Pharmaceutical Society of Australia

2021-22 AUSTRALIAN GOVERNMENT BUDGET SUBMISSION

Contact

Mark Kinsela
Chief Executive Officer
Pharmaceutical Society of Australia
ceo@psa.org.au
02 6283 7777
Level 1/17 Denison Street
Deakin, ACT, 2600

Above image: Catherine Trosky,
community pharmacist, Boronia, Victoria

Cover image: Khanh Nguyen MPS,
community pharmacist, Ascot Vale, Victoria

Pharmaceutical Society of Australia

Executive summary

Medicines are the most common intervention in health care.[1] However, problems with the use of medicines are also alarmingly common. In Australia, 250,000 hospital admissions 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]

The Pharmaceutical Society of Australia recommends provision is made in the 2021/2022 Financial Year Australian Government Budget to:

1

Adopt the MBS Taskforce recommendation to rebate non-medical health professional participation at case conferences

PSA recommends the Australian Government immediately adopt Recommendation 4 of the MBS Taskforce's findings - General Practice and Primary Care Clinical Committee.

2

Amend aged care funding instruments to engage pharmacists in Australia's residential aged care facilities

PSA proposes the Australian Government revise aged care funding instruments, investing $197.8 million over 4 years to support residential aged care facilities to directly engage pharmacists to reduce preventable harm caused by medicines – including safely reducing use of clinical restraint.

3

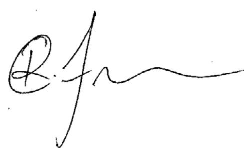
Establish a digital nationally coordinated pharmacovigilance system for primary care

PSA proposes the Australian Government establish a nationally coordinated pharmacovigilance system which provides central feedback on the safe and effective use of medicines. The system, which would commence through a $15 million to pilot program, would cover general practice, community pharmacy, residential aged care and disability care.

4

Fund pharmacists within Aboriginal Community Controlled Health services

PSA proposes the Australian Government commit $30.90 million over 4 years to enable Aboriginal Community Controlled Health Organisations (ACCHOs) to employ 85 FTE pharmacists within their primary health care teams to support their 483,073 clients.



Associate Professor Chris Freeman
PSA National President

About PSA

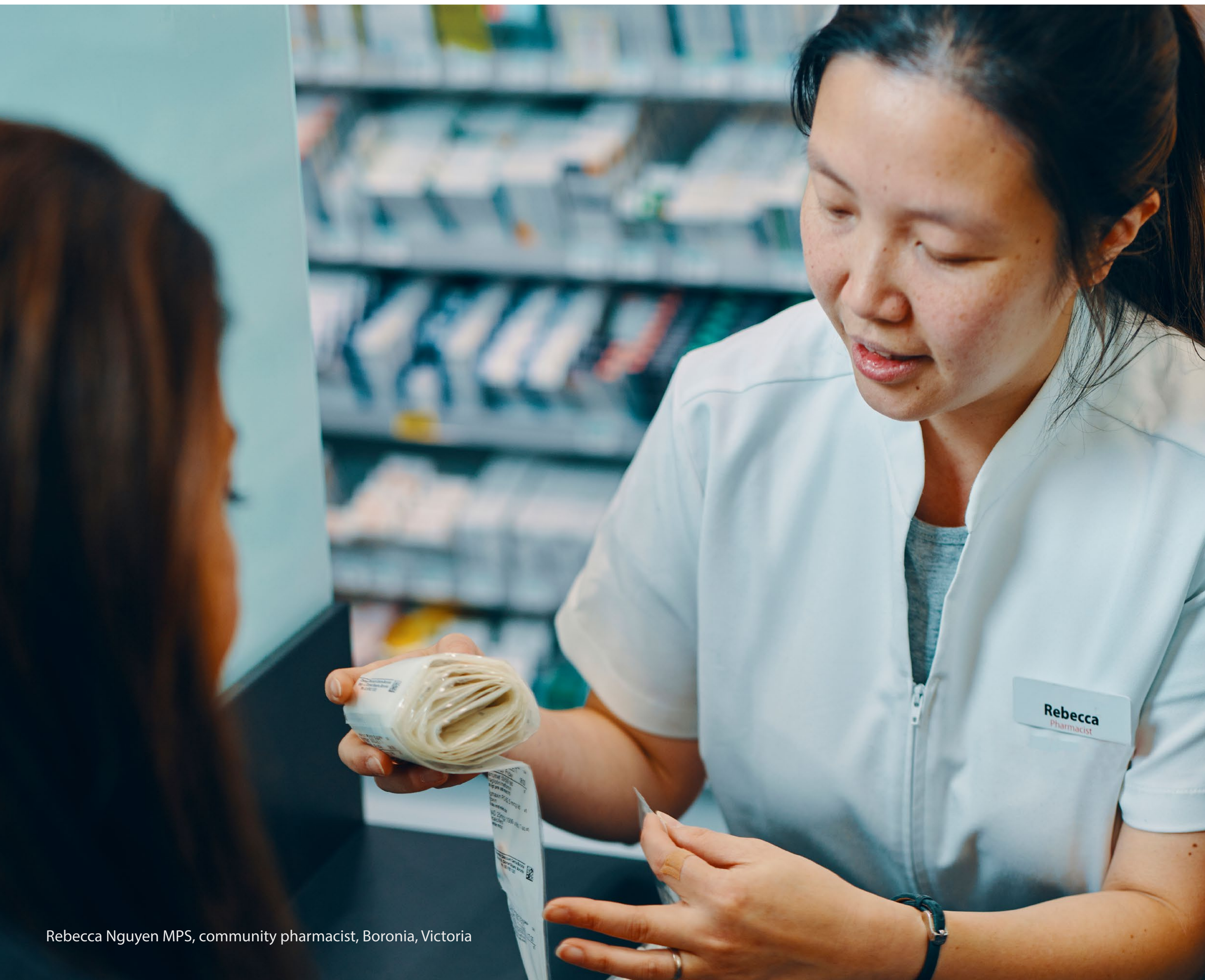
PSA is the only Australian Government-recognised peak national professional pharmacy organisation representing all of Australia's 32,000 pharmacists working in all sectors and across all locations.

PSA is committed to supporting pharmacists help 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.



Rebecca Nguyen MPS, community pharmacist, Boronia, Victoria

1. Adopt the MBS Taskforce recommendation to rebate non-medical health professional participation at case conferences

The challenge

Collaborative health care is widely accepted as necessary for good human health. And the more complex someone's health becomes, the more important it is the whole health-care team works together effectively. Sadly, and often tragically, this often doesn't happen as it should.

Case conferencing, where members of the health team sit-down and discuss ways to plan patient care, does not currently support active contribution from the patient's primary care health team. Many members of the team, including pharmacists, are not remunerated for participating and are therefore unable to devote the time to contribute. This puts patient health and medicine safety at risk.

The MBS Review Taskforce has examined the need for effective case conferencing and considered improvements to better engage in collaborative care, making a considered package of recommendations to government in mid-December 2020.

The proposed approach

PSA recommends the Australian Government immediately adopt Recommendation 4 of the MBS Taskforce's findings - General Practice and Primary Care Clinical Committee[3], particularly with respect to rebating attendance of non-medical health professionals at case conferences:

> ***Recommendation 4 – Implement a comprehensive package of longitudinal care for enrolled patients with chronic health conditions that promotes effective use of primary care chronic disease management items***
>
> *4.6. Encourage increased patient participation and rebate attendance of non-medical health professionals at case conferences*
>
> *b. Creating three new items to rebate attendance at a case conference by non-medical health practitioners, one for 15-20 minutes to align with item 747, and one for 20-40 minutes to align with item 750, and one for >40 minutes to align with item 758.*

Why it will work

Creating MBS items for non-medical health practitioners to align with the equivalent GP items will foster better collaboration and enhanced safe and quality use of medicine outcomes for patients. Recommendation 4 recognises the extensive evidence base which supports case conferencing as necessary for effective, safe, patient-centred team-based care.

The recommendation means pharmacists will, for the first time, be one of the eligible groups to be remunerated for participation in interdisciplinary case conferences. This will lead to greater participation; identification of many medicine safety issues and resolution before they become a problem.

Across community pharmacies, aged care, and in general practice the change to case conference reimbursement in addition to the recent introduction of the follow up medicine reviews would dramatically improve the safe and quality use of medicines.

Implementation

Immediately

Budget

$34.50 per case conference of 15-20 minutes

$64.20 per case conference of 20-40 minutes (aligned to allied health items 10950-10970)

$120.00 per case conference of >40 minutes

Benefits to Australians

- More coordinated health care, leading to fewer medicine safety problems, fewer avoidable hospitalisations for people with chronic health conditions
- Better quality of life for people with chronic health conditions
- Cost savings from reduced avoidable hospital admissions linked to chronic health conditions, such as COPD exacerbations, cardiac representations and complications of diabetes.

Nicolette Ellis MPS,
consultant pharmacist, Brisbane Qld

2. Amend aged care funding instruments to engage pharmacists in Australia's residential aged care facilities

The challenge

Australia's population is aging. Currently 3.8 million people or 15% of the total population are aged 65 or over.[4] The Royal Commission into Aged Care's interim report[5] 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'.* It 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"*

> *"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 (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 5 unplanned hospital admissions of residents living in aged-care facilities taking are due to the inappropriate medicine use.

To address these problems, counsel assisting the Royal Commission into aged care quality and safety recommended:[6]

> *"approved [aged care] 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 proposed approach

PSA proposes the Australian Government revise funding instruments for residential aged care facilities to ensure pharmacists are directly engaged to reduce preventable harm caused by medicines – including safely reducing use of clinical restraint.

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 0.5 full-time equivalent (FTE) pharmacists should be dedicated per 100 aged care residents in order to perform the recommended activities. Based on current residency, this would equate to 910 FTE pharmacists to support Australia's 181,200 people living in residential aged care.

What does a RACF pharmacist do?

The non-dispensing role of a pharmacist employed in an aged care facility includes:[7,8]

- **Resident-level activities** identifying, preventing and managing medicine-related problems, reducing polypharmacy and improving medicines working with residents, family and their prescribers. This includes at transitions-of-care when patients move in and out of RACFs;
- **Clinical governance activities** around using medicines appropriately including leading programs and systems to reduce use of high-risk medicines such as antipsychotics and benzodiazepines, and provide stewardship of opioid and antimicrobial use, including monitoring and reporting;
- **Education and training** of other health professionals and facility staff in the quality use of medicines and medicines information;
- 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 'including pharmacist in a residential aged care home can improve medication administration practices by reducing inappropriate dosage form modification and staff time spent on medication administration rounds, and increasing the documentation of resident allergies, adverse drug reactions and medication incidents'.[9]

The role of the pharmacists employed within the aged care facility was well received by patients, family, care staff, doctors and other health care professionals involved in the care of patients. The facility now maintains an on-site pharmacist as a member of staff. Aged care pharmacists are part of normal RACF services in the UK, Ireland and the USA.

Neil Petrie MPS, consultant pharmacist, Donvale, Victoria

Case example: RedUSe program

The RedUSe program is a multi-strategic quality improvement intervention funded in aged care facilities, with three main components.[10–12] The program includes:

- audit and benchmarking of sedative and antipsychotic medicine use
- aged care home staff education about the benefits, risks, and guidelines for psychotropic use
- targeted multi-disciplinary sedative review for all residents taking regular doses of antipsychotics and/or benzodiazepines.

Benefits identified included reductions in:

- **agitation** with both antipsychotic and benzodiazepine dose reduction
- **occupational disruptiveness** related to agitation with antipsychotic reduction
- **sleep disturbances** with benzodiazepine reduction.

There were also savings with antipsychotic and/or benzodiazepine dose reduction, mainly driven by lower costs related to hospitalisations.

Implementation

Staged implementation from 1 July 2021, ramping up to full capacity in 2024/25 FY.

Budget

FY	Capacity	Budget (million)
2021-22	10%	$9.98
2022-23	25%	$25.72
2023-24	50%	$52.98
2024-25	100%	$109.13
Total		**$197.81**

Benefits to Australians

- Reduction in the use of psychotropic medicines/chemical restraints, improving the quality of life for residents through reduced side effects (sedation, weight gain, impaired cognition etc)
- Reduction in hospitalisations from medicine-related adverse events
- Better use of antimicrobials and reduced antimicrobial resistance
- Ensuring pharmacist are present and available within the residential care facility to identify, respond to and resolve medicine safety problems in a timely manner.

3. Establish a digital nationally coordinated pharmacovigilance system for primary care

The challenge

Medicines are the most common intervention in health care.[1] Medicines are a modern miracle, but can also cause harm. As a result of medicine safety problems, the Council of Australian Governments (COAG) Health Council agreed to make the Quality Use of Medicines and Medicines Safety the 10th National Health Priority Area (NHPA) in October 2019.

Achieving medicine safety is focussed on one thing; reducing harm. This means drastically reducing avoidable deaths, hospitalisation, prolonged hospital stay duration and quality-of-life impacts caused by medicines.

While too many incidents still occur, Australia has done well to reduce the harm caused by medicines inside our hospitals. These gains have been achieved through long-term system and cultural changes – including a reporting culture for medicine safety incidents such as administration errors, adverse reactions to medicines and dispensing errors.

However, the overwhelming majority of medicine harm occurs in the community and in aged care. These environments do not have effective performance improvement systems for medicine use – particularly in documenting and reporting medicine related problems. This means medicines cause unnecessary harm to Australians.

The proposed approach

Establish a nationally coordinated pharmacovigilance system for primary care which provides central feedback on the safe and effective use of medicines. The system would cover general practice, community pharmacy, residential aged care and disability care.

PSA foresees this commencing through a pilot program of a pharmacovigilance system with the goal of broader rollout to a national incident logging and monitoring system. The pilot would initially focus on multiple primary care providers in a specific geographical location, possibly a rural centre, to enable the system to be developed, tested and refined before broader roll out. This system would:

- allow patients and primary care providers (general practice, community pharmacies, aged care etc.) to **electronically record medicine safety incidents**. This would include recording adverse effects from medicines, medicine incidents and errors
- allow primary care providers to **review and analyse incidents**, including in aggregated reporting to systematically identify trends and opportunities for medicine safety improvement and meet accreditation standards
- shared **de-identified adverse event data** with the Therapeutic Goods Administration to improve pharmacovigilance of new and existing medicines/therapeutic devices on the Australian Register of Therapeutic Goods (ARTG)
- allow for **development of benchmarks** for reporting and responding to safety issues relating to medicines.

Why it will work

Patient safety incident monitoring is recognised as fundamental to reducing harm within health settings.[13–16] Over recent years, several government agencies have highlighted the need for such a system, including:

- Australian Commission for Quality and Safety in Health Care (ACSQHC) has previously investigated the feasibility of establishing a national reporting system for medicine safety incidents
- National Digital Health Strategy[17] identifies the need for improving incident reporting capabilities and replacing underused, disjointed paper recording with a dedicated digital national framework for medicines adverse event reporting
- The Therapeutic Goods Administration has undertaken public consultations regarding improving reporting of adverse events for medical devices.

Mandatory incident logging (including errors and near-misses) has been introduced in other like countries such as Canada, United Kingdom, Ireland and New Zealand.

Implementation

Staged implementation, including:

- Developing pilot structure and engagement of technology and departmental partners
- Pilot program in limited geographical area
- Development of business case to government for national implementation.

Budget

$5 million to fund pilot development

$10 for pilot program, including incentivisation of participating primary care service providers

Benefits to Australians

- Safer primary care, leading to reduced deaths and hospitalisations caused by medicine errors
- Central reporting of medicine-related problems to regulatory bodies (e.g. TGA), Department of Health to inform health policy and health system functioning
- Patients and their carers provided greater opportunity to report problems with medicines which contributes to central warning systems and local review.

4. Fund pharmacists within Aboriginal Community Controlled Health services

The challenge

In Australia, Aboriginal peoples and Torres Strait Islanders are five times more likely to die from chronic disease before the age of 75 years than other Australians (2011-15).[18] The impact of chronic disease is estimated to be responsible for 70% of the health gap.[19]

There is an inextricable link between medicines and the management of chronic disease and illness. However, while several programs have been developed to improve medicines access and use for Aboriginal and Torres Strait Islander people, much more needs to be done to address the known disparities in medicines access and quality use of medicines compared to other Australians. Despite the larger burden of disease, Aboriginal people on average take less medicines than non-Aboriginal people.

The *National Agreement on Closing the* Gap[20], identifies building formal Aboriginal and Torres Strait Islander community-controlled sectors as one of the four priority reform areas to address health disparity.

The proposed approach

PSA proposes the Australian Government fund a program to enable Aboriginal Community Controlled Health Organisations (ACCHOs) to employ pharmacists within their primary health care teams.

PSA recommends funding of 0.2 full-time equivalent (FTE) pharmacists per ACCHO, plus a proportional FTE based on 1.0 FTE per 8295 patients. Appropriate loadings based on rurality would apply to the funding model. Based on current population estimates this would equate to approximately 85 FTE pharmacists to support the 483,073 clients of Aboriginal primary health care services.

What does an ACCHO pharmacist do?

The non-dispensing role of an integrated pharmacist employed in an ACCHO includes[7]:

- **Patient activities** identifying, preventing and managing medicine-related problems, particularly for chronic disease management (e.g. diabetes, cardiovascular disease). Resolving medicine access issues, enhancing transitional care and patient education

- **Clinical governance** for using medicines appropriately including leading programs and systems to ensure optimum management of medicines in relation to chronic disease. Provide stewardship of antimicrobial use, such as for Rheumatic heart disease prophylaxis. Assist meeting targets for the *Implementation Plan goals for the Aboriginal and Torres Strait Islander Health*

- **Education and training** of Aboriginal Health Workers and other health professionals in the quality use of medicines and medicines information.

ACCHO pharmacists complement rather than replace the role of other pharmacists, such as community pharmacists, involved in the safe and quality provision of medicines to ACCHO clients

Why it will work

The Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve chronic disease management (IPAC) project (2018-2020) trialled the impact of ACCHO pharmacists. The trial, funded by the Department of Health, was successfully implemented in 18 ACCHOs across the Northern Territory, Queensland and Victoria. The results of the trial are currently under consideration by the Department of Health.

Implementation

Staged implementation from 1 July 2021, increasing to full capacity in 2024/25 FY. Initial establishment includes the establishment of training and support programs in 21/22 FY.

Budget

FY	Capacity	Budget (million)
2021-22	25%	$4.58
2022-23	40%	$5.82
2023-24	50%	$7.10
2024-25	100%	$13.40
Total		**$30.90**

Benefits to Aboriginal and Torres Strait Islander people

- More empowered patients with a better understand their condition and medicines and be more adherent with their medicine regimes
- Health professionals providing care to Aboriginal people and Torres Strait Islander people will have improved knowledge and ready access to information related to quality use of medicines
- Better access to medicines through strengthened relationships between ACCHO's and community pharmacies
- Reduced avoidable emergency presentations and hospital admissions
- Reduced undertreatment of medicine necessary for effective management of chronic health conditions in Aboriginal and Torres Strait Islander people.

Pippa Travers-Mason, ACCHO Pharmacist, Yarrabah, QLD

References

1. Roughead L, Semple S, Rosenfeld E. Literature Review: Medication Safety in Australia . Sydney: Australian Commission on Safety and Quality in Health Care; 2013 Aug. At: www.safetyandquality.gov.au.

2. Medicine Safety: Take Care . Canberra: Pharmaceutical Society of Australia; 2019 Jan. At: www.psa.org.au.

3. Taskforce Findings – General Practice and Primary Care Clinical Committee Report. Australian Government Department of Health. Australian Government Department of Health; 2020. At: https://www.health.gov.au/resources/publications/taskforce-findings-general-practice-and-primary-care-clinical-committee-report.

4. Older Australia at a glance . Canberra: Australian Institute of Health and Welfare; 2018 Sep. At: https://www.aihw.gov.au/getmedia/7f3b1c98-c308-45c6-956b-b599893bdf33/Older-Australia-at-a-glance.pdf.aspx?inline=true.

5. Interim Report of the Royal Commission into Aged Care. Royal Commission into Aged Care Quality and Safety; 2019 Nov. At: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx

6. Counsel Assisting's Proposed Recommendations at Final Hearing [PDF] | . Royal Commission into Aged Care Quality and Safety; 2020 Oct. At: https://agedcare.royalcommission.gov.au/media/29098.

7. Pharmacists in 2023; Roles and remuneration. Canberra: The Pharmaceutical Society of Australia; 2019 Jul p. 40. At: https://www.psa.org.au/advocacy/working-for-our-profession/pharmacists-in-2023-roles-and-remuneration/

8. Pharmacists in 2023: For patients, for our profession, for Australia's health system. Canberra: Pharmaceutical Society of Australia; 2019 p. 64. At: https://www.psa.org.au/advocacy/working-for-our-profession/pharmacists-in-2023/.

9. The effect of a residential care pharmacist on medication administration practices in aged care: A controlled trial - McDerby - 2019 - Journal of Clinical Pharmacy and Therapeutics - Wiley Online Library. At: https://onlinelibrary.wiley.com/doi/full/10.1111/jcpt.12822.

10. Westbury JL, Gee P, Ling T, Brown DT, Franks KH, Bindoff I, et al. RedUSe: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities. The Medical Journal of Australia. 2018 May 14;208(9):398–403.

11. Westbury J, Gee P, Ling T, Kitsos A, Peterson G. More action needed: Psychotropic prescribing in Australian residential aged care. Aust N Z J Psychiatry. 2019;53(2):136–47.

12. Hoyle D, Bindoff I, Clinnick L, Peterson G, Westbury J. Clinical impact of antipsychotic and benzodiazepine reduction: Findings from a multicomponent reduction program within long-term aged care. International Psychogeriatric Association Congress, 1-3 September 2019.

13. Allen P. Clinical governance in primary care: Accountability for clinical governance: developing collective responsibility for quality in primary care. BMJ. 2000 Sep 9;321(7261):608–11.

14. Jones A, Killion S. Clinical governance for Primary Health Networks . Canberra: Australian Healthcare and Hospitals Association; 2017 Apr, p. 15. Report No.: 22. At: https://ahha.asn.au/system/files/docs/publications/210417_issues_brief_no_22-_clinical_governance_for_phns.pdf

15. National Model Clinical Governance Framework. 1st ed. Sydney: Australian Commission on Safety and Quality in Health Care; 2017. 44 p.

16. Australian Standard 85000:2017 Quality Care Community Pharmacy Standard. The Pharmacy Guild of Australia; 2017.

17. National Digital Health Strategy: Framework for Action - Medicines Safety . Canberra: Australian Digital Health Agency. At: https://conversation.digitalhealth.gov.au/4-medicines-safety.

18. Aboriginal and Torres Strait Islander Health Performance Framework 2017 . AIHW Indigenous HPF. At: https://www.indigenoushpf.gov.au/publications/hpf-2017.

19. 1.23 Leading causes of mortality. Australian Institute of Health and Welfare National Indigenous Australians Agency; 2020. (Health Performance Framework - measures). At: https://www.indigenoushpf.gov.au/measures/1-23-leading-causes-mortality.

20. Closing The Gap: Priority reforms. Australian Government Department of Prime Minister and Cabinet; 2020. At: https://www.closingthegap.gov.au/priority-reforms.