The Direction of General Practice and Pharmacy in Australia

A Discussion Paper

The Hunter General Practitioners' Association (HGPA) wishes to express its concern at recent announcements regarding the 6th Community Pharmacy Agreement (6CPA). Pharmacists are an indispensable and essential part of primary care. However, reports suggest that the direction of the 6CPA will encourage further siloing and fragmentation of primary care, rather than promoting integrated and coordinated models which have already been proven to be effective.

We support instead the integration of pharmacists into GP-led multidisciplinary teams based in general practices. Such a model, involving non-dispensing pharmacists, has already been developed. As a matter of priority, this model should be funded from the 6CPA.

In the absence of 6CPA funding, we propose that self-funded trials could commence, based on revenue generated by the integration of non-PBS ("private prescription") dispensing pharmacists within general practice.

Multidisciplinary team-based health care

HGPA agrees with the National Primary Health Care Strategic Framework that the best and most efficient primary healthcare is integrated and coordinated. [1]

The National Primary Health Care Strategic Framework also recognises that there "is increasingly compelling international evidence that multidisciplinary team-based health care delivery models, such as patient centred medical homes (PCMH), contribute to improved health outcomes, enhance the consumer experience of care, and reduce the need for expensive and avoidable hospital and emergency care". [2]

The framework recognises that the growing demand for service provision will require the skills of all health professionals to, "…be maximised to enable all team members to work to their full scope of practice." In particular, the framework suggests that by "…focusing GPs at the top of their scope, this enable others within the care team…to work at their scope of practice and better contribute to patient care. This will assist in promoting multidisciplinary teams in which all team members are fully supported to develop their clinical skills and potential."

[1] http://www.health.gov.au/internet/publications/publishing.nsf/Content/NPHC-Strategic-Framework~strategicoutcome1

[2] Deloitte (2008) *The Medical Home: Distributive Innovation for a New Primary Care Model* cited in http://www.health.gov.au/internet/publications/publishing.nsf/Content/NPHC-Strategic-Framework~strategicoutcome2

6th Community Pharmacy Agreement

There is limited information available about the upcoming 6CPA. What is available is that:

- The agreement will commence on 1 July, 2015, and run until 30 June, 2020[3]
- There is a lump sum of $18.9 billion over five years; compared to the 5CPA, this represents a $700 million increase per year[4]
- the professional services component has doubled to around seven percent of the total 6CPA budget ($1.2 billion). "This would include $50 million for a Pharmacy Trial Program and $600 million in a contingency reserve to support new and existing community pharmacy programs and services."[5]
- current location rules will extend through to 2020
- there is a new Administration, Handling and Infrastructure Fee to insulate pharmacy from the impact of PBS price disclosure cuts
- there is an "optional" one dollar copayment[6]

The Federal Minister for Health, Sussan Ley, has provided some information about the $1.2 billion allocated to pharmacy programs, saying it will help fund, "…pharmacy moving into some areas of primary care".[7] Some of these may be pre-existing activities, such as visiting aged care facilities, but "We want to make sure that we give them a key role in the primary care teams of the future…So the trials we're going to start with pharmacy will allow pharmacists to apply for funding, to operate innovat[ive] programs, to do something differently…we know that over time the investment that we will make in this area will entrench our pharmacists as key members of our primary care teams."

Whilst there has been no specific detail about the areas of primary care discussed between the government and the Pharmacy Guild in the context of the 6CPA negotiations, on January 18, 2015, the Guild released a media statement announcing that they would be "advocating vigorously" for "enhanced pharmacy services" that included:[8]

- Enhancing access to prescription repeats for stable, long term conditions
- Extending the treatment of minor ailments to community pharmacies
- Improving access to vaccinations
- Post-hospital and transitional care medicine reconciliation support
- Basic health checks, screening and preventative health services
- Mental health support

There appears to be very little or no scope for other stakeholders to be part of the discussion regarding the 6CPA ("Professional Pharmacists Australia is disappointed…that there's 20,000

[3] http://www.pharmacynews.com.au/news/latest-news/all-systems-go-for-6cpa
[4] http://www.news.com.au/lifestyle/health/it-will-take-seven-years-of-your-taxes-to-pay-off-this-117000-pay-rise-granted-by-the-government/story-fneuzlbd-1227360593568
[5] http://www.guild.org.au/news-page/2015/05/18/sixth-community-pharmacy-agreement-negotiations-progress
[6] http://www.pharmacynews.com.au/news/latest-news/co-payment-competition-or-choice
[7] http://ajp.com.au/news/ley-on-prof-services-handling-fee/
[8] http://www.guild.org.au/vic_branch/victoria-branch/2015/01/18/pharmacy-can-help-deliver-better-health-outcomes-and-a-more-sustainable-medicare

employee pharmacists and millions of consumers who are completely shut out of the process of determining the shape and form of pharmacy services over the next five years…")[9]

Current community pharmacy model

The discussion paper released this year by the Professional Pharmacists Australia, titled, "*A new system of pharmacists' remuneration*"[10] notes that, "…the current PBS remuneration stream that is simply based on the supply of the drug with no incentive to ensure good patient outcomes is outdated and inefficient, and ultimately costly to the health system. The focus of the current system is to maximise the number of prescriptions dispensed to maximise the income of the approved pharmacy…" The paper goes on to point out that the pharmacy fee-for-service model encourages process rather than care. This clearly does not enable pharmacists to operate "at the top of their scope".

To that it can be added that a substantial amount of community pharmacy income is generated from selling over-the-counter products of little or no proven therapeutic benefit.[11] There is a clear conflict of interest when the primary income of a profession is generated not from a clinical consultation but from the sale of products recommended in that consultation.

The important role of pharmacists

High-quality pharmacy is unquestionably a critical part of primary care. Pharmacists are highly skilled professionals who have:

- A comprehensive knowledge of medications, side-effects and drug interactions, including those with herbal medications
- A valuable role in double-checking of medication and medication doses
- Various special interests where they have detailed clinical knowledge of individual patients, such as in opiate substitution programs
- Potentially more time and accessibility than general practitioners

Expanding the scope of pharmacy

The Code of Conduct for Australian Health Professionals[12] notes that

- "Providing good care includes…recognising the limitations to a practitioner's own skills and competence and referring a patient or client to another practitioner when this is in the best interest of the patients or clients…"

In this context it is important to recognise the areas where pharmacists have a limited skill set:

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[9] http://ajp.com.au/news/ppa-keen-on-pharmacy-location-rules-review/

[10] http://www.professionalsaustralia.org.au/pharmacists/wp-content/uploads/sites/37/2015/04/final_copy_PPA_CPA_Renumeration.pdf"

[11] http://blogs.crikey.com.au/croakey/2014/05/06/are-pharmacists-thieves-or-therapists/; http://www.smh.com.au/lifestyle/diet-and-fitness/pharmacies-to-push-supplements-as-fries-and-coke-to-prescriptions-20110925-1krun.html

[12] http://www.pharmacyboard.gov.au/Codes-Guidelines/Code-of-conduct.aspx

- No medical training
- No formal clinical diagnostic skills
- Financial pressures of small business ownership (in many cases)

It has been said by a GP about role substitution by pharmacists, "If this was a good way to practise a profession, we could all just buy a book on law and represent ourselves in court, organise our own house sales and never need a tradie either. But we all know that there is more to a 'job' than it appears."[13]

If pharmacists are to expand their scope of practice to the areas the Pharmacy Guild has previously declared, then they should, in the interests of safe, ethical and credible practice :

- Stop selling products which are without an evidence base for efficacy
- Hold comprehensive medical indemnity insurance
- Provide adequate privacy for consultations
- Maintain comprehensive medical records
- Ensure the confidentiality of those records
- Have adequate training in the differential diagnosis of the conditions that they are treating and in the management of untoward events (including the management of anaphylactic reactions)
- Provide information on clinical interventions to the usual treating GP

In other words, they should comply with most of the standards that are required for accredited general practices. This is not currently the case It is therefore clear that a typical pharmacy environment is not appropriately set up to be a "medical home".

The appropriate environment for a "medical home" already exists in general practice surgeries. It therefore makes a great deal more sense for pharmacy to expand its scope within the general practice environment.

A qualitative Monash study looked at the results of embedding pharmacists within two general practices in Melbourne.[14] Over a six-month period, the pharmacists provided medication reviews, patient and staff education, medicines information and quality assurance services. One of the authors of the study commented that, "the placement of highly trained pharmacists within Australian GP settings improved patient health outcomes, the use of medicines by patients, quality of prescribing, staff drug-knowledge and professional collaboration." His evaluation was that, "Overall, the results of this study support the benefits and feasibility of practice pharmacists in the Australian health system…"[15]

Another study looking at medication reviews done by a pharmacist integrated in Australian general practice[16] found that 71% of recommendations were implemented, compared to 53% of recommendations made by a pharmacist external to the practice. The study noted that the "ability

[13] http://www.australiandoctor.com.au/opinions/guest-view/5-reasons-why-pharmacists-should-not-be-playing-do?t=635581457761721358

[14] http://bmjopen.bmj.com/content/3/9/e003214.full

[15] http://www.oztrekk.com/blog/2013/11/monash-research-shows-role-of-pharmacist-in-general-practice-is-crucial/

[16] http://cff.org.br/userfiles/59%20-%20FREEMAN%20C%20R%20An%20evaluation%20of%20medication%20review%20reports%20across%20different%20settings.pdf

for the pharmacist to access the patient's medical file…potentially facilitate[ed] more targeted and less conjectural recommendations to general practitioners".

Such a model would also be consistent with the recommendation from the UK's Royal Pharmaceutical Society, in which they state, "Pharmacists must collaborate with…other healthcare professionals, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support with medicines as they move between care settings."

Another clear benefit to having a GP pharmacist with access to the GP comprehensive medical record would be the increased capacity to maintain an up-to-date and accurate medication record. This is a key step that would help facilitate the implementation of the PCEHR.

The Pharmaceutical Society of Australia (PSA) has already been working with the AMA on integrating non-dispensing pharmacists into general practice.[17] This would involve the introduction of a Pharmacist in General Practice Incentive Program (PGPIP), similar to the currently existing program for practice nurses, at the rate of $25,000 per annum per standardised whole patient equivalent (SWPE) for a pharmacist working at least 12 hours and 40 minutes per week, with a cap of five incentives per practice and a 50% loading for rural practices. In this highly integrated model, the GP pharmacist could be part of team-based medication management (resulting in better adherence and fewer medication mishaps), as well as participating in health screening, educational programs, point-of-care testing and monitoring, clinical audits, health assessments, immunisation and transitional care.

The expected benefits would include reduced exacerbations of chronic disease and reduced hospitalisations. An independent analysis from Deloitte Access Economics shows that every $1 invested in the program would generate $1.56 in savings to the health system.[18]

It has been noted by the Pharmaceutical Society of Australia that pharmacists within general practice medical centres could be a liaison between community pharmacists and general practitioners, facilitating greater coordination and consistency in patient care, and should thus be viewed as an ally and not a threat.[19]

Funding of GP pharmacists

As previously noted, community pharmacy is currently funded on a fee-for-service basis. For pharmacists in general practice to truly operate at the top of their scope, a PGPIP program would need to be implemented.

The 6CPA represents an ideal opportunity for such a program to be funded.

In the absence of 6CPA funding, general practice could instead explore fee-for-service models to fund the integration of pharmacists into GP-led multidisciplinary primary care teams.

To explore this further, we need to examine (a) the availability and employment cost of pharmacists, and (b) what revenue stream can be tapped to employ a pharmacist.

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[17] http://www.pulseitmagazine.com.au/index.php?option=com_content&view=article&id=2279:psa-proposes-integrated-gp-pharmacist-model-of-care&catid=68:allied-health&Itemid=334

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

[19] http://www.psa.org.au/download/ap/apjan14/Cover_story_A_future_so_bright.pdf

Pharmacists in the workforce

The Pharmacy Guild primarily represents the interests of pharmacy owners. The vast majority of pharmacists are employees who have been effectively prevented from becoming pharmacy owners because of the location restrictions in the 5CPA; these barriers will be preserved in the 6CPA.

The oversupply of pharmacy graduates has resulted in "rates of pay for pharmacists [being] the lowest of all graduates in Australia", at $35.55 per hour/$39K per annum. Anecdotally, pharmacists are being paid as little as $23 per hour. A 2012 survey of 1320 pharmacists across Australia and a Fair Work Ombudmsan 2012 audit of pharmacies in QLD found:[20]

- The average base hourly rate has increased by 2.3% compared to 3-4% achieved by other groups
- 63% of pharmacists work through lunch, with 50% not being paid
- 43% of pharmacists are employed as part-timers and 24% as casuals
- 33% of Pharmacists would like more hours of work
- 37% of Pharmacists have not had a salary review since 2009
- A large number of part-time or casual pharmacists would like to work more than they currently do; in effect, many pharmacists' take home pay is further reduced because they cannot work the hours they want
- Of 575 Queensland pharmacies, 44% were not paying their staff properly.

In summary, there is a significant pool of available pharmacists and the potential cost of employing them is not prohibitive.

Dispensing medications in general practice

Many general practices are already dispensing medications. These typically include free "sample" packs, as well as the sale of vaccines.

In order to facilitate this existing process, practices will already have in place limited supply, stocking and billing procedures.

Could GPs and/or GP pharmacists dispense PBS medications, thereby producing a revenue stream that would cover the cost of a GP pharmacist?

Under the 5CPA, the rules governing pharmacy ownership and location would appear to prohibit the former. However, from a document titled "Dispensing by other health professionals", which was published in Nov 2006 by the Pharmaceutical Society of Australia[21]:

- "*Under the National Health Act 1953 (s. 92) a doctor may only be approved to supply pharmaceutical benefits in the area in which they practise where there is no pharmacist*

[20] http://www.professionalsaustralia.org.au/pharmacists/advocacy/pay-conditions/
[21] http://www.psa.org.au/download/policies/dispensing-by-other-health-professionals.pdf

approved in respect of premises from which, in the opinion of the Secretary, a convenient and efficient pharmaceutical service may be supplied"

- BUT "*An authorised health practitioner other than a pharmacist may dispense non-PBS pharmaceuticals (ie. below copayment Pharmaceutical Benefits Scheme (PBS) medicines or private items) in accordance with the state's drugs and poisons legislation*."
- AND "*PSA notes that the Australian Medical Association provides a statement on dispensing doctors and related issues as follows: 'Practising doctors who also have a financial interest in dispensing pharmaceuticals are in a prima facie position of conflict of interest. The Association therefore recommends doctors should not dispense pharmaceuticals etc. for material gain unless there is no reasonable alternative*.' PLUS "*Some state legislation also prohibits non- pharmacist practitioners dispensing medicines for profit*".

In other words, GPs should be able to dispense non-PBS ("private script") medications, at a reasonable price that covers costs. This would not be prohibited by the local restrictions rules in the 5CPA (which are expected to carry through to the 6CPA).

With regards to a GP pharmacist dispensing medications, similar principles appears to apply. That, is there are multiple restrictions on the location of new or relocated pharmacies,[22] but a "pharmacy" is defined in the National Health Act 1953 – sect 90 (30AB)[23] as a "business in the course of the carrying on of which *pharmaceutical benefits* are supplied".[24] In other words, a GP pharmacist should be able to dispense non-PBS medications without being subject to the current location rules.

The cost of generic medications is not high. A list of the retail cost of common medications from a local pharmacy follows:

- Aciclovir 200mg x25 $14.39
- Amoxycillin 500mg x20 $6.10
- Amoxycillin 250mg/5ml 100ml $6.50
- Amoxy/Clav 875/125mg x10 $6.10
- Aspirin 100mg x112 $2.99
- Atorvastatin 20mg x30 $9.99
- Cephalexin 500mg x20 $6.10
- Cephalexin 250mg/5ml 100ml $6.10
- Citalopram 50mg x28 $6.99
- Digoxin 250mg x100 $7.39
- Doxycycline 100mg x7 $5.90
- Fluticasone 250mcg Accuhaler $25.50
- Gabapentin 300mg x100 $13.99
- Hydrocortisone 1% x30g $4.99
- Metoprolol 100mg x60 $6.10
- Mirtazapine 30mg x30 $7.99
- Mometasone 0.1% oint x15g $7.39
- Montelukast 5mg x28 $19.99
- Olanzapine 5mg x28 $14.99
- Omeprazole 20mg x30 $8.99

[22] http://www.comlaw.gov.au/Details/F2009C00188
[23] http://www.austlii.edu.au/au/legis/cth/consol_act/nha1953147/s90.html
[24] http://www.austlii.edu.au/au/legis/cth/consol_act/nha1953147/s84.html#pharmaceutical_benefit

- Ondansetron 4mg wafter x4 $12.69
- Pantoprazole 20mg x30 $6.10
- Perindopril 4mg x30 $6.99
- Perindopril/Indap 4mg/1.25mg $11.50
- Ramipril 5mg x30 $6.50
- Roxithromycin 150mg x10 $6.10
- Salbutamol MDI x2 $11.40
- Sertraline 100mg x30 $6.10
- Simvastatin 20mg x30 $6.50
- Thyroxine 50mcg x200 $19.50

These prices would represent the wholesale cost of the medication (albeit in bulk quantities), as well as handling and dispensing fees.

Under the PBS, the cost for medications is up to $37.70 for general patients and $6.10 for concessional patients (plus any applicable special patient contribution, brand premium or therapeutic group premium).[25]

From the above retail price list, it is notable that many common medications come in under or very close to $6.10, even on a private script. For non-concessional patients, almost every generic medication comes in under $37.70. For many patients, and looking at medication on a script-by-script basis (acknowledging the PBS safety net), getting medications under PBS results in little or no financial benefit for them compared to a private prescription.

If general practices were to join together to increase their "buying power" (which could be facilitated by their local Primary Health Network), the cost of supply may enable the ultimate charge made to the patient to be very similar to what is charged in a retail pharmacy. Even if the GP retail price needs to be a bit higher to cover the cost of the pharmacist in their other (non-dispensing) roles, it is probable that many patients would be willing to pay a little more for the convenience.

Another benefit of non-PBS prescriptions is that there are no effective limitations on the quantity dispensed. Therefore, a saving on dispensing fees could be realised by dispensing several months' supply in a single transaction.

Throughout this process, it is important to note that the patient is not disadvantaged. They remain free to choose their medication supplier. A concession card holder, particularly for more expensive medications, could still choose to use their local chemist for the benefits of the PBS subsidy. Those who choose to have their GP pharmacist dispense their medications would do so either because they are not incurring any additional cost or because they are willing to pay a bit more for the sake of convenience.

For the government, this concept could result in a substantial reduction to the cost of the PBS.

Also of note is that a GP-pharmacist-based, non-PBS dispensing system would work most efficiently if the range of medications stocked remained relatively limited. This would represent a valuable opportunity to review best practice/pharmaceutical costs across a practice – and if the medication supply was facilitated by a Primary Health Network, across a whole region. The cost savings to both

[25] http://www.pbs.gov.au/info/healthpro/explanatory-notes/section1/Section_1_4_Explanatory_Notes

patient and government by, for example, changing all patients (where possible) from esomeprazole to omeprazole or from rosuvastatin to simvastatin, could be staggering.

Conclusion

HGPA believes that the 6CPA represents a rare opportunity for general practice to work with pharmacists towards a truly integrated and multi-disciplinary primary health care model. The evidence for the integration of pharmacists in general practice is readily available, and we believe it represents an innovative model that is in keeping with the National Primary Healthcare Strategic Framework. We would welcome discussion with all key stakeholders to further this concept, particularly with the funding opportunity that the 6CPA affords.