The Pharmacy Guild of Australia

SUBMISSION

National Rural Health Commissioner's Discussion Paper for Consultation:

Rural Allied Health Quality, access and distribution – Options for Commonwealth Policy Reform and Investment

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INTRODUCTION

The Pharmacy Guild of Australia (the Guild), is the peak pharmacy organisation representing Community Pharmacy. The Guild aims to promote, maintain and support community pharmacies as the most appropriate primary care providers of services related to optimum therapeutic use of medicines and medication management to improve the health care outcomes of the community.

There are approximately 5,700 community pharmacies across Australia, delivering highly accessible professional health services, medicines and health advice. Community pharmacy is consistently seen by the Australian public as a trusted and valued part of our nation's health care system.

The community pharmacy sector provides a highly qualified and skilled health professional workforce that can help to address problems of access to health services experienced by some 7 million Australians living in regional, rural and remote areas. 65% of Australians living in regional areas are within 2.5km of a pharmacy[1].

Community pharmacies are struggling with workforce shortages and workforce distribution inequities, on top of problems with accessing appropriately funded training and services. These issues compound the challenges that community pharmacies face in providing services to a population with high rates of chronic disease, lower health literacy and socioeconomic status – all of which require more time to be spent with patients to ensure quality health outcomes.

Rural community pharmacies can help to achieve equity of access for patients to culturally safe primary healthcare services in rural, regional and remote Australia with the support of the Commonwealth Government through policy reform and investment.

The Guild acknowledges that the discussion paper has taken an inclusive approach and does not focus on any specific health professional. However, we are concerned about the breadth of consultation and the placement of the pharmacy profession within the grouping of 'allied health'.

BACKGROUND

Literature Review and Consultation process

The Guild understands that the Commissioner has conducted a lengthy and widespread consultation process to prepare this paper. We note that the list of organisations consulted does not include specific professional groups other than optometry. There appears to be an assumption that allied health organisations reflect membership of all health professions intended to be covered by this paper but this is not the case.

Allied Health Professionals Australia (AHPA) is a peak organisation that represents the interests of 20 national allied health association members and 6 organisational friends[2]. Pharmacy, however, is not represented by AHPA and, similarly, is not represented by its counterpart, the Australian Allied Health Leadership Forum (AAHLF).

[1] MacroPlan Dimasi (2016) Geospatial Analysis

[2] NRHC (2019) Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution – Options for Commonwealth Government Policy Reform and Investment, p39.

Similarly, other organisations made up of alliances of various health professions, for example, the National Rural Health Alliance, although having representation from pharmacy groups, provide a consensus view and would not be equipped to discuss specific implications of strategic policy on any particular profession.

The Guild is concerned that the pharmacy profession and community pharmacy has not been consulted and we welcome the opportunity for further specific consultation on how community pharmacy can contribute to the policy intentions proposed in this paper.

The pharmacy profession and allied health

There is a long history of misunderstanding of where pharmacy sits in the healthcare system and, more often than not, pharmacy is included as an allied health profession. This has implications on the ability of profession to be seen for its unique expertise as medicine management experts and the access to funding specific for a pharmacist's role and activities in the health system.

It is generally accepted that there is no universally accepted definition of allied health professions. The only consistency amongst governments, organisations, health service providers, education providers, is that 'Allied Health' excludes the health disciplines of medicine and nursing. Some also exclude dentistry. The discussion paper refers to the Australian Allied Health Leadership Forum's (AAHLF) description of allied health professionals as "*university qualified with 'skills to retain, restore or gain optimal physical, sensory, psychological, cognitive, social and cultural function of clients, groups and populations'.* The AAHLF do not define the specific disciplines included in 'Allied Health'.

Pharmacists provide a distinct skill set that varies from Allied Health professionals and goes beyond the AAHLF definition of allied health. Medicines are the main treatment for the majority of medical conditions, both acute and chronic[3]. Pharmacists are experts in medication use, management and safety and must have a broad and deep knowledge of human pathophysiology that differs from physical therapies offered by allied health professionals.

Community pharmacies are the most frequently accessed and most accessible primary health care destination, with over 451 million individual patient visits annually and the vast majority of pharmacies open after-hours, including weekends. Beyond dispensing medicines, pharmacists respond to patient requests for assessment, treatment and advice for a wide range of symptoms and self-limiting conditions and refer to medical care when appropriate.

It is for this reason that the Guild supports pharmacy being recognised as a discipline in its own right, and community pharmacy being recognised as primary health care.

Therefore, the Guild will take the approach in this response of how pharmacy can be included in the policy areas described in this discussion paper and would encourage the Commissioner to take a whole of health workforce approach rather than a silo approach to any strategies for addressing rural health quality, access and distribution.

[3] Pharmaceutical Society of Australia 2019. *Medicine Safety: Take Care.* Canberra: PSA

POLICY AREAS

The Guild urges the Commission to consider the following priority areas to address Rural Health Quality, Access and Distribution.

Equity across health professions

There is a significant need for the Commonwealth to address the workforce issues being experienced by all health professionals working in rural and remote Australia, not just the medical and nursing professions which has long been the focus. The National Rural Health Alliance's Election Charter states the need for the government to fund an additional 3,000 allied health positions (which includes pharmacists) and the provision of Medicare rebates to GPs and other health professionals for telehealth consults to outer regional, remote and very remote areas. The aim is to expand the allied health workforce in rural, regional and remote areas, and support its capacity to provide services in outer regional, remote and very remote areas, with a view to achieving equivalent levels of healthcare access as occurs in metropolitan areas.[4]

A report by the Royal Flying Doctor Service (RFDS) on the decline in the rural health workforce predicts that by 2028, rural Australia will only have half the number of pharmacists compared to metropolitan areas (52 as compared to 113 per 100,000 population)[5]. This is extremely concerning for the Guild and our members and needs urgent attention.

There are approximately 307 towns in PhARIA[6] 4-6 (moderately accessible, remote, very remote) that have only one pharmacy, and in many cases, the pharmacist is the only health professional in the town. Data indicates that there are 57 towns in PhARIA 4-6 with one pharmacy and no medical centre[7]. If rural and remote community pharmacies cannot recruit or retain staff as the RFDS report predicts, then there will be a significant number of Australians that will no longer have access to medicines and primary care services that is core to many of the national health priorities.

Addressing service access with health professionals working at full scope of practice

The Guild believes the professional training, skill and knowledge of community pharmacists should be acknowledged and that service gaps could be addressed by pharmacist working to their full scope of practice.

The benefits of pharmacists practising to their full scope is most pronounced in rural and regional communities where access to health professionals and health outcomes are lower than metropolitan areas. Pharmacy is well placed to assist because of the better geographic spread of pharmacists across regional Australia when compared to other health professionals.[8]

[4] National Rural Health Alliance (2019) Election Charter
[5] Royal Flying Doctors Service, August 2018. Looking Ahead: Responding to the Health Needs of Country Australia in 2028 – The Centenary Year of the RFDS. https://www.flyingdoctor.org.au/assets/documents/RN064_Looking_Ahead_Report_D3.pdf
[6] PhARIA is the Pharmacy Accessibility/Remoteness Index of Australia. PhARIA categories range from 4 (moderately accessible) to 6 (very remote). Category 5 is classified as remote. https://www.adelaide.edu.au/hugo-centre/services/pharia
[7] MacroPlan Dimasi (2016) Geospatial Analysis
[8] Royal Flying Doctor Service Research Report (2018) Looking ahead: responding to the health needs of country Australia in 2028 – the centenary year of the RFDS

The concept of rural generalist practice addresses the broad and extended roles that health professional can provide, within their scope of practice, in response to the healthcare needs of the community.

Supporting all health professionals working to their full scope of practice can support a model of triaging the provision of services to those health practitioners that have the skills, competency and qualifications to provide the required services. For example, pharmacists have the core competencies to prescribe medicines and would require additional training to become autonomous prescribers, with the ability to ensure access to medicines when there may be limited or no availability of a medical prescriber.

One size does not fit all

The quality and access to health care for rural, regional and remote areas should be equal to the standards available in metropolitan areas[9]. Community Pharmacy is an essential part of the primary health care team dedicated to providing valuable primary health services across Australia.

Rural and remote members of the Guild stress that a one size fits all approach will not work in addressing health service access issues in their communities. Each community has unique needs based on so many determinants of health including, demographics, socioeconomic status, literacy and health literacy, chronic disease burden and access to number and type of health professions. This has an effect on the type and number of services that a rural pharmacy provides, the time taken, and the cost of providing that service.

The relationship between community pharmacy and remote health services is a critical and vital link for patients living where there is no pharmacy, however medication education and management activities are limited due to inappropriate funding or unfunded service models.

Describing the challenges of patients in remote Australia, a community pharmacist providing services in remote WA says:

> "*You can walk in the door of a pharmacy and access information, education and a MedsCheck. The pharmacist comes to you in a remote community, the time is limited, you can't self-select when you want to talk, you can't address your concerns when you have them, and then medicine talks are not to be claimed by the pharmacist. Situations like this don't close the gap, they widen it".*

Consideration is needed for a system wide approach that ensures equitable access but remains flexible and adaptive to the health needs of individual communities and patients at any point in time, and into the future. It needs to address the variation in costs and resources required for a rural health professional to provide equivalent health services to their metropolitan counterparts which can be achieved by loadings for rurality, or other relevant metrics.

[9] National Rural Health Alliance (2019) Election Charter

In addition to the above policy areas, the Guild provides the following feedback on the proposed policy areas in the discussion paper.

Policy Area 1 - Rural Allied Health Policy, Leadership and Quality and Safety

The Guild supports leadership of the rural health workforce within the Department of Health to ensure advocacy and intra and inter-sectoral collaboration to address the quality, access and distribution of health professionals working to deliver services in rural, regional and remote Australia.

Appointment of a Commonwealth Chief Allied Health Offer would not necessarily meet the objective of addressing rural health quality and safety as they would presumably have a remit to address broad issues for the allied health professions similar to that required of the Chief Medical Officer, or Chief Nursing and Midwifery Officer.

Currently, the Chief Medical Officer is responsible for the Health Workforce Division which includes the branches of Rural Access, Health Workforce Reform, and Health Training. The Guild would support a Chief Rural Health Officer/Advisor or similar, to specifically address the workforce and access needs for the delivery of health services rural, regional and remote Australia across all health disciplines.

The objectives of a leadership position for the rural health workforce would be to:

- Ensure rural health has a high profile in health workforce and service delivery policy, data, and planning processes, and that all health disciplines are reflected in these processes.
- Ensure extensive consultation with stakeholders to develop clear objectives, plans and agreements
- Establish guidelines addressing funding, consultation and conflict resolution amongst stakeholders
- Establish a regular rural health forum to enhance the Commonwealth's liaison and consultation with these disciplines

Priorities for Commonwealth Chief Rural Health Officer/Advisor

The Guild would suggest the top priorities for improving rural health distribution, access and quality in the next five years be:

- To elevate the role of rural pharmacists and allied health professionals in health workforce and service delivery policy, data and planning processes, including workforce incentives
- Identify community needs and address workforce issues and service gaps across all health professions, especially community pharmacists, delivering services in rural and remote Australia
- Support the education and training of rural health professionals, including pharmacists, to enable them to work at full scope of practice, including any required legislative changes
- Recognising community pharmacy as an integral part of the primary health care team, and enabling multiple disciplines, including community pharmacy, to work collaboratively and be adaptive to the needs of the community
- Create a funding model, or structure multiple funding streams, that fosters multidisciplinary care when and where the patient needs it, including community health hubs, telehealth, and pharmacist access to MBS items

Rural (Allied) Health College

The Guild recognises that there are various professional education providers/organisations that provide postgraduate support, education and training for health professions that are usually discipline specific. An interprofessional learning environment focused on the postgraduate generalist education and service delivery requirements of rural and remote health would support the professional integration and collaboration that is so necessary in this environment.

Establishing a Rural (Allied) Health College should not duplicate the role of University Departments of Rural Health or other organisations with this objective, but support and use them to their full capacity.

Accreditation of education, such as the Allied Health Rural Generalist Pathway, should be conducted by an independent, skills based body not involved in the design or delivery of the education.

Rural (Allied) Health Workforce Dataset

The Guild is supportive of investment in a national rural health workforce dataset as a means of providing better capability to monitor and investigate distribution of available resources – workforce and services. A dataset would allow for measurement of health outcomes and service delivery in rural Australia and therefore the impact of the proposed rural health policies, as well as informing the development of future funding models and policy direction. The dataset may not have the ability to capture personal choices for recruitment and retention factors such as lifestyle, family requirements and education.

We note that the Department of Health's Health Demand and Supply Utilisations Patterns Planning (HeaDSUPP) tool was not referred to in the paper, and would be a logical first step to collect and include workforce and service access data for all health professions.

Policy Area 2 - Opportunities for Rural Origin and Indigenous Students

The Guild has been advocating for an increase in Commonwealth Supported Places (CSP) quotas for rural students to study pharmacy as a means of addressing the workforce mal-distribution of the profession.

The Guild suggests CSP quotas to be at least in parity with the population demographics (25-30%), or increased to meet areas and disciplines of workforce needs.

Additionally, there should be Commonwealth support for regional universities that offer health disciplines to allow rural students to study closer to home.

Policy Area 3 - Structured Rural Training and Career Pathways (MMM2 – 7)

As with other registered health professions, pharmacy programs leading to registration as a pharmacist are required under the National Registration and Accreditation Scheme (NRAS) to be accredited, and approved by the Pharmacy Board.

The Accreditation Standards for Pharmacy Programs[10] encourage universities to provide rural placements but these are not mandatory. The do require universities to provide pharmacy students with the opportunity to undertake work integrated learning in community and hospital pharmacy.

Expansion of the John Flynn Program would certainly be beneficial to pharmacy students especially if criteria were not restricted to a single supervisor but to a rural community where interprofessional and intraprofessional mentoring and supervision could build collaboration across the health care team.

The Allied Health Rural Generalist Pathway is currently limited to seven allied health professions, and this includes pharmacists. However, the content of training and funding is more aligned with pharmacists working in public hospitals. Broadening the relevance, funding and support opportunities to all pharmacists, regardless of where they practise, could provide mentoring and professional satisfaction for early career pharmacists.

Pharmacists working in rural community pharmacy currently provide a broader set of services than their metropolitan counterparts, to meet the community's needs. This breadth of skills and competency is currently within a pharmacist's scope of practice.

The Guild sees the Commissioner having a role in advocating for all health professionals to work to full scope of practice, and broader generalist practice, to meet the service access gaps in rural and remote Australia. For example, pharmacists have shown that they can safely deliver influenza vaccinations and have made an impact nationally on vaccination rates and herd immunity. Pharmacists are therefore a trained workforce that can deliver other immunisation programs in rural towns as an additional service to reduce burden on general practice.

The findings of the literature review informing the discussion paper suggest that allied health assistants or other health workers could substitute some of the work delivered by allied health professionals. The discussion describes that maintaining continuity of access to medicines as patients moved between hospital and community was challenging in rural areas. "*Generalist nurses and doctors were over-loaded and managing medications was an additional demand on their time*". One of the solutions suggested was "*developing 'extended community medication roles' with oversight of rural pharmacist*".

The Guild makes the following comments in relation to this issue and proposed solution.

Pharmacist involvement in medicines management and prescribing

Pharmacists are medicine experts and if supported to work to full scope of practice, as autonomous prescribers, can assist in addressing the workload of managing medications in rural communities.

There are many examples that Guild rural members share that describe how they have no GP in town which means, without an increase scope of practice, there is no way of maintaining health services which leads to rural communities shrinking as people are forced to relocate to regional centres.

The ability for pharmacists to prescribe would assist in ensuring that there is continuity of access to medicines, especially during periods of transition of care between health providers. Medication management is critical to prevent readmission to hospital which often occurs in the immediate period following discharge.

[10] Australian Pharmacy Council (APC), 2012. Accreditation Standards for Pharmacy Programs in Australia and New Zealand (currently under review). https://www.pharmacycouncil.org.au/policies-procedures/standards/standards_pharmacyprograms2014.pdf

Dispensing by other health professionals

The Guild is concerned about the suggestion that dispensing of medicines could occur as an 'extended community medication role', either by other health professionals, or outside the pharmacy.

Current national law enables doctors and registered nurses to supply certain scheduled medicines in remote and isolated areas. Recognising the difficulties of supply unique to isolated areas, there are not the same stringent restrictions on premises in these locations. This is a compromise between best practice and sufficient supply where medical services are not adequate. However, review of these programs have shown these schemes fall below average standards for patient education and consumer medicine information.

The National Rural Health Alliance, in its discussion paper on the supply of medicines in rural and remote Australia, states that the preferred process is for dispensing by a pharmacist and other authorised processes (i.e. those not involving pharmacists dispensing medicines) involve supply only, with little or no advice from a pharmacist. The report also states that medicine dispensing processes involving non-pharmacists (e.g. nurse or Aboriginal health worker) are likely to have lower levels of safety and efficacy.

Policy Area 4 - Sustainable Jobs and Viable Rural Markets

Integrated Allied Health Hubs

The Guild agrees that community health hubs are an excellent way to use existing infrastructure in rural communities to provide health professional services on a regular or sessional basis. Having a hub with physical and technological infrastructure to support consultations, telehealth, and group education would provide communities with a central point of access to a health professional, and possibly rural generalist, whilst maximising service and economic efficiencies.

The integration of the multiple streams of services has the potential to remove duplication and to expand the range of services, provided there is a well-managed easily accessible HUB or sub-HUB in each area. It would also be able to accommodate for provision of once-off or episodic provision of services by a specific health professional or specialist in response to the individual needs of a patient, for example, speech pathology after a stroke.

With over 5700 pharmacies across Australia, 65% of Australians living in regional areas are within 2.5km of a pharmacy. The Guild would encourage the Commissioner to consider community pharmacies as an existing physical infrastructure that could be a health hub for rural communities. In fact, many pharmacies already have consultation rooms and are considering telehealth. Full access to the patient's clinical data via shared care plans and secure messaging would be required to ensure the success of such an approach.

Support in the form of capital grants or service agreements could expedite the use of this resource to meet this policy intention.

Additionally, the Commonwealth should consider providing seed funding to establish integrated health networks and professional hubs in rural areas to assist in peer support, ensuring adequate supervision of students and early career practitioners, and access to continuing professional development.

Paraprofessional staff

Support for paraprofessional staff, such as allied health assistants and pharmacy assistants, should be prioritised in the same way as the professionals they support such as workforce and training incentives. Pharmacy assistants are a vital asset and have specialist technical skills that create efficiencies to allow pharmacists to provide more patient centred and generalist care.

Policy Area 5 - Telehealth Allied Health Services

In 2016, our data indicated that there were almost 250 towns with only one pharmacy and no medical centre or one pharmacy and one medical centre (including Aboriginal and Torres Strait Islander Health Services), providing services in PhARIA regions 4 to 6[11].

Community pharmacies are an existing physical infrastructure that would support delivery of telehealth services by a variety of professionals, provided appropriate seed funding and support is arranged.

A pharmacy-based technology hub can manage appointments and provide resources to optimise the practitioner or specialist's time. A business model would need to be developed to adequately reimburse the pharmacy for hosting or coordinating telehealth services.

In remote and very remote areas, however, community pharmacies play a very important role providing telepharmacy and remote community visits, including Indigenous communities, where they provide important medicines information, education and reviews. These 'medicines talks' serve peoples whose burden of chronic disease is significant and access to medication education is so limited due to inappropriate funding or unfunded service models.

Pharmacists are currently the only AHPRA registered health professional who are not eligible to provide health services through the chronic disease management service items. Access to the MBS for chronic disease management, case conference and telehealth items by pharmacists practising from any setting, can only benefit rural and remote communities.

[11] MacroPlan Dimasi (2016) Geospatial Analysis