The Pharmacy Guild of Australia

SUBMISSION

Primary Care Reference Groups Consultation – Medicare Benefits Schedule (MBS) Taskforce Reports[1]

Allied Health Reference Group

Date June 2019

[1] http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-pcrg-consult

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INTRODUCTION

The Pharmacy Guild of Australia (the Guild) is the national peak organisation representing community pharmacy. It supports community pharmacy in its role delivering quality health outcomes for all Australians. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicines management and related services.

We welcome the opportunity to provide feedback on the Primary Care Reference Groups Consultation – Medicare Benefits Schedule (MBS) Review Taskforce reports. This submission restricts feedback to those areas relevant to the practice of pharmacy and community pharmacy.

SUMMARY

- The Guild agrees that it would be appropriate for pharmacists to access the MBS when delivering services to consumers irrespective of where the pharmacist is practising.

- We do not believe that the concept of "non-dispensing pharmacists" accessing MBS should exclude community pharmacy or be exclusive to GP surgeries. Pharmacists who are not dispensing can practise wherever there is a consumer need for such services as medicine reconciliation, medicines reviews, counselling and education services.

- Pharmacists involved in the collaborative care of a patient as part of the health care team should not be excluded from the MBS due to their location. Pharmacists practising in community pharmacies are an integral member of a patient's multidisciplinary healthcare team and should be involved in, and remunerated for activities consistent with other members of the team, such as case conferencing.

- A patient accessing health services should not be disadvantaged by where they choose to access those services or by which health professional delivers them. Pharmacists currently have no option but to charge the patient a service fee for items that other health practitioners may be claim an MBS item for. The Guild supports the addition of pharmacists to the list of eligible health professions that can claim against specific items on the MBS, as set out in the *Health Insurance Act 1973.*

- The Guild supports access to MBS under expansion of allied health categories and we also would suggest that pharmacists should be eligible for MBS items for provision of primary care health services to patients recognising equivalent competencies of pharmacists to other health professionals, such as nurse practitioners. This would be increasingly valuable in areas of reduced access to GPs or other health practitioners such as afterhours or in rural and remote Australia, where pharmacists could deliver equivalent services at equivalent costs.

- Pharmacists should also be eligible for MBS items relating to chronic disease management and case conferencing activities. Examples of primary care health services include, and are not limited to, vaccination administration, wound management, chronic disease management (blood pressure, cholesterol, BGL checks), and asthma education. This recognises that pharmacists are integral to the collaborative care of a patient with chronic disease including all aspects of medication management. Integration of community pharmacy into the health care team through case conferencing and monitoring of aspects of care is vital for the holistic management and health outcomes for patients.

RECOMMENDATIONS

Recommendation 2 – Expand allied health involvement under team care arrangements

There is a long history of confusion or misunderstanding of where 'pharmacy' sits in the healthcare system. More often than not, 'pharmacy' is included as an 'Allied Health' profession. This has implications on pharmacist's ability to be seen for their unique expertise as medicine management experts and their access to funds specific for our role and activities in the health system.

Whilst we realise in the context of this recommendation 'allied health' means other health professionals other than the general practitioner we would highlight that pharmacists should be recognised as a discipline in their own right similar to medicine, nursing and dentistry, rather than being group with allied health disciplines.

We agree with this recommendation and believe that pharmacists should be included as one of the health professionals that can contribute to the care of a patient. Pharmacists can and do contribute to a patient's care plan as a member of the primary health care team. They are often in communication with a patient's GP or other health professionals regarding the therapeutic management of their conditions, and directly refer to the GP when issues are identified.

Pharmacists can and already do help with chronic disease management such as monitoring of blood pressure, Point of Care Testing (POCT), medicine adherence and disease state management.

The Guild believe that pharmacists can contribute as follows:

Item 729 – Contribution to a multidisciplinary care plan, or the review care plan
Item 731 – as above for someone in an aged care facility

We believe that pharmacists are an essential member of the multi-disciplinary team and should not be omitted from team care arrangements. A pharmacist can and should be involved in the care of the patient, regardless of their where the pharmacist is working. Whilst these items can be done by a pharmacist at a GP's surgery or a Residential Care Facility we believe that be most appropriate pharmacist to be involved in the health care team is a pharmacist working in an "outreach" capacity from the local community pharmacy. We do not believe that the pharmacist has to be physically co-located to be part of a team. In fact it is probably the pharmacist from the local pharmacy that supplies the medicine who is best placed to be involved in this arrangement.

Pharmacists should be one of the health professions a GP can refer to (for specific medication education/ administration/ device/ adherence and assessment) (Rationale 2). We do not believe that the pharmacist needs to be in GP practice to do this. A GP should be able to refer to a pharmacist for a longer education consult.

The federal Minister for Health Greg Hunt MP clearly stated in the Landmark Compact[2] with the Pharmacy Guild in May 2017 that *"The Government also recognises the key role that community pharmacy plays in the primary health care team, and the assistance that community pharmacy can provide in achieving the whole-of-health system goals of providing the right care in the right place at the right time."*

[2] https://www.health.gov.au/internet/main/publishing.nsf/Content/landmark-compact-Pharmacy%20Guild

Recommendation 4 – Incentivise group therapy for chronic disease management

The Guild agrees that there should be incentives for group therapy for chronic disease management to encourage health professionals to provide group therapy irrespective of the number of participants attending. This is especially important in rural and remote areas where the pharmacist may be the sole health professional in the town and therefore the only one available to provide such group therapy or education sessions.

Community pharmacists can, and do, provide group education sessions for a number of chronic diseases such as diabetes, asthma and Chronic Obstruction Pulmonary Disease (COPD) – many of these involve the contribution of other specialised health professionals. Some pharmacies are putting in training rooms, or would have enough floor space after hours to conduct and host sessions whilst others would need to rent a venue to provide these education sessions. This can often be a barrier to running group sessions due to the fixed costs associated in hosting these sessions.

Recommendation 5 – Understand the effectiveness of group allied health interventions

We agree that the M9 listing should be expanded to other groups e.g. post Myocardial Infarction and asthma etc. There is evidence that cardiac rehabilitation after a myocardial infarction improves functional health outcomes and reduces risk of death and infarction. Pulmonary rehabilitation programs are shown to reduce symptoms and improve quality of life and exercise capacity. The Guild believes that pharmacists can contribute to group interventions from a medication management perspective.

We would agree that there should be a systematic review to support evidence-based expansion of group allied health interventions.

Recommendation 13 – Support the codifying of allied health research and evidence

The Guild agrees that it would be useful to build a research base. We believe that too often community pharmacists are forgotten about when it comes to inter-professional research and are often excluded as a member of the multi-disciplinary primary care team. We would argue that as the patient's medicine management expert the pharmacist is an integral part of the patient's primary health care team.

A considerable body of high-quality evidence exists of the nature and benefits of pharmacists' contribution to health care in Australia. Greater recognition of this evidence within the context of the broader healthcare team would permit more innovative multidisciplinary approaches to care.

Recommendation 14 – Improve access to allied health services via telehealth

As highlighted by Susan Thomas *et al*, people living in rural and remote areas in Australia experience poorer access to health care services, exhibit a higher prevalence of health risk factors and greater rates of illness, hospitalisation and death compared to metropolitan populations. These health outcomes generally worsen with distance from capital cities. Other developed countries such as Canada and the United States experience similar health disparities between rural and remote populations and those living

in metropolitan areas. Poorer access to primary health care (PHC) in rural and remote areas, due to a lack of necessary infrastructure and workforce, contributes to poorer health outcomes.[3]

The Guild agrees that telehealth could improve access to allied health services in rural and remote areas. Community pharmacists have a critical role to play as a primary health care service especially in rural areas where they are sometimes the only health professional that people have regular and easier access to. The rural pharmacy has significant potential to be the 'health care hub' where patients could access GP's or specialists via a telehealth program. Additionally, pharmacists could make initial assessments and recommendations of minor ailments via telehealth for people who live remotely or who cannot attend the pharmacy.

Our rural and remote pharmacist workforce have extremely collaborative relationships with GPs, practice nurses, Aboriginal and Torres Strait Islander health services, and other health providers. However the geographical distances in many areas has created disparities for many Australians in receiving the same level of care enjoyed by their more urban counterparts. Pharmacists participating in telehealth services can help minimise barriers in accessing the unique and specialised knowledge about medicines use that they offer. This would also support rural and remote workforce management, and support more culturally appropriate care when a telehealth consultation with a remotely located pharmacist is facilitated by a local Aboriginal or Torres Strait Islander health worker.

We would suggest that grants to support the implementation of telehealth technology infrastructure in rural pharmacies to support inter-professional collaboration and community to access to GP care, specialists, and pre and post tertiary hospital assessment and education. Medicare eligibility for telehealth services would support equitable access and reduce financial barriers for patients who live in towns where there is no GP readily available (or after hours GP services available).

Recommendation 15 - Pilot non-fee-for-service allied health payment models

We agree that non-fee for service allied health payment models would be worth piloting and we would refer the Reference Group to the Health Care Homes which may be of interest[4].

Community Pharmacy is participating in the Community Pharmacy in Health Care Homes Trial[5] which is a bundled service model of care. The Community Pharmacy in Health Care Homes is funded under the Sixth Community Pharmacy Agreement (6CPA), as part of a package of measures to support new and expanded 6CPA Community Pharmacy Programs including incorporation of medication management programs within Health Care Homes. Health Care Home patients benefit from patient centred, coordinated medication management services delivered by their community pharmacy of choice in conjunction with their Health Care Home. This includes an initial reconciliation of their medications and development of a collaborative Medication Management Plan and a flexible category of services available for all Tier 2 and Tier 3 patients. This is supported by regular follow-up reviews by the community pharmacy to maximise continuity of care and improved chronic disease management.

Community Pharmacy and the Health Care Home care team work together to deliver the Medication Management Plan, to ensure that the patient's medication goals are achieved and to support their patients in change management and lifestyle approaches.

[3] https://bmcfampract.biomedcentral.com/articles/10.1186/1471-2296-15-143?fbclid=IwAR02LlEzV5AWB1YBTRr6gsHvLNBu3oQOjDUvTLFRa3b7ohqlTyczhRfv_kE
[4] https://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes
[5] http://6cpa.com.au/2018/09/community-pharmacy-in-health-care-homes-trial/

Recommendation 16 – Enhance communication between patients, allied health professionals and GPs

Community pharmacies are the most frequently accessed and most accessible health destination, with over 451 million individual patient visits annually. Digital enablement for enhanced communication, including the sharing and access to patient health information, is critical for community pharmacists to practise to their full scope of patient care. The Guild is working with the Australian Digital Health Agency (ADHA) this ensure this is a priority.

Digital enablement to enhance communication capability for health care professionals should be prioritised for community pharmacy through key initiatives such as the My Health Record and Secure Messaging.

Pharmacists have been documenting their clinical activities and services with respect to improving the safe and effective use of medicines through medication management services such as MedsChecks and Home Medicines Review services, and clinical intervention monitoring for many years. Furthermore, much of the wider healthcare team is unaware of the extent of pharmacists' provision of care and advice to their patients. We understand from the ADHA that future iterations of the My Health Record might accommodate shared documentation of these patient care activities, but currently this data and evidence of practice and health outcomes is retained within the confines of the pharmacy's clinical information system (CIS) only. An enhanced system that facilitates communication and improves recognition and contribution of care would provide considerable benefits to patients.

We would stress that pharmacists are part of the primary health care team and should be considered and included in any communication/referral mechanisms.

Recommendation 17 – Allow non-dispensing pharmacists to access allied health items

The Reference Group recommends adding an item to allow pharmacists to provide medication management services to patients with complex care requirements outside of usual retail pharmacy operations as part of Team Care Arrangements (TCAs) under M3 MBS items (up to twice a year).

The Guild agrees with the reference group that there should be an item to allow pharmacists to provide medication management services. However we disagree with the sentiment that it should be outside of the usual retail pharmacy operations or only located in a GP surgery. A pharmacist can provide medication management services wherever they practise and provision should not be restricted to a particular practice setting but be available to wherever the consumer requires the service. We believe that the supply pharmacy is the most logical place for medication management services to be provided.

What is a "non-dispensing pharmacist"?

Pharmacists are a registered health professional under the Australian Health Professional Registration Authority (AHPRA). The Pharmacy Board of Australia is responsible for registering pharmacists and students. It also develops standards, codes and guidelines for the pharmacy profession, handles notifications, complaints, investigations and disciplinary hearings. The Pharmacy Board registers pharmacists as "general" and does not have a definition of "non-dispensing" pharmacist nor is there an endorsement available for such a type of pharmacist. The Guild believes that, depending on the particular activity they may be engaged in at a particular time of the day, all community pharmacists could be described as a "non-dispensing pharmacist".

A pharmacist might well work in a PBS-approved community pharmacy with more than one pharmacist. One may do the dispensing and another may be the “non-dispensing pharmacist” who will be engaged in non-dispensing activities. Community pharmacies provide a wide range of services in their undertaking to improve the health of all Australians. Some of these services are listed below.

Medicines management and Quality Use of Medicines activities

- MedsCheck, Diabetes MedsCheck, Chronic Pain MedsCheck
- MedsIndex and adherence support
- Staged supply
- S100 Remote Aboriginal Health Services Program
- Chemotherapy medicines preparation
- Compounded medicines
- New to Therapy services
- Home Medicines Reviews
- Dose Administration Aids
- Pharmacovigilance including adverse event reporting
- Product recalls and safety alerts
- Consumer Medicines Information provision
- Residential Medication Management Reviews
- Emergency contraception provision and counselling
- Complementary medicines advice

Public/population health activities

- Immunisation services
- Project STOP pseudoephedrine supply monitoring
- Closing the Gap Pharmaceutical Benefits Scheme Co-payment measure
- Needle and Syringe Programs
- Opioid Dependence Treatment
- Maternal and Child Health clinics
- Health aids and equipment provision
- Return of Unwanted Medicines
- Absence from Work Certificates
- Home delivery services

Disease management, monitoring and support

- Respiratory (asthma and chronic obstructive pulmonary disease) services
- Diabetes management services including National Diabetes Services Scheme
- Cardiovascular disease services
- Dementia management support
- Pain management services
- Arthritis management support
- Mental health support services
- Aged care services
- Continence Aids Payment Scheme
- Sleep apnoea services
- INR (anticoagulant therapy) monitoring
- Palliation support services

Minor ailments

- Pharmacy and Pharmacist Only medicines
- Skin care support and products (dermatitis, eczema, acne)
- Wound care support and products
- First Aid support and products

Wellness, screening and prevention services

- Blood pressure and cardiovascular disease risk assessment
- Diabetes risk assessment
- Smoking Cessation support and products
- Point of Care Testing cholesterol and blood glucose
- Self-test screening: bowel cancer and chlamydia
- Bone density testing (external provider)
- Weight management and nutrition services
- Compression garment fitting for deep vein thrombosis
- Lifestyle advice and support
- Travel health support

A survey recently conducted by AJP[6] showed that 25% of pharmacies employed a professional services pharmacist dedicated to the provision of professions services. This by definition is a 'non-dispensing pharmacist' and there is no reason why these pharmacists could not access MBS for the services they provide to consumers.

We note in the discussion paper that the AMA and the PSA have released a proposal[7] to establish a funding program to integrate non-dispensing pharmacists within general practices.

We also note that under the Stronger Rural Health Strategy, the Workforce Incentive Program (WIP)[8] will commence from 1 January 2020. The WIP will provide targeted financial incentives to encourage doctors to deliver eligible primary health care services in regional, rural or remote areas that have difficulty attracting and retaining doctors. The WIP will also provide financial incentives to support eligible general practices to engage the services of nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and allied health professionals, including 'non-dispensing' pharmacists.

The Guild believes that community pharmacy and general practice are integral parts of the primary health care system. Collaboration between community pharmacy and general practice provides integrated patient-centred care, improving the quality use of medicine and reducing fragmentation of care.

In principle, the Guild supports integration of pharmacists into general practice as an opportunity to enhance the collaboration between general practice and community pharmacy. However, due to the current maldistribution of the pharmacy workforce, particularly in rural and remote Australia, the Guild is concerned that the employment of pharmacists in general practice will exacerbate existing workforce pressures and the sustainability of the community pharmacy network.

[6] https://ajp.com.au/news/poll-does-your-workplace-have-a-professional-services-pharmacist/?utm_source=AJP+Daily&utm_campaign=5ac2b46459-EMAIL_CAMPAIGN_2019_05_14_06_51&utm_medium=email&utm_term=0_cce9c58212-5ac2b46459-109551493

[7] https://ama.com.au/system/tdf/documents/Pharmacists_in_General_Practice_Proposal.pdf?file=1&type=node&id=42083

[8] https://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-wip-factsheet

The key emphasis should be on the importance of not duplicating services or roles, but using the available workforce in community pharmacy to increase integration of pharmacists into the primary healthcare team, especially in areas with limited health workforce.

The Guild believes that the best way to integrate community pharmacy with general practice setting is through an outreach model of care using local community pharmacists as ‘non-dispensing’ pharmacists. This will ensure closer collaboration between community pharmacy and general practice, achievable by enhanced communication and information technology such as secure messaging systems, shared care planning software, tele-medicine and the My Health Record.