition)
- reduction in hospitalisations from medicine-related adverse events
- more rational use of opioid medicines, resulting in improved pain management and alertness of residents
- more rational and targeted use of antimicrobials in accordance with local resistance patterns and treatment recommendations
- increased staff access to pharmacist's expertise in medicines and medication management within the residential care facility

Recommendation Five

Fund Hepatitis C public health initiatives by pharmacists to support positive health outcomes and patient self-care

PSA recommends the NSW Government:

- to fund a $1.5 million Hepatitis C public health initiative that raises awareness, facilitates detection and provides access to antiviral treatment by trained community pharmacists
- to amend the NSW Regulation to enable collaborative prescribing for Hepatitis C antiviral treatments.

The challenge

Public health initiatives form an important component in prevention and education as well as raising awareness of symptoms and associated conditions to facilitate early detection and treatment for various diseases. Many health-related initiatives rely on mass campaigns and are unable to target at risk groups, who are a specific priority.

Chronic Hepatitis C virus (HCV) infection is a major public health challenge for Australia, affecting about 200,000 people who are at risk of progressive liver fibrosis leading to cirrhosis, liver failure and hepatocellular carcinoma (HCC). HCV infection is the most common cause of liver disease requiring liver transplantation in Australia. However, HCV infection is curable, and viral eradication is associated with multiple clinical benefits, including improvement in quality of life, and reduction in mortality [40].

In 2016, the 194 Member States of the World Health Organization committed to eliminating Hepatitis C as a public health threat by 2030 which include four key targets [41].

- Reduce the incidence of Hepatitis C by 80%
- Reduce Hepatitis C mortality by 65%
- 90% of Hepatitis C cases are diagnosed
- 80% of Hepatitis C cases are treated

With only 10 years to go until the 2030 deadline is reached, and although much progress has been made towards elimination, there are still gaps in awareness, testing and access to treatment.

In Australia 36% of patients remain undiagnosed and only 8% of those diagnosed are receiving treatment [42].

To reach the WHO elimination targets of 80% of people with Hepatitis C being treated and incidence being reduced to 80% of the 2015 level by 2030, the number of Hepatitis C-exposed people identified and tested needs to be increased by at least 50%.

Until recently, Hepatitis C was treated with interferon therapy, which had limited efficacy and was poorly tolerated. New direct-acting antiviral (DAA) therapies are highly effective and well tolerated. All Australian adults living with Hepatitis C should now be considered for antiviral therapy. More than 70,000 Australians have accessed DAAs, highly effective and curative Hepatitis C treatments, however approximately two-thirds of the estimated population living with Hepatitis C is yet to be treated [42].

International and Australian data have shown that people living in rural and regional areas where there are fewer specialists have lower rates of Hepatitis C treatment [43]. The NSW Hepatitis Strategy aims to increase the number of people accessing Hepatitis C treatment in NSW by 100% [44].

The proposed approach

To eliminate Hepatitis C as a public health threat in Australia by 2030, Hepatitis C elimination programs should maintain treatment uptake by focusing on increasing testing and linkage to care. For the benefits of direct-acting antiviral drugs to be fully realised, models of care should target the needs of the people who are most likely to be infected[45].

To support the Hepatitis C targets, it is proposed that a community pharmacy public health initiative be implemented that focuses on:

- **Raising awareness of Hepatitis C in targeted populations** – including those living with Hepatitis C, people who inject drugs, people from culturally and linguistically diverse backgrounds, Aboriginal people and young people at risk of injecting.
- **Facilitate screening of at-risk populations** – utilising the dry spot blood test provided by NSW Health. This would be supported through training and resources in screening criteria, the screening tool and point-of-care testing.
- **Initiating antiviral treatment** – including those living with Hepatitis C, people who inject drugs, people from culturally and linguistically diverse backgrounds, Aboriginal people and young people at risk of injecting.
- **Implementing a self-care program** – revitalise an established self-care program that provides patients education and resources to support people to effectively manage their condition

Self-care has been highlighted by the World Health Organization (WHO) as integral to primary health care and is defined as *"the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider"*[46]. The importance and relevance of self-care and patient engagement in health policies and health care systems is critical as the evidence indicates that individual and population involvement results in significantly improved clinical, economic and humanistic outcomes [47]. International health services and providers have moved toward incorporating ways to increase patient involvement [48-50], and embedding patient-centred care principles.

Why it will work

Community pharmacists are one of the most accessible health care professionals to the general public. The effectiveness of community pharmacy-based public health interventions has been shown in smoking cessation, health promotion, disease screening and preventive activities, provision of emergency hormonal contraceptive, and vaccination services [51].

Community pharmacies are well-placed to offer public health initiatives that support the early identification and treatment of Hepatitis C, as well as ongoing patient self-care. Pharmacists currently deliver harm minimisation services including the needle syringe program (NSP), take home naloxone (THN) and the opioid treatment program (OTP), which provide an untapped opportunity to reach the targeted at-risk population. This aligns with the NSW Hepatitis C strategy of improving access to Hepatitis C treatment through primary care models and builds on established prevention efforts such as the NSP.

NSW Health strategy reports there is a "*high level of trust placed in Needle and Syringe Programs by clients which is a key resource yet to be harnessed in the Hepatitis C sector.*' It also notes that *"Needle and Syringe Programs could become the site to host services to address Hepatitis C, including referrals, testing for, monitoring and treating the infection, and to address other key health and social issues which are important to people who inject drugs".*

Studies have found provision of community-based Hepatitis C treatment increases treatment uptake without compromising cure outcome [45]. A Scottish trial in community pharmacies found people were more than twice as likely to be cured of Hepatitis C if their test and direct acting antiviral drug prescription was provided by their community pharmacist (intervention group) than if they were referred to a multidisciplinary team at a local treatment centre (conventional care group)[45].

In both study groups, community pharmacists offered opportunistic screening for Hepatitis C with dried blood spot tests to people receiving opioid substitution therapy. In both groups, antiviral treatment was dispensed as daily modified directly observed therapy with opioid substitution therapy at the community pharmacy[45].

Cost

$1.5 million in funding for a Hepatitis C public health initiative

Benefits to NSW

- Greater awareness of Hepatitis C to at-risk populations
- Increased screening opportunities
- Facilitate early detection
- Improve initiation of anti-viral treatment
- Support patient education and self-care

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