

CONTEMPORARY COMMUNITY PHARMACY PRACTICE: **WHITE PAPER**

Community of Specialty Interest





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FOREWORD

I am pleased to launch the White Paper developed by the inaugural PSA Contemporary Community Pharmacy Practice – Community of Specialty Interest (CSI-CCPP). This White Paper articulates the current landscape of community pharmacy practice, including its challenges and opportunities, and aims to stimulate constructive discussion. This paper presents a consolidated view of the CSI-CCPP on issues facing community pharmacy practice in Australia and proposes direction to achieve viability and sustainability in contemporary practice. The matters raised in this paper need immediate intervention, enabled through collaborative efforts from all stakeholders, including practising pharmacists, pharmacy proprietors, professional organisations, as well as Australian and State/Territory Governments.

In the past two and a half years, the COVID-19 pandemic has led to noteworthy evolution of the role of community pharmacists and pharmacies. Existing momentum in the wider Australian primary health care space, including those articulated in the *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032* and the *National Preventive Health Strategy 2021-2030*, highlights a significant opportunity for community pharmacists as primary health care providers. As such, the integration of community pharmacies and pharmacists into Australian primary health care is critical, and should be considered a priority and the focus of our advocacy efforts.

Whilst consumer and health system demand-driven needs have somewhat improved the roles and recognition of community pharmacists, they further highlight the gaps in remuneration for pharmacists and call for a complete cultural shift in the way we practise community pharmacy. Recent events have fast-tracked digitisation and automation within the industry. Pharmacists and policy makers should be pragmatic when considering the impact and role of digital health in how we practise community pharmacy.

To enable strategy and policy development informed by members, the PSA launched the CSI-CCPP in September 2021 which seeks to identify, debate and articulate the complexities, opportunities and challenges facing community pharmacy within contemporary practice environments. The group aims to guide advocacy efforts of the PSA, which ultimately supports our profession toward achieving a patient-centred, viable and sustainable practice model in the Australian community pharmacy sector – one that meets contemporary needs of the community, the health system, and our own community pharmacists.

In January 2022, Practice Group members were surveyed to explore key strategic priority areas, which were then debated at length by the Leadership Group. This CSI recognises and acknowledges the need for a multifaceted, collaborative, innovative and strategic approach to inform and drive practice improvement, service delivery, practitioner development and remuneration.

To achieve our vision for **Community Pharmacies of the Future**, we present three key elements of consideration which we believe form the foundation of a viable and sustainable contemporary community pharmacy practice model. To achieve success, we need capacity and capability in our workforce; community pharmacists need recognition and remuneration which they deserve; and the community pharmacy practice model needs to innovate to achieve sustainability, consistency and quality. The Pharmacy Industry Award rates for community pharmacists need to be increased to accurately reflect current wage patterns, and recognise the experience and expertise of pharmacists. Career path in community pharmacy needs to be fostered, with aspiring early to mid-career pharmacists encouraged and mentored to build a career within community pharmacy. Pharmacists should continuously be empowered to practise to full scope, undertaking pivotal roles as primary health care providers and medicine experts. The need for on-going quality measures and evaluation is not negotiable. Services should be assessed for quality and impact, with remuneration tailored to reflect the complexity of tasks, as I have always advocated – quality over quantity.

I would like to take this opportunity to acknowledge our CSI-CCPP Leadership Group and the PSA Policy Team for their valuable input into the development of the strategy and White Paper, and thank them for sharing their insight, experience and expertise.

I now look forward to working with leaders and members of our beloved pharmacy profession, consumers and government to achieve a successful, viable and sustainable model of community pharmacy practice that is contemporary and purposeful. Now is the time to unite.



Dr Fei Sim

BPharm (Hons) PhD FHEA GAICD FPS

Chair, Contemporary Community Pharmacy Practice CSI

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. The PSA is committed to supporting pharmacists in helping Australians to access quality, safe, equitable, efficient, and effective health care. PSA believes the expertise of pharmacists can be better utilised to address the health care 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 evidencebased health care 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

COMMUNITIES OF SPECIALTY INTEREST (CSI)

The PSA Communities of Specialty Interest (CSI) are collaborative groups of volunteer members whose passion for pharmacy is channelled into specific specialty interest areas to set new and exciting horizons for pharmacy in line with organisational objectives that include:

- Pharmacists practising to full scope.
- Developing new models, career pathways and evidence.
- Leading and enabling practitioner development.
- Member value proposition.

Members of CSI groups are actively involved in policy and advocacy discussions and group forums provide members with an opportunity to discuss and advise on current and emerging practice needs.

The CSI forums are a facilitated platform that assists the PSA in developing policy, strategies, and translational tools, which will propel the profession into the future. Members discuss and advise the PSA on current and emerging practice needs and specialty interests of pharmacists. The principle focus of the CSIs is to provide a pharmacist's perspective in a defined practice area and support the vision and mission of the PSA relating to that area of practice.

The current CSI groups as at 15/03/2022 include Contemporary Community Pharmacy Practice (CCPP), Early Career Pharmacists (ECP), Interdisciplinary Team-based Care (ITBC), Respiratory Care (RC), Aboriginal and Torres Strait Islander health (ATSIH) and Digital Health (DH). Members may join a PSA CSI at psa.org.au/csi

MISSION AND VISION STATEMENT

To achieve a patient-centred, contemporary, viable and sustainable community pharmacy practice model in Australia.

This CSI recognises and acknowledges the need for a multifaceted, collaborative, innovative and strategic approach to inform and drive practice improvement, service delivery, practitioner development and remuneration.



LEADERSHIP GROUP



Dr Fei Sim

BPharm (Hons) PhD FHEA GAICD FPS



Caroline Diamantis

BPharm MPS JP



Prof. Bruce Annabel

FCA, MPS (Assoc.), BA(acc)
Adjunct Professor pharmacy
management QUT



Hannah Mann

BPharm MPS



Karen Brown

BPharm MPS



Bridget Totterman

BPharm GAICD MPS



Keegan Wong

BPharm MPS Cert IV TaE



Jeni Diekman

BPharm DipHospPharm MSc MBA MPS



Noel Fosbery

BPharm MPS

EXECUTIVE SUMMARY

Pharmacists in Australia have continued to adapt their practice to new and evolving challenges to meet the health care needs of our communities. Over the past 24 months, community pharmacists have faced immense pressure with the pandemic reinforcing the pivotal role they play in the health care system. Challenges facing community pharmacists and pharmacy proprietors are complex, and there is an urgent need for a patient-centred, viable and sustainable practice model in the Australian community pharmacy sector that meets contemporary needs of the community, the health system, and the community pharmacist practitioner.

There is an urgent need to reform community pharmacy practice, to achieve a model which facilitates **Community Pharmacies of the Future** to be true health destinations, integrated within the wider primary health care in Australia, where pharmacists are clinicians providing professional cognitive services to support the primary health care needs of the local communities. In addition to conventional roles of dispensing, provision of adequately funded professional services that are within the scope of practice of a pharmacist should be central and core roles of community pharmacists, including:

- medicine review, reconciliation, management, adherence, and follow-up,
- screening for early detection of acute and chronic diseases
- management of minor ailments,
- triage urgent and non-urgent care,

- vaccine administration,
- self-care promotion,
- harm minimisation,
- smoking cessation,
- weight management, and
- other public health programs.

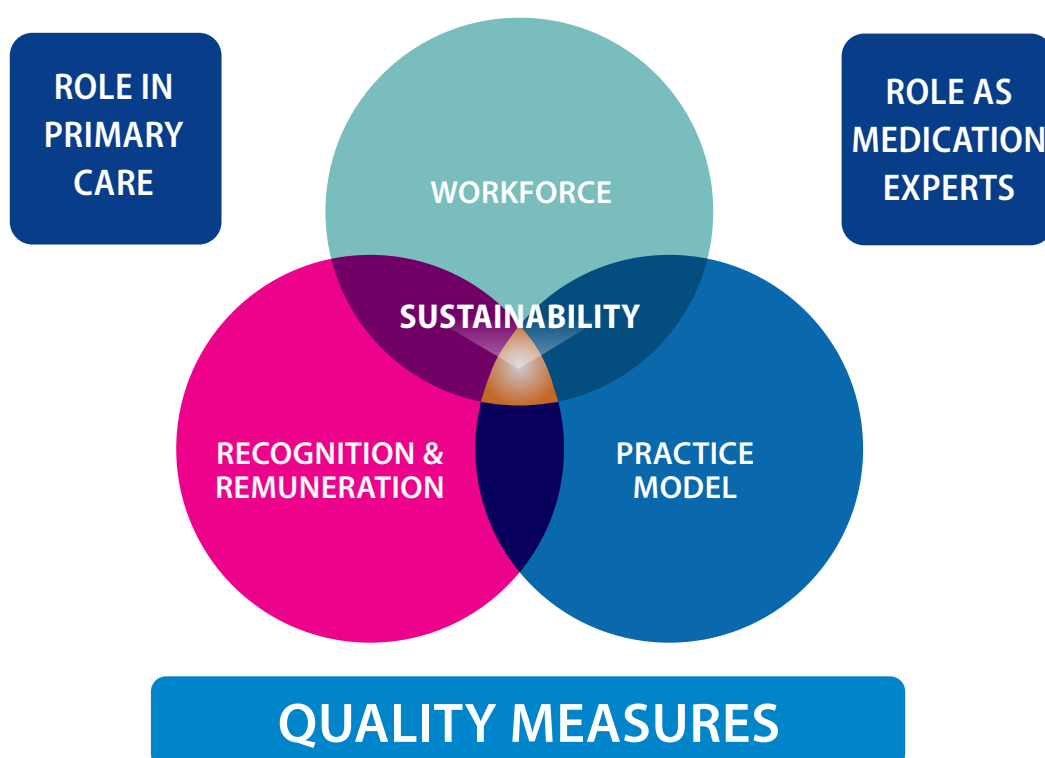
Considering the accessibility and reach of community pharmacies, every contact a patient has with a pharmacist is an opportunity to impart a health message, and deliver primary health care. Integration of community pharmacists within the wider primary health care team is essential to improve the health of the community.

During the last decade, the significance of the role pharmacists play has led to practitioners quietly absorbing additional burdens and responsibilities. As pharmacists adapt to increasing community needs, the remuneration of community pharmacists has continued to lag, pegged to an outdated supply model.

The CSI-CCPP seeks to identify where further support is needed for pharmacists as they face significant organisational, economic, and technological changes. In addition to the Community Pharmacy Agreements, diversification and sustainability of funding sources for professional pharmacy services must be considered. An advocacy and education campaign targeting consumers should also be considered.

This White Paper highlights three key elements of consideration which form the foundation of a viable and sustainable contemporary community pharmacy practice:

KEY DRIVERS OF PHARMACY SUCCESS



ELEMENT 1: KEY DRIVERS OF SUCCESS

Following debate between January and April 2022, three drivers were identified that underpin successful contemporary community pharmacy practice. These drivers are:

- Community pharmacy workforce capacity and capability
- Recognition and remuneration for community pharmacist practitioners
- Innovative and sustainable community pharmacy practice model

These three factors are intertwined and influence the current and future roles of pharmacists as primary health care providers and medicine experts. It is important to recognise that the overarching element of success relies on effective pharmacist leadership within their own pharmacies.

ELEMENT 2: ROLE OF COMMUNITY PHARMACISTS

Pharmacists' role within the community must be explicit and focused. It is identified that community pharmacists should play two critical roles in the Australian health care system, as:

- Primary health care providers, and
- Medicine experts.

Strong leadership and consistent advocacy efforts must be in place to achieve formal recognition and agreement by all stakeholders (pharmacists, pharmacy proprietors, professional organisations, government and other health care professionals and their representing bodies) that community pharmacists are primary health care providers and medicine experts, integrated into the wider Australian primary health care. To achieve this, pharmacist representation, visibility and input at relevant government and non-governmental committees must be present.

ELEMENT 3: QUALITY MEASURES

It is recognised that any intervention or practice change will require explicit quality measures, indicators, and ongoing evaluation not least to determine their impact and effectiveness to justify funding, but also to provide a robust evidence base for future initiatives. Effective matrices, audit tools, and quality indicator programs must be in place to ensure standard, quality and consistency of community pharmacy services. Research collaboration should occur between stakeholders including peak bodies, banner groups, universities, and practising pharmacists, to support research translation into practice. There must also be a commitment to review and refine relevant health policy based on evidence-based practice.



BACKGROUND

PHARMACISTS IN 2023

In *Pharmacists in 2023: For patients, for our profession, for Australia's health system*¹ the Pharmaceutical Society of Australia (PSA) described the system changes which need to occur within our health system to better utilise pharmacists, wherever they may be working, as regular members of the health team, practising to their full scope and being appropriately recognised and remunerated for their training, skills and expertise. Whilst all 11 actions for change are relevant to community pharmacist practice, in particular actions 2 and 6 specifically called to “*enhance the role of community pharmacists to have a greater level of responsibility and accountability for medicines management*” and “*utilise and build upon the accessibility of community pharmacies in primary care to improve consumer access to health services*”.

PURPOSE OF THIS DOCUMENT

Our pharmacist workforce is reaching crisis point, with many who entered pharmacy with admirable intentions to help and care for our community, now leaving the profession. Questions have been raised about the sustainability and aptness of the current practice model that rewards the act of supply (quantity) without recognising the value (quality) of primary health care delivery.

This document adds to existing discussions, including PSAs call to improve pharmacist remuneration (see here www.psa.org.au/remuneration). It seeks to recognise, restructure, and remunerate the contribution of community pharmacists within the Australian health system and is intended to set the direction for the next five years and drive community pharmacy toward a sustainable and effective practice model.

This document will specifically address the:

- role of community pharmacists as primary health care providers and medicine experts
- remuneration and recognition of individual community pharmacist practitioners and community pharmacies
- diversification and sources of community pharmacy funding
- workforce culture, capacity, capability and competence
- community pharmacy practice model that facilitates professional services provision as a health destination
- impact of digital health and automation on community pharmacist practice
- operational and productivity impediments
- community pharmacy assessment and audit for quality, standard and consistency of service delivery
- role of technicians as part of the overall community pharmacy team
- need to lobby for representation and impact on health policy refinement

SCOPE OF DOCUMENT

This document focuses primarily on operational aspects of a pharmacist's role in contemporary community pharmacy practice settings. It includes consideration of current activities performed by pharmacists and areas where remuneration and role clarification may increase the utility of a pharmacist's role. It does not specifically speak to responsibilities associated with business management or pecuniary interest, nor attempt to describe the effect of these responsibilities on the pharmacist's role or remuneration. It does not address pharmacist roles which do not have a direct interface with patient care, such as within pharmaceutical industry, academia, research, and professional bodies.



ELEMENT 1: KEY DRIVERS OF SUCCESS

1.1 WORKFORCE CAPACITY AND CAPABILITY

THE ISSUE

It is essential and fundamental that the community pharmacy sector has workforce capacity and capability to undertake enhanced and extended roles to meet contemporary needs. Multifaceted efforts should be in place to build and maintain community pharmacist workforce capacity and capability. The imminent digitisation and automation in pharmacy will have a significant impact on workforce, and should be carefully considered and leveraged positively where appropriate. Our community pharmacy workforce must be adequately prepared and agile to meet the outcomes and expectations of primary health care reforms.

Community pharmacists are a key component of the health care workforce and are the most accessible health care profession. However, there appears to be a significant workforce issue with workforce shortages and workloads already at breaking point. In addition to the challenges posed by the COVID-19 pandemic and isolation, the ageing population health care has resulted in more people living with multiple co-morbidities that require access to more medicines

and support in the primary care setting. This has placed further demand on pharmacists. Many are working long hours with their core role related to dispensing, underutilising their skillset.

Pharmacists should be fully supported to practice to their full scope. This means pharmacists practising to the full extent of their competencies, knowledge and skills that they are educated and authorised to deliver, which reflects higher level clinical activities in most cases. This should lead to improved patient health outcomes and bring career satisfaction to the community pharmacist practitioner.

People living in regional, rural and remote Australia have poorer access to primary health care services than those in major cities. As a result, there is a greater reliance on pharmacists to provide primary health care. However, many regional areas are struggling to recruit and retain pharmacists. Without the capacity and capability, pharmacists cannot meet the contemporary needs of the community in which we serve. This crisis situation requires urgent action to ensure Australians have access to timely, high quality and comprehensive care, regardless of where they live.

THE CHANGING FACE OF PHARMACY PRACTICE

The World Health Organization (WHO) estimates that there is a global health care workforce shortage of 7.2 million, which is predicted to grow to 12.9 million by 2035.² Globally, people are living longer with multiple co-morbidities and require increased access and use of medicines.

The pharmacy profession must evolve from its traditional role as drug-dispenser to a primary health clinician. It is important to recognise that this evolution is in large attributed to direct and deliberate demand from consumers. This advancement in the role of pharmacists calls for them to be the part of the broader health care team, contributing to better health outcome for patients. Their education and training allow a greater ability for critical thinking, improvement in problem-solving and decision-making during pharmacotherapy and primary health care delivery.

ROBOTIC AUTOMATION

Pharmacists and community pharmacy were early adopters of technology in health care. Further robotic automation, paperless e-scripts requiring forward facing dispensing and fully integrated recording systems are key to the next phase. Streamlining of administrative tasks will allow pharmacists to focus on patient interaction and clinical activities to deliver better health outcomes.

Careful and considered introduction of robotic automation and electronic integrated recording systems to streamline administrative tasks may allow pharmacists to focus on patient interaction and clinical activities to deliver better health outcomes. No automation or artificial intelligence should replace the valuable interaction between a pharmacist and a patient.

ROLE OF PHARMACY TECHNICIANS

Consultation with stakeholder groups raised the possibility of formalising the role of the professional community pharmacy technicians in Australia. Expanding the responsibilities and scope of practice of technicians will improve workflow and reduce administrative burden on pharmacists, allowing pharmacists to focus on clinical duties and tasks with a direct impact on patient care. The expanding role of pharmacy technicians is evident in our hospital system and already exceeds that of community pharmacy. More highly qualified technicians allow for more support staffing. In turn, this allows hospital pharmacists to provide more clinical services and opportunities to impart their cognitive health message. In the United Kingdom and other European countries, there is a defined career path and a structured career model for technicians³. Furthermore, the Dutch have a pharmacist and technician program that creates efficiencies and sustainability.⁴

There needs to be further exploration into formalising the technician role in Australian community pharmacies. Appropriately trained community pharmacy technicians could undertake administrative and technical duties related to dispensing and dose administration aid (DAA) preparation. Nevertheless, if such an initiative were to progress, there

must be a defined scope and role expectation for such technicians and clear delineation of roles and responsibilities between pharmacists and technicians. Dispensing is a clinical activity, and a pharmacist must have clinical involvement in the dispensing of every medicine to ensure medicine safety, regardless if the administrative task is undertaken by a dispensary technician or through robotic automation. Similarly, whilst packing of a DAA based on a 'pharmacist order' may be undertaken by a trained technician, pharmacists should still be responsible for assessing each DAA profile for clinical and pharmaceutical considerations.

As a priority, exploratory work to achieve formal registration of technicians as a regulated health professional under the Pharmacy Board of Australia should commence, to ensure patient safety as a constant consideration. Accreditation standards, practice guidelines and trainings must be developed to support the integration of technician workforce, with the aim to complement, rather than duplicate or compete, with the pharmacist workforce. Whilst a formal dispensary technician career path may be recommended, it is vital the division of duties is maintained with pharmacists as the ultimate medicine gatekeeper prior to receipt by patients. The involvement of a technician in pharmacy should not replace the role of a pharmacist.

1.2 RECOGNITION AND REMUNERATION FOR THE COMMUNITY PHARMACIST

THE ISSUE

Remuneration and recognition for community pharmacists in Australia needs to reflect their skills, training, expertise, and responsibility in the health care system. The award rate for community pharmacists is currently below that of professions with comparative levels of professional responsibility and training.⁵ Pharmacists working in community pharmacies continue to be significantly undervalued and underpaid for their services. Despite demonstrated needs and impact, most primary health care consultations, including minor ailment management, provided by community pharmacists are unremunerated.

PROFESSIONAL PURPOSE

Pharmacists are experts in medicines and have a primary responsibility to see that medicines are used safely, judiciously, and effectively. As the health system evolves, pharmacy practice is becoming increasingly complex. Pharmacists should be adequately remunerated and supported with career pathways that build on their competence through the advanced practice framework.

The PSA's Roles and Remuneration Report⁵ articulated how the profession must work together to make sure funding for pharmacist activities can achieve salaries which reflect the true value of their contribution to the health system.

Community pharmacy has struggled to define a career pathway for emerging pharmacists other than via ownership. While ownership suits some, it may not be a desired goal for many. The current three level award (pharmacist, pharmacist-in-charge, pharmacist manager) does not remunerate clinical service delivery. During the pandemic, pharmacists demonstrated their clinical ability as they embraced significant additional responsibilities, including vaccinations, home medicine services, and rapid antigen test observations. The COVID-19 pandemic has highlighted that the Pharmacist Industry Award does not reflect the additional responsibilities taken on by many community pharmacists.

The Industry Award is the only source of printed information in relation to pharmacist remuneration for anyone not currently practising in the community pharmacy sector. With that in mind, without the widely publicised Industry Award raised to adequately reflect current pay patterns, the profession will continue to struggle with attracting and retaining talents within the profession. The PSA's Roles and Remuneration Report⁵ proposes the following minimum salary bandings:

FUNDING STREAMS

The big question facing the profession is on who pays for the changes. While the recent Queensland pilot⁶ has shown a willingness of patients to pay for pharmacist services, a large proportion of our society are vulnerable and unable to afford prescriptions and services without Government assistance. Changes to these co-payment levels may lead to some patients avoiding pharmacists in primary care settings, which may raise equity concerns especially in small pharmacy towns in regional areas where access to other health care services is limited. Workforce supports are required in these instances. The health workforce currently does not include appropriate workforce planning and structure and may also require consideration of workforce flexibility and the ability to respond to an increasing frequency of medicine-related changes. This includes safe, appropriate, and timely down-scheduling of medicines in response to clinical needs and changing health trends.

DIVERSIFIED FUNDING ARRANGEMENTS

Pharmacists will need to consider several funding sources to improve financial viability, promote operational sustainability and mitigate single-funding risk. Alternative remuneration models will assist diversified practice and allow other opportunities for pharmacists in the future. Current PBS funding model provides most of the funding to community pharmacy by way of a dispensing and administration, handling and infrastructure (AHI) fees. With poor oversight of the quality of primary health care delivered, the PBS funding model is a commoditised transactional style of model that incentivises the high-volume low-service delivery of medicines at the expense of productivity. This situation gets further compounded by certain pharmacies cross subsidising with discounted fees for non-concession patients. These pharmacies charge little professional dispensing fee to encourage consumers to come to the pharmacy for non-health related products with high margins, and often have low pharmacist to prescription ratios. Under such circumstances, these pharmacists have less time to interact with the consumers to deliver primary health care and medicine management services that meet consistent high-quality care. Instead, the model should support and value the clinical role of community pharmacists in delivery primary health care services and medicine advice.

Access to other funding mechanisms, such as through the Medicare Benefits Schedule (MBS) or through Primary Health Networks (PHNs), will allow for an increase in total remuneration for the pharmacy sector to fund more patient-focused professional activities, as well as an increase in the salaried remuneration that is afforded to pharmacists. Efforts should be in place to demonstrate how pharmacists can provide a myriad of services more effectively and efficiently than other health care professionals.

Pharmacist level of advanced practice [^]	Years and area of experience [@]	Indicative hourly minimum rate banding (excluding superannuation)	Indicative annual minimum salary banding (excluding superannuation)
Foundation	General pharmacist registration	\$38.30 to \$47.90	\$80 000 to \$100 000
Advanced practice Level I (transition)	2-3 years general pharmacy practice experience ¹⁶	\$47.90 to \$54.47	\$100 000 to \$120 000
Advanced practice Level II (consolidation)	2-5 years' experience in the defined area of practice ¹⁶	\$54.47 to \$67.05	\$120 000 to \$140 000
Advanced practice Level III (advanced)	More than 5 years' experience in the defined area of practice ¹⁶	\$67.05 and above	\$140 000 and above

[^] excludes overtime, penalty rates and loadings.

[@] Indicative experience required to progress through advanced practice pathway, in addition to post-registration qualifications, scope of practice experience and competency demonstration requirements.

FUNDING UNDER MBS

Advocacy for MBS item numbers have recently been supported by a positive recommendation for pharmacists to access allied health MBS items.⁷ Ongoing advocacy efforts is required to achieve equitable pay for pharmacist activities. Claimable items such as MBS or NDIS, being provider based, will require individual pharmacists and pharmacy owners to have appropriate *profit/cost sharing* arrangements in place.

NDIS PROVIDERS

Pharmacists should consider becoming providers for the National Disability Insurance Scheme (NDIS) for their services and expand their scope to include services associated with disability.⁸ The process for becoming a provider should be streamlined for both pharmacists and GPs.

MEDICINE SAFETY FUNDING

On 25 September 2020, coinciding with World Pharmacists Day, the Federal Government announced a \$25 million investment grant for funding medicines safety and quality use of medicines research through the Medical Research Future Fund (MRFF).⁹ The grant supports the 10th National Health Priority Area, Quality Use of Medicines, and Medicines Safety.

Research undertaken through this funding will go a long way in improving the health of Australians through medicine safety. The intended outcome of the research grant opportunity is to:

- reduce the amount of medicine-related harm in the community and help promote the safe and effective use of medicines.
- to help people take the right dose of medicine at the right time.
- continue to encourage and foster innovation in the role of pharmacists.

PRIVATE HEALTH INSURERS

Hospital and extras health insurance can help with the cost of prescription medication, specifically private pharmaceuticals which are not covered under the Pharmaceutical Benefits Scheme (PBS). There is a growing opportunity for Private Health Insurers (PHI) to subsidise pharmacy services such as those seen in some banner groups, not just medications, but other items – e.g. Continuous positive airway pressure (CPAP) therapy, health checks, dose administration aids (DAAs) and vaccinations.¹⁰

PRIMARY HEALTH NETWORK AND LOCAL HEALTH DISTRICTS

Primary Health Networks (PHN) assess the health care needs of their community and commission health services to meet those needs, minimising gaps or duplication. The PSA is involved in the 31 PHN within Australia and ongoing advocacy is occurring in this space, particularly around the provision pharmacy data into decision-making methodologies. Community pharmacists should be equally represented (i.e. have the same number of representatives) as general practitioners on these councils and boards.

USER PAY AND FEE FOR SERVICE

The “user pay” approach has more recently been explored and debated. It involves a system whereby consumers pay in full the costs of services they receive. For services that are not otherwise covered or subsidised by the government or private health insurance, such as blood pressure and blood glucose monitoring, it is reasonable to expect consumers to pay for such service. However, service charges are inconsistent across pharmacies. The development and adherence to a service delivery framework for each professional service will enable consistency in the standard and quality of such services across the sector.

1.3 INNOVATION AND SUSTAINABLE COMMUNITY PHARMACY PRACTICE AND FUNDING MODELS

THE ISSUE

A sustainable pharmacy practice model in contemporary community pharmacy practice needs to adequately reflect the contribution and expertise of individual community pharmacists as clinicians while maintaining the viability of the community pharmacy. The practice model should enable productivity and prioritise quality over quantity of services provided. It should consider existing operational, business and remuneration models, and leverage advancement in health-related technologies. The model should enable remuneration to reflect the complexity of the tasks involved.

TRADITIONAL MODELS

The traditional model of community pharmacy focused on supply of medicines with little regard for advice and healthcare delivered at the point of dispense. Productivity outputs were measured in terms of supply of medicines. The pharmacist was rewarded for dispensing (supply) of medicines as quickly as possible with minimal interaction with the patient. The community pharmacy being a retail outlet maximised revenue and profit by adding other over-the-counter and non-health related high margin products such as perfumes.

As the training of community pharmacists improved their clinical knowledge, clinical services were added but remained a very small proportion of community pharmacy revenue. The major funding for community pharmacies has been from the Community Pharmacy Agreements (CPA). Although there is some CPA funding for clinical services (e.g. Medscheck), most of the funding is supply-focussed. Some describe dispensing as a clinical service however there is little oversight of the quality of the clinical service at the point of dispense.

This focus on remuneration for supply has allowed the rise of the discount pharmacy where medicines are discounted to encourage consumers to enter their retail environment to purchase other discounted high margin items. In these pharmacies, items from the “front of shop” form a higher percentage of revenue. In the traditional

community pharmacy there was a higher percentage of revenue generated by the dispensary and many community pharmacists provided care and clinical services for little direct remuneration. The margin from prescription and over-the-counter medicines was enough to remunerate pharmacists for providing the “free” consultations.¹¹ If medicines are discounted, there is little margin left to fund the professional role of the pharmacist to deliver clinical services and the care traditionally delivered to communities. The discount pharmacy relies on prescription volume dispensed by lower paid technicians and pharmacists to maintain profitability.

CONSIDERATIONS FOR A NEW MODEL

As contemporary community practice moves toward the delivery of patient-centred care, rewarding strong performance is critical to the overall sustainability of the profession. Clinical services and the sale of product medicine must be viewed separately and independently to overcome the status quo.

For instance, the efficient supply of medicines could be remunerated through the PBS model of a dispense and AHI fee and clinical services could be remunerated through an MBS item number. Examples of MBS item numbers are listed in box below. This would separate supply from the clinical function of the pharmacy. Individual pharmacists would receive the clinical remuneration much like a GP receives remuneration for their clinical service delivery and the pharmacist could pay the community pharmacy a share of their remuneration to use the community pharmacy premises, infrastructure and goodwill.

It is the view of the PSA that community pharmacies should be health destination that deliver primary health care in addition to supply. If this were to occur the community pharmacy that wishes to deliver a complete primary health care service including medicine supply, this could be remunerated at the point of dispense.

Examples of MBS Item Numbers should be considered for:

- Pharmacist administration of vaccination
- Pharmacist advice to patient with new oral medicine
- Pharmacist advice to patient with new injectable medicine
- Pharmacist advice to patient with new topical medicines including nasal spray, otic, or ocular drops
- Pharmacist review of medicines 2-5 medicines
- Pharmacist review of medicines management > 6 medicines
- Pharmacist medicine reconciliation
- Pharmacist medicine follow-up consultation
- Pharmacist provision of smoking cessation service
- Pharmacist assessment of minor ailments
- Pharmacist assessment of symptoms of major disease
- Pharmacist screening for chronic disease
- Pharmacist advice on non-pharmacological management

For a pharmacist to receive these Medicare benefits, they must be delivered in a PBS-licensed pharmacy with strict program rules to determine eligibility as a health care destination. Pharmacists may be able to receive Medicare remuneration for advice provided with the online supply of medicines if there is evidence of a face to face telehealth consultation, and that face to face presentation is not possible or less preferable.

The pharmacy profession may wish to explore a profit and risk sharing model moving forward – a pharmacist would receive a base annual wage and on top of that be eligible to receive an incentive or portion of the services they provide. In creating new financial rewards, employee pharmacists and proprietor pharmacists share risk and profit which could help boost productivity and overall career satisfaction. Proprietors carry fiscal risk when operating their pharmacy, which often leads to fear and hesitancy to increase employee wages. This is a valid risk which needs to be addressed. Considering the level of financial investment and liability, pharmacy proprietors need to be supported as well through a model that provides an acceptable level of confidence, predictability, and sustainability of remuneration and funding stream. It is essential that pharmacy proprietors, pharmacists and pharmacy staff work collaboratively as a team. Full financial risk sharing in pharmacy is not widely adopted, but it is expected that the greater level of financial risk sharing will lead to greater care quality and costs benefits. A profit-sharing model may redirect pharmacist attention to high value clinical interventions and away from repetitive administrative tasks which may be replaced by appropriate trained technicians or automation. If such a model is to be implemented, it will require careful documentation and consensus such that both parties honour their sides of the productivity bargain. Furthermore, there will also be an opportunity cost to consider if a consulting room is tied up doing long consultations eg. diabetes education. The MBS model may be an introduction to this. If this model were to be adopted, the pharmacist would provide fee for service at the community pharmacy. The pharmacist could either be employed or pay the community pharmacy a percentage of the MBS fees for the infrastructure provided by the PBS-licensed community pharmacy.

Functional, effective, efficient and productive professional pharmacy programs are building blocks of the future of community pharmacy practice model. Our profession in Australia should draw on positive international experience. Contemporary professional programs that exist internationally currently which contributes to, and facilitates, an innovative community pharmacy practice model include the Pharmacist Prescribing for Minor Ailments (PPMA) programs introduced in some Canadian provinces and several parts of the UK, as well as the NHS Community Pharmacist Consultation Service (CPCS) in the UK. These programs focus on the crucial role of community pharmacies as primary health care destinations and enable an integrated approach between community pharmacists and hospital emergency departments/general practice. When built into the model of community pharmacy practice, will not only improve patient access to health care and essential medicines, but at the same time cement the role of community pharmacists and contribute to the overall sustainability of the sector.

Despite the need to formalise professional pharmacy services and primary health care programs within community pharmacies, our profession should not shy away from medicine dispensing as a core role. Dispensing is, and should be regarded as, a clinical activity. Public perceptions of the professional role of pharmacists are expressed through patient attitudes, trust, and expectations as health and illness consultants, or qualified 'retailers' of medicines. This perception is influenced by numerous determinants, both health-related and social. Most consumers consider a pharmacist to be "a person qualified to sell medicines", with some regarding pharmacists as "ordinary retailers".¹² The traditional practice model reaffirms these perceptions, particularly when it encourages volume and leads to over-dispensing practices. While dispensing is an important clinical governance activity requiring medical expertise of pharmacists, an ideal model for pharmacists or community pharmacy should reinforce and recognise their expertise, advice, and influence as a medicine expert within their communities. Future models of pharmacy will need to support both the clinical decision-making involved in dispensing and expert value provided by pharmacists. The issue stems from within our own profession - **a cultural shift amongst pharmacists and proprietors needs to occur immediately**. Community pharmacists are not, and should not be, regarded as ordinary retailers. This means a pharmacist must value add in every interaction with a patient or a consumer.

INNOVATOR PHARMACY MODEL

When considering innovative practice models, the CSI-CCPP Leadership Group calls on the profession to prioritise clinical impact of community pharmacists' services, and to consider the innovator pharmacy model. The key focus is on productivity and is typified by the:

- high margins that fund the intensive professional service offer
- unwavering focus on driving professional services income

- merchandise mix skewed heavily away from sundries
- doing the hygiene elements well (efficiency, cost control & buying)

Evidence as depicted below shows that this sustainable practice model outperforms the averages in sales and script volume growth, professional services income, wages/income % and, most importantly, the bottom line. However, in order to achieve this innovator pharmacy model of practice, employee pharmacists and proprietors must work collaboratively with this being the explicit intent and model of operation for the pharmacy. The challenge is in empowering, motivating, and reframing this novel approach. Proprietors and managers must demonstrate consistent leadership, and set guiding principles and lead by example in their pharmacy.

PHARMACY OWNERSHIP

The owners of community pharmacies have a tremendous opportunity to change the landscape of community pharmacy but need to be supported to do so. As pharmacist employers, they can assist with:

- commitment to action and outcomes, leading by example and mentoring the team, through an owner-operated model of practice,
- empowerment of pharmacists to be more responsible and accountable for medicines safety and management and primary health care delivery, and
- increased integration and effective collaboration with other members of a patient's health care team.

Successful proprietors seem to have a 'help patient' oriented growth mindset to innovate and continuously improve how they serve the population. However, payment models need to support owners to move away from high script volume, low wage, and reduced clinical oversight practices, and support owners to invest in continuous quality improvement with a focus on medicine safety and primary health care delivery.

Funding needs to support the clinical decision-making that occurs at every area where a pharmacist's fingerprint is needed.

Table 1: Headline KPI results year ended 30 June 2020

	Hard discounter	Soft discounter	Innovator pharmacies ³	Traditional pharmacies ²	Guild data ⁴
Total sales (ex HCD)	\$6.1m	\$5.2m	\$3.5m	\$4.1m	\$3.35m
Sales growth (ex HCD)	2%	(0.2%)	5.9%	2%	2.5%
Gross profit % (ex HCD)	26.9%	35.1%	46%	36.9%	37%
Script growth volumn	2.2%	0%	5%	0.24%	0.56%
Rx/total sales (ex HCD & professional services)	42%	54%	64%	66%	63%
Professional services	\$29,311	\$35,789	\$144,309	\$44,073	\$32,411*
Wages/sales (ex HCD)	11.7%	14.6%	20.1%	15.5%	17.2%
Wages/(GP\$ + services)	45%	41.7%	40.3%	41.4%	45.3%
EBITDA/sales% (ex HCD)	5%	7.8%	17.7%	10.4%	7.7%

*6CPA services only as it's not known if Other income \$71,000 includes other professional services such as vaccinations and patient DAA fees.

Sources:¹ Member of hard discounter banner² Pitcher Pharmacy Services (PPS) client series 2020³ Innovator pharmacy clientele⁴ Guild Digest 2021 (13) Annabel, B., & Scrymgeour, M. (2022). Retail matters: Not being average. *AJP: The Australian Journal of Pharmacy*, 103(1213), 60–61.

COMMUNITY PHARMACIES OF THE FUTURE

Community Pharmacies of the Future need to embrace new practice approaches that respond to the changing needs of patient communities and the next generation of aspiring pharmacist owners. It calls for progressive practices to explore and implement new in-house leadership and ownership development programs for early career pharmacists, managers, and partners. These programs nurture important leadership skills that reinforce a collaborative approach and a sustainable patient-centred business model.

Community pharmacists with ownership aspiration, including early career pharmacists, should be encouraged and empowered. The separation of remuneration models, such as those that remunerate professional cognitive services from administration-related tasks, may create new opportunities

for early career pharmacists with ownership aspirations and who would like to be rewarded directly for their individual contribution and personal exertion. This may encourage new ownership transition pathways that redistribute the overall legal and fiscal risks of existing proprietors in addition to any regulation changes that stipulate the minimum hours required of a practising proprietor. A redistribution of professional responsibilities, accompanied by mutually agreed remuneration plan, may allow a staggered exit by retiring owners while progressively reducing their overall business risk. Such transition pathway may also allow dedicated early career pharmacists to progressively build-up an ownership portfolio around areas of professional interest. Community pharmacists would have opportunities to own their practice while being directly rewarded for their passion, increasing responsibilities, and personal commitment and contribution.



ELEMENT 1 - CALL TO ACTION:

- Establish a Community Pharmacy Reform Implementation Working Group consisting of internal and external pharmacy stakeholders to develop a new funding model that incentivises primary healthcare delivery and medicines management, including in the 8CPA.
- Advocate for government investment in a whole-of-profession workforce strategy.
- Commence exploratory work to enable formalisation of the role of community pharmacy technicians, including the development of defined scope of practice, role expectations, the proposal of an implementation plan, in consultation and collaboration with the Pharmacy Board of Australia.
- Advocate for increase in Pharmacy Industry Award rates to accurately reflect current wage patterns, recognising pharmacists' skills and expertise as well as the complexity of tasks.
- Develop and achieve consensus on a fit for purposes remuneration structure amongst industry stakeholders, including cementing an advanced practice recognition program in community pharmacy which facilitates remuneration and skills recognition.
- Develop a service delivery framework for each professional service to achieve consistency in remuneration, quality and standard of services across Australian community pharmacies.
- Collaborate with universities and pharmacy student organisations on programs to attract and retain talents within the profession.
- Develop mentoring programs and collaborate with the Early Career Pharmacists CSI Group to support career advancement of early to mid-career community pharmacists, including specialisation in clinical and/or management, leadership and proprietorship in pharmacy.
- Establish a Gender, Equity, Diversity and Inclusion Working Party in Pharmacy.



ELEMENT 2: ROLE OF COMMUNITY PHARMACISTS

2.1 PRIMARY HEALTH CARE PROVIDER

Pharmacists provide accessible, patient-focused health care and continue to go above and beyond for their communities at a primary health care level, helping the nation achieve vaccination targets, and ensuring patients continue to have timely access to essential medicines, improving consumers' health literacy, providing non-urgent care, and other services including triage, minor ailments management, self-care, education, and mental health support. Pharmacists should play a proactive and integral part of the primary health care system, focusing on patient health needs. Self-care advice for both acute and chronic conditions, in the form of verbal and written information, should be considered by pharmacists as part of service provision. Community pharmacists are primary health care and urgent care providers, and our services must be integrated into the wider Australian primary health care system.

The attributes of pharmacy practice common to all roles are outlined with the *National Competency Standards Framework for Pharmacists in Australia* (2016):¹⁴

- "Pharmacists use their expertise in medicines to optimise health outcomes and minimise medication misadventure.
- They apply their knowledge of medicines and poisons to promote their safe use and avoid harm to users and others in the community.
- The practice of pharmacy includes the custody, preparation, dispensing and provision of medicines, together with systems and information to assure quality of use.
- Pharmacists provide health care, education, and advice across all settings to promote good health and to reduce the incidence of illness. Pharmacists provide direct care to patients and have a broader role in enhancing public health and quality use of medicines in the community.
- A sound pharmaceutical knowledge base, effective problem-solving, organisational, communication and interpersonal skills, together with an ethical and professional attitude, are essential to the practice of pharmacy."

GAP ANALYSIS

The current pandemic has highlighted areas where the involvement of pharmacists is needed and would lead to improvements in patient health outcomes:

- Increased medicine safety roles through access to digital health records, quality indicators, secure messaging, inter-professional collaboration, and effective pharmacovigilance systems.
- Increased prescribing roles, such as maintaining supply of existing therapy or dose adjustments.
- Increased vaccination provision (private and under the National Immunisation Program), including travel health and childhood vaccination.
- Increased triage of minor ailments and referral via formal patient consultations
- Greater participation and engagement in clinical governance systems
- Technological transformation and records
- Greater involvement in patient care, such as case conferencing and coordinating medicine management services
- Integration of community pharmacists into the wider primary health care and urgent care team

PRIMARY HEALTH CARE

Primary care is generally the first point of contact people have with the health system. Community pharmacists are great assets to assist primary health care reform. The accessibility of pharmacists in primary care settings is essential to avoiding unnecessary presentations at GP clinics and hospital emergency departments. Australia has an aging population with people staying at home longer. Pharmacists play a critical role in primary health care by supporting people to age at home. The Federal Government has announced the commitment of 275,000 In-Home Care packages¹⁵ by June 2023 which presents an opportunity for community pharmacies to support people who wish to remain at home in preference to residing in a residential aged care facility.

The [consultation draft of the Primary Health care 10 Year Plan](#)¹⁶ draws on input from individuals and organisations across the country and synthesises ambitions for primary care into three broad streams:

1. Future focussed primary health care (**Stream 1**)
1. Person-centred primary health care, supported by funding reform (**Stream 2**)
1. Integrated care, locally delivered (**Stream 3**)

Pharmacists could play a critical role in being able to meet the quadruple aims of the Government that seeks to:

1. Improve people's experience of care.
2. Improve the health of populations.
3. Improve the cost-efficiency of the health system.
4. Improve the work life of health care providers.

Pharmacists could assist with reform objectives under four central pillars that govern medicines use and administration:

1. Timely, equitable and reliable access to needed medicines at a cost that individuals and the community can afford (**Pillar 1**)
2. Medicines meet appropriate standards of quality, safety, and efficacy (**Pillar 2**)
3. Quality use of medicines and medicines safety (**Pillar 3**)
4. Responsive and sustainable medicines industry and research sector with the capability, capacity, and expertise to meet current and future health challenges (**Pillar 4**)

Community pharmacists should provide primary health care for acute conditions and minor ailments management, but also extend and supplement existing primary care services in chronic diseases management, population and public health measures, supporting healthy ageing and mental health and wellness. Australia should look to other countries, such as those in the UK and Canada who have managed to successfully implement advanced structured programs for community pharmacists in primary health care, including those mentioned in the earlier sections.

SELF-CARE

A critical role of community pharmacists as primary health care providers is the provision of consistent, evidence-based advice on self-care and self-management in chronic diseases. Self-care is relevant to both acute (including minor ailments) and chronic health conditions. Pharmacists have a role to improve patients' and consumers' health literacy and provide education about disease prevention through healthy lifestyle. Self-care advice should be delivered to patients in a manner which meets their needs. Pharmacists should be self-care ambassadors, with their role supported and empowered by professional pharmacy bodies.

COMMUNITY PHARMACISTS WORKING AS PART OF INTERDISCIPLINARY TEAM-BASED CARE

Pharmacists use their expertise in medicines and health care delivery to optimise health outcomes. Through their work in many different types of roles, and across health care settings, pharmacists continue to adapt their services to an ever-changing environment. While pharmacists continue to be responsive to the needs of Australia's diverse population, there is further opportunity for providing care tailored to an individual's needs. Pharmacists embrace collaborative care models, increasingly working in interdisciplinary team environments to remove silos and deliver bespoke treatment plans to optimise patient health outcomes. The PSA's Interdisciplinary Team-based Care CSI continues to advance practice in this collaborative domain while the PSA advocates for the separation of dispensing activities from the provision of professional services and new pharmacist prescribing initiatives. This may include:

1. Prescribing under protocol/structured prescribing arrangements with adequate checks and balances and auditing to ameliorate conflict-of-interest risk (eg. continued dispensing, S3M, UTIPPQ, among others)

2. Collaborative prescribing under supervision of another practitioner to build appropriate checks and balances on prescribing.
3. Autonomous prescribing which separates prescribing and dispensing (with limited exceptions) and extends to S2/S3/unscheduled medicines.

Conflict of interest isn't limited to prescribing or dispensing. It also extends to recommending unnecessary care for which there is a vested interest of the health professional to recommend (eg. surgery, hospital services, vaccination services, MBS items etc.). Pharmacists have an obligation to work with other health professionals to achieve best possible evidence-based care for patients and must not recommend unnecessary care, or channel patients towards sub-optimal care and dubious practices.

OTHER HEALTH PROFESSIONALS

As the role of pharmacists in primary health care evolves and achieves the well-deserved recognition, transparency on what happens (or should happen) in community pharmacy is needed. Pharmacists will need to continually demonstrate their value in medicines management as well as management of minor illness, management of chronic illness, prevention of major disease, promotion of healthy lifestyle and improving consumer health literacy. The future of primary health care practice involves greater collaboration in general practice, community-controlled health centres, residential aged care facilities, and the disability sector. All medical organisations agree on the benefit of having collaborative team-based care, information transparency, shared responsibilities, and a patient centric treatment approach.

2.2 MEDICINE EXPERTS

Medicine-related problems remain a serious health issue for Australia. Within the community as many as 1.2 million Australians experience an adverse medicine event. Pharmacists are medicine experts, and a core professional function of a pharmacist in community pharmacy practice is to ensure quality and safe supply of medicines and optimisation of medicines and therapies. Proactive engagement of community pharmacists has already been proven to significantly reduce the number of adverse medicine events in Australia. Ongoing advocacy efforts are required to cement community pharmacists' role in medicines management.

Quality use of medicines is one of the central objectives of Australia's National Medicines Policy (NMP), the overall aim of which is to improve health outcomes through access to, and the appropriate use, of medicines.¹⁷ The PSA's [Clinical Governance Principles for Pharmacy Services](#) outlines how governance acts as a key mechanism to achieve and improve safety, quality and effectiveness in the provision of health care.¹⁸

Within multidisciplinary health care teams, community pharmacists are often the most accessible or even the sole point of access to health care advice and services for patients.¹⁹

Pharmacists have significant potential to reduce the number of medication-related hospital admissions and adverse medication events in Australia. There is significant potential for pharmacists to assist in identifying and reducing the number of people living with adverse medication events via proactive monitoring for adverse events after a person first starts a new medicine and at the time a person presents for their first repeat prescription after starting a new medicine. There is also potential to significantly reduce the proportion of admissions that are due to adverse reactions through proactive monitoring. Pharmacists can also play an important role in improving care for aged-care residents during transitions of care – eg. building on existing models MMR / QUM embedded pharmacists. There is also a role for community pharmacy to integrate and provide clinical pharmacist role in residential aged-care facilities (RCAFs) they support in addition to a supply role.

CURRENT TRENDS

In 2019-2020, there were 11 million hospital admissions in Australia and over 250,000 Australians admitted to hospital each year from medication problems at an estimated cost of AUD \$1.4 billion.²⁰ Another 400,000 presentations to emergency departments are likely due to a problem with medicines. While some of this harm may be unavoidable, it is startling that 50% of this harm is preventable.²¹

DIGITAL PHARMACY

The future of health care is digital, with systems empowering community pharmacists and other health professionals to connect to health information in new, more efficient ways.²² Community pharmacists should capitalise on technology to improve efficiency and productivity in the workplace, as well as engagement with patients and other health care providers.

Technological advancements have created opportunities for pharmacists to carefully delegate time-consuming administrative activities. This in turn will allow community pharmacies to expand their clinical services and develop new strategies that allow for community pharmacists to maximum utility of their cognitive abilities. Currently "bolt-on" clinical packages do not fully integrate with dispensing software, they interrogate dispensing software and draw relevant information into their workflow but do not reintegrate information in reverse. For example, one provider recommends a MedsCheck when dispensing, but the result is not visible in dispensing software to review inhaler technique for the next 3 visits and improve effective treatment. This needs to be rectified to enable better clinical monitoring.

Proactive engagement of pharmacists has the potential to significantly reduce the number of medication-related hospital admissions and adverse medication events in Australia due to their place in the health care system, the frequency with which they have patient contact, developments in health infrastructure, including My Health Record, and the availability of digital tools to support medicine management.

The PSA's [Connecting the dots: Digitally empowered pharmacists report](#)²² described ongoing digital transformation within the Australian health system that has continued to change the primary health care environment – leading to new practices in medicine safety. **Robotics and automation** have driven improvements in workflow along with mitigated risk. Pharmacists now have more information available to them and can better inform clinical decisions and improve the quality-of-care patients receive—particularly in the provision of clinical care services that are seamless, more customised, more effective, and safer.

My Health Record will continue to provide pharmacists with the opportunity to proactively intervene to both document and reduce the adverse reactions, with improved documentation leading to less use of contraindicated therapy and the availability of the complete medication history enabling better detection of multi-medicine interactions.

Telehealth has emerged as digital disruptor for traditional pharmacy practice. When introduced with due care and diligence, it allows pharmacists to promote medicine safety initiatives through real time collaboration with patients, general practitioners, and other health care professionals. Whilst telehealth allows continuity of care in emergency situations when face-to-face contact is not possible, the value of face-to-face interaction with a patient should always be considered.

Community Pharmacies of the Future will continue to embrace these digital innovations. Creating efficiencies in existing operations will allow pharmacists to continue to expand their scope of practice and demonstrate their critical importance to health care settings, ultimately improving the care provided to patients. The emergence of artificial intelligence will have an impact on pharmacy practice, and when utilised effectively, could be beneficial in fostering productivity, such as in identifying patients who may qualify for certain professional services.

MEDICINE SAFETY SERIES

This strain can be seen in part through increasing harm experienced through gaps in medicine safety. The PSA's [medicine safety report series](#) revealed the extent and nature of problems with medicine safety in Australia and has shone a light on the medicine safety issues. The medicine safety report series highlighted opportunities where inserting a pharmacist fingerprint could make a meaningful improvement to the standards governing medicine use (safety, quality and efficacy) – protecting consumers from harm and improving their quality of life.

1. Medicine Safety: Take Care

Use of medicines is the most common intervention we make in health care, which means that problems with medicine use are also common. The PSA's [Take Care Report](#)²³ described the extent of harms in Australia as a result of medicine use. The report revealed that 250,000 Australians are hospitalised each year, with another 400,000 presenting to emergency departments, as a result of medication errors, inappropriate use, misadventure, and interactions. At least half of this could have been prevented. The report calculates the annual cost of medication-related problems in Australia at nearly \$1.4 billion – equivalent to 15 per cent of total PBS expenditure. provides sobering data about the real and current problems afflicting our aged care residents across Australia.

2. Medicine Safety: Aged Care

The PSA's [Aged Care Report](#)²⁴ provided sobering data about the real and current problems afflicting our aged care residents across Australia and found:

1. Over 95% of people living in aged care facilities have at least one problem with their medicines detected at the time of a medicines review; most have three problems
2. 50% of people with dementia are taking medicines with anticholinergic properties, which can worsen confusion and other symptoms of dementia.
3. One fifth of people living in aged care are on antipsychotics; more than half use the medicine for too long.

The data is clear. New approaches are needed to improve medicine use in aged care. This in itself is opportunity for **Community Pharmacies of the Future** to increase their range of clinical service provision to residential aged care facilities in addition to medicines supply and dose administration aid packing.

3. Medicine Safety: Rural and Remote Care

The PSA's [Rural and Remote Care](#)²¹ report outlined the extreme challenges patients in rural and remote Australia have in accessing health care, and the impact that this has on their safe and appropriate use of medicine:

1. 72,500 rural and remote Australians admitted to hospital each year due to medicine-related problems
 2. The estimated cost to the Australian health care system of these admissions is \$400 million each year. At least half of this harm is preventable.
- 1.3 million rural and remote Australians do not take their medicines at all or as intended adding an estimated \$2.03 billion to our annual health

4. Medicine Safety Forum

In October 2019, 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). At the [medicine safety forum](#)²⁵, a consortium of Australia's health care partners, consumers, health professionals, industry and academic recommended actions to prevent unnecessary harm caused by medicines and to save lives.

Funding will need to target the Medicine Safety initiatives. The challenge is in empowering, motivating, and reframing this novel approach.



ELEMENT 2 - CALL TO ACTION:

- Develop, launch, and evaluate a community pharmacist minor ailments and urgent care program, modelling the NHS Community Pharmacist Consultation Service. This includes the development of:
 - a service framework to integrate community pharmacist services into primary and urgent care
 - remuneration and funding model to sustain community pharmacist services
 - toolkits and practice guides for pharmacists, pharmacy staff, and general practitioners, including briefing notes and detailing on referral pathways
- Revamp, launch, and evaluate a Contemporary Community Pharmacist Self-Care Program for both acute and chronic health conditions.
- Develop and action a communications plan targeting both internal and external stakeholder groups, positioning community pharmacists as key primary health care and urgent care providers in Australia. This should include campaigns targeting members of the profession, consumers and consumer groups, governments and other external funders and policy makers.
- Establish and coordinate a nationally coordinated pharmacovigilance program, enabling community pharmacists to document, report and receive reliable information relating to medicine safety.
- Support ongoing advocacy efforts to expand pharmacist-led vaccination services and achieve national consistency and access to National Immunisation Program funded vaccinations.
- Collaborate with the Interdisciplinary Team-based Care CSI group to facilitate pharmacist prescribing, improved pharmacist stewardship of medicine management and transitions of care through interdisciplinary collaboration between pharmacists and other health professionals practising across clinical settings.



ELEMENT 3: QUALITY MEASURES

THE ISSUE

Any intervention or practice change will require explicit quality measures, indicators, and ongoing evaluation not least to determine their impact and effectiveness, but also to provide a robust evidence base for existing and future initiatives. The most appropriate mechanism to support increased remuneration for pharmacists is to demonstrate the evidence of impact, and to link remuneration with activities as well as the skills, expertise, and training of the pharmacist. New funding models should incorporate quality assessment, audit and monitoring, to ensure consistent, high quality and standard of service provision.

CURRENT METRICS

The [Professional Practice Standards](#) (PPS)²⁶ outlines the requirements of pharmacists in their role as a health care provider. However, this is not audited, with wide variation in practice based on geography, competition, and various operational pressures placed on practicing pharmacists who are the service providers, whether they are proprietors or employed pharmacists. Ongoing quality measures and evaluation is not negotiable, and continuous demonstration by a pharmacy should underpin the maintenance of practice requirements e.g. PBS licence.

Many pharmacies continue to provide the same service with little reference to clinical services pressures. The quality system currently in place, Quality Care Pharmacy Program (QCPP), is tied to Government funding for pharmacy-related services. The system needs to be updated or replaced with a system that assesses and audits meaningful clinical practice, raises the standard of practice, and responds in a timely manner to changes in the National Medicines Policy. The desired impact on the health care system will require the evaluation of quality measures together with a specific implementation plan that supports long term relevance, resilience, and provides appropriate incentives for best practice. Mechanisms are needed that encourage forward progression and achievement, while removing ad hoc or piecemeal activities.

QUALITY INDICATOR PROGRAMS

Quality Indicator Programs are recommended as a method to advocate for funding. The PSA has outlined strategies in [Aged-Care](#)²⁴, [General Practice](#)²⁷, and [Disability](#)²⁸. There is limited assessment of the provision of professional services in current practice environments. Quality indicators established for community pharmacy need to be easily measured, and they may include examples such as medicines information provision with new medicines, and documenting the number of times the My Health Record is consulted to check pathology

in order to make dose adjustments. Nevertheless, it needs to be acknowledged that documentation for the purposes of research or evidence-gathering can be onerous and add administrative burden to the already stretched community pharmacy workforce. Therefore, any such initiative should be accompanied by adequate funding to undertake the research work to the required standard without compromising on the time that pharmacists can spend on the clinical activity itself.

PRIMARY AND COMMUNITY HEALTH CARE STANDARDS

The **Primary and Community Health care Standards**²⁹ aim to protect the public from harm and improve the quality of health care delivered by describing a nationally consistent framework, which all primary and community health care services can apply when delivering health care and that ensures good clinical outcomes for consumers. Meeting these standards allow consumers to be confident that systems are in place to deliver safe and high-quality health care. This drives person-centred health care service in which patients and consumers are:

1. Included in shared decision-making
2. Partners in their own health care
3. Involved in the development and design of quality health care services.

RATIONALISE PROGRAMS

There are an increasing number of pharmacy programs and systems that pharmacists need to consider within their practice. The ever-growing list includes Real Time Prescription Monitoring, Professional Service software, electronic prescriptions including tokens and Active Script List (ASL), Provider Digital Access (PRODA), Australian Immunisation Register (AIR), My Health Record (MHR), and Pharmacy Program Administrator (PPA) data, to name a few. While the programs have improved significantly, they continue to add additional administrative burden and complexity to pharmacists. There is benefit to streamline and improve integration of systems to avoid duplication and improve efficiency.

AUDITS REQUIRED TO BENCHMARK QUALITY METRICS

The CSIRO's Future of Health report³⁰ describes major system changes which will influence the role of pharmacists over the next 10-15 years, including a shift from:

- treating illness to managing health and wellbeing
- a 'one-size-fits-all' approach to personalised individual health solutions
- being reactive to more holistic and predictive
- focusing on extending life to focusing on improving quality of life over a whole lifetime.

WHAT DOES SUCCESS LOOK LIKE?

At a macro level, success means community pharmacists having a patient-centred focus to their practice, consistently enabling medicine safety and providing high quality primary health care services. Success will see Community Pharmacies of the Future being integral in primary health care delivery. Success in achieving reduced harm and improved primary health care will present as outcome measures such as:

- ✓ Significant reduction in avoidable death caused by medicines
- ✓ Significant reduction in avoidable hospital admissions caused by medicines
- ✓ Significant reduction in unnecessary emergency department presentations and hospitalisations caused by medicines
- ✓ Improved health literacy of consumers through community pharmacists' interventions and education
- ✓ Enhanced community pharmacists' role as integral part of the primary health care team, preventing and screening diseases and minor ailments, empowering, and activating consumers to prioritise their own health including self-care

Success can also present through improvement in patient experience, patient safety and process metrics. By allowing community pharmacists to practise to full scope and focus on quality service provision, consumers, patients, and the health system will be the beneficiary of the success. Success in raising the standard of clinical care may include activities that demonstrate that the pharmacist has:

- ✓ discussed the medicine in the context of the patient's condition and medical history
- ✓ provided written and/or digital information, including Consumer Medicines Information
- ✓ assessed adherence to therapy and directions for use
- ✓ provided information about the condition e.g. mental health resources, Self-Care Fact Cards, or other information provision about non-pharmacological management
- ✓ consulted the My Health Record to check pathology results
- ✓ dispensed and counselled on opioids and naloxone
- ✓ recommended drug and alcohol, hepatitis B or C, or mental health services to clients accessing sterile injecting equipment under the Needle and Syringe Program
- ✓ provided medication reviews that meet an assessed benchmark quality including information about medicine-related problems, adverse effects and monitoring requirements
- ✓ assessed antibiotic usage including use without clinical indication





ELEMENT 3 – CALL TO ACTION:

- Develop a quality assessment matrix which assesses and accredits the clinical competencies of community pharmacists.
- Lead advocacy efforts which incentivise achievement of quality metrics, benchmarks and outcomes, and recognition of the time and expertise dedicated to clinical activities.
- Establish medicine safety and quality measures for dispensing activities and the provision of non-prescription medicines.
- Update competency standards and professional practice standards to reflect contemporary practice of community pharmacists.
- Foster a research culture amongst community pharmacists and increasing involvement in quality audits and evaluation.

A multifaceted approach is required to address the challenges and leverage the opportunities articulated in this White Paper. The PSA Contemporary Community Pharmacy Practice CSI Leadership Group puts forth strategies outlined in this document, and calls on all stakeholders in the profession to collaborate on implementing these plans. Together, we can achieve a successful, viable and sustainable model of practice for community pharmacists.

APPENDICIES

APPENDIX 1: PHARMACISTS IN 2023; 11 ACTIONS FOR CHANGE

	01. Empower and expect all pharmacists to be more responsible and accountable for medicine safety.
	02. Enhance the role of community pharmacists to have a greater level of responsibility and accountability for medicines management.
	03. Embed pharmacists within healthcare teams to improve decision making for the safe and appropriate use of medicines.
	04. Facilitate pharmacist prescribing within a collaborative care model.
	05. Improve pharmacist stewardship of medicine management to improve outcomes at transitions of care.
	06. Utilise and build upon the accessibility of community pharmacies in primary care to improve consumer access to health services.
	07. Equip the pharmacist workforce, through practitioner development, to address Australia's existing and emerging health challenges.
	08. Establish additional funding models and facilitate access to existing funding models to recognise the value and quality of pharmacist care.
	09. Allow greater flexibility in funding and delivery of pharmacist care to innovate and adapt to the unique patient needs in all areas, with a specific focus on regional, rural and remote areas.
	10. Develop and maintain a research culture across the pharmacist profession to ensure a robust evidence base for existing and future pharmacist programs.
	11. Embrace digital transformation to improve the quality use of medicines; support the delivery of safe, effective, and efficient healthcare; and facilitate collaborative models of care.

APPENDIX 2: PSA ROLES AND REMUNERATION REPORT

COMMUNITY PHARMACIST

DESCRIPTION Pharmacist practising in a community pharmacy. This includes pharmacist, pharmacist-in-charge, pharmacist manager and pharmacy owner roles.

ROLE	
CURRENT ROLE (2019)	
Supply of medicines 	• Dispense medicines: The safe supply of medicines prescribed in primary care, residential aged care and hospital outpatients. This includes review of medicine safety and medicine counselling which empowers the consumer to use their medicine safely and effectively • Facilitate complex supply arrangements; such as dose administration aids, clozapine dispensing, and staged supply to improve patient safety and medicine adherence • Facilitate ongoing supply of medicines; through continued dispensing and emergency supply • Appropriately prescribe non-prescription medicines; including review of safety, therapeutic need and provision of tailored counselling • Preparation of compounded medicines; including review of product formula. • Procurement of medicines, including S100 and Special Access Scheme medicines
Patient-level activities 	• Triage and referral of patient symptoms, including self-limiting conditions (e.g. indigestion), flare-up of chronic conditions (e.g. asthma) • Administer opioid substitution therapy# • Administer vaccines*, such as influenza and pertussis in the pharmacy • Medicine use reviews; patient-centred review and discussion of medicine regimen with a focus on adherence and empowering self-management of chronic health conditions • Preventative health services: Including weight management, smoking cessation or identification of possible cases of chronic health conditions (e.g. diabetes, depression, COPD), which may include including point of care testing (where relevant). Potential cases are referred for diagnosis and appropriate management • Facilitate continuity of medicines at transitions of care
Clinical governance 	• Participation in quality accreditation programs (e.g. Quality Care Pharmacy Program)¹⁷ • Provision of data to externally funded programs to contribute to quality monitoring and evaluation activities.
Education and training 	• Engage consumers in health promotion initiatives; this could include supporting national campaigns (e.g. smoking cessation, vaccination, diabetes, weight management) • Education of undergraduate and postgraduate pharmacy students, such as through professional placements or employment.
Qualifications, skills and training	Requires the knowledge and skills developed in a Bachelor of Pharmacy or Masters of Pharmacy, intern training program and ongoing continual professional development post-initial registration. General pharmacist registration with AHPRA Recognised pharmacist-vaccinator course (to provide vaccination services)
Responsibility and accountability	Medicine safety of consumers accessing community pharmacy service Custody of medicines, including Controlled Drugs (e.g. morphine), Prescription Only Medicines, Pharmacist Only Medicines and Pharmacy Medicines.

FUTURE ROLE (2023)

Changes to role by 2023

Increased medicine safety role through:

- **access to electronic health records;** improving ability to identify, pre-empt and resolve drug related problems
- **quality indicators;** demonstrating and incentivising clinical performance at an individual practitioner level
- **secure messaging;** improving connectivity with other health providers who contribute to therapeutic decisions of patients
- **inter-professional collaboration;** connection the health team to provide more holistic care
- **effective pharmacovigilance systems;** informing guidelines, government policy, regulators demonstrating pharmacist contribution at a collective level
- **increased prescribing role in a protocol or collaborative model,** such as maintaining supply of existing therapy, deprescribing or dose adjustment
- **increased immunisation role,** including travel health and childhood vaccination
- **increased triage and referral through formalised patient consultations.** This role will also increase through greater access to health records and opportunistic identification through enhanced medicine safety role.
- **increased clinical governance role,** focussing patient care on indicators of quality care or indicators of patient health impact. Leadership and oversight at a pharmacy level may require more advanced practice in patient care, leadership and management practice.
- **technological transformation,** particularly in shift towards shared electronic systems (e.g. MHR, PSML)¹⁸

Development pathway required for evolved role

Prescribing Schedule 4 medicines: collaborative prescribing endorsement via recognised certification pathway

Advanced practice credentialing provides pathways to mastery of clinical skills and outcome

Ongoing continual professional development

RECOGNITION

Value to consumers

- More patient-centric care through timely access to medicines and quality advice, supporting self-care. 87% of Australians are able to access a community pharmacist's services within 2.5km of their home; and generally for longer hours than other primary health providers.¹⁹
- Safeguard consumers against medicine misadventure from inappropriate prescribing
- Effective management of minor ailments, triaging, treating and referring for further care where required.
- Support preventative health

REMUNERATION

Indicative salary in 2023 (ex. super)

- Foundation
\$80 000 to \$100 000
- Advanced practice Level I (transition)
\$100 000 to \$120 000
- Advanced practice Level II (consolidation)
\$120 000 to \$140 000
- Advanced practice Level III (advanced)
\$140 000 and above

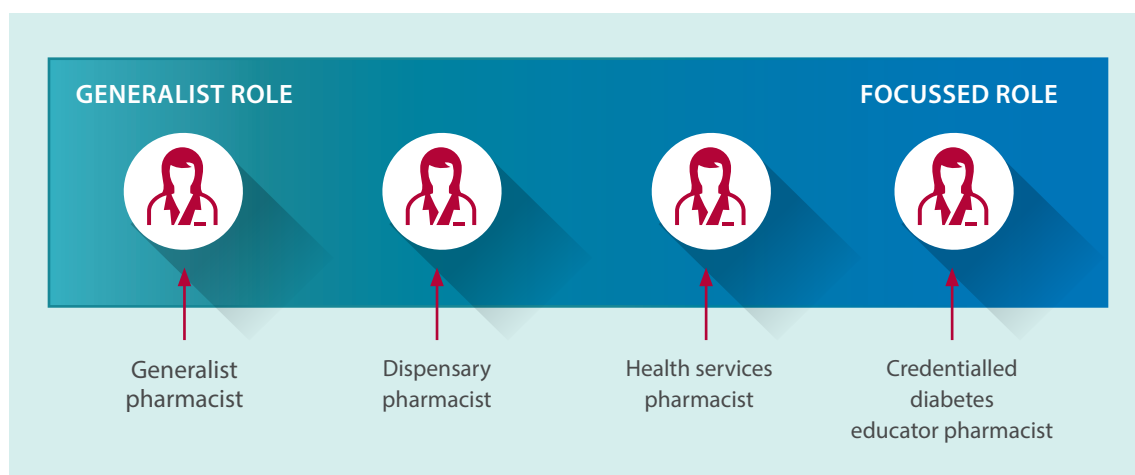
ROLES WITHIN COMMUNITY PHARMACY

The roles of pharmacists in community pharmacy vary depending on the size, structure and business strategy of the community pharmacy. While all roles draw on the functions described above, some roles are more focussed in their scope than others. Some roles require a more advanced level of practice than others (see Advanced Practice, page 11).

Generalist pharmacist: practice spanning all functions of community pharmacy, predominantly including supply of medicines and patient-level activities which support safe and appropriate medicine use as well as other health services (e.g. case detection).

Dispensary pharmacist leader: in larger pharmacies, pharmacist roles may be dedicated to dispensing services overseeing safe and effective supply of prescribed medicines. As pharmacists are supported to take more responsibility for medicine safety, these roles will take on a greater clinical governance accountability through measurable medicine safety and quality initiatives.

Health services pharmacist: This role typically focusses on delivering non-dispensing health services within the pharmacy to allow for longer consultation services (e.g. medicine review services. Pharmacists may perform this role as their primary role, or during designated times to support rostering and workflow.



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PHARMACEUTICAL SOCIETY OF AUSTRALIA LTD.

ABN 49 008 532 072

NATIONAL OFFICE

Level 1, Pharmacy House
17 Denison Street
Deakin ACT 2600

PO Box 42
Deakin West ACT 2600

P: 02 6283 4777
F: 02 6285 2869
E: psa.nat@psa.org.au

BRANCH CONTACT DETAILS

P: 1300 369 772
F: 1300 369 771

**AUSTRALIAN
CAPITAL TERRITORY**

Level 1, Pharmacy House
17 Denison Court
Deakin ACT 2600

PO Box 42
Deakin West ACT 2600
E: act.branch@psa.org.au

NEW SOUTH WALES

32 Ridge Street
North Sydney NSW 2060

PO Box 162
St Leonards NSW 1590
E: nsw.branch@psa.org.au

QUEENSLAND

225 Montague Road
West End QLD 4101

PO Box 6120
Buranda QLD 4102
E: qld.branch@psa.org.au

SOUTH AUSTRALIA

Suite 7/102
Greenhill Road
Unley SA 5061
E: sa.branch@psa.org.au

TASMANIA

161 Campbell Street
Hobart TAS 7000
E: tas.branch@psa.org.au

VICTORIA

Level 1, 381 Royal Parade
Parkville VIC 3052
E: vic.branch@psa.org.au

WESTERN AUSTRALIA

21 Hamilton Street
Subiaco WA 6008
E: wa.branch@psa.org.au

PSA5854