SUBMISSION BY THE PHARMACEUTICAL SOCIETY OF AUSTRALIA TO THE SENATE COMMUNITY AFFAIRS COMMITTEE INQUIRY INTO THE FACTORS AFFECTING THE SUPPLY OF HEALTH SERVICES AND MEDICAL PROFESSIONALS IN RURAL AREAS.

PURPOSE

1. The purpose of The Pharmaceutical Society of Australia's (PSA) submission, to the Senate Community Affairs Committee inquiry into the factors affecting the supply of health services and medical professionals in rural areas, is to inform the committee of factors affecting the supply of pharmacists and pharmacy services in rural areas. This submission has been informed by the views and perspectives of PSA's Rural Special Interest Group, as well as by the Australia Pharmacy Council Remote Rural Pharmacists project and pharmacy workforce studies.

ABOUT PSA

2. The Pharmaceutical Society of Australia (PSA) is the peak national professional pharmacy organisation representing pharmacists working in all sectors across Australia. PSA's core functions are: supporting pharmacists' commitment to high standards of patient care; providing continuing professional development (CPD), education and practice support; and representing their role as frontline health professionals.

3. PSA maintains its own Rural Special Interest Group which provides a forum for PSA members to discuss issues of relevance and to develop appropriate policy and other solutions in order to achieve improved health outcomes for consumers together with sustainable models of pharmacy practice in rural, regional and remote Australia.

MAIN PSA RECOMMENDATIONS:

4. PSA recommends that an assessment be undertaken of mechanisms to directly remunerate pharmacists located outside the capital cities for the provision of clinical pharmacy services (see Paragraphs 15,17,19,23,24)

5. PSA **recommends** the Commonwealth Government fund a pharmacist position in each remote Aboriginal Health Service. (see Paragraphs 17,21)

6. PSA **recommends** that there be a sliding scale for all rural pharmacy support incentives which increase with remoteness. PSA also recommends that the

pharmacy intern incentive payment should be split between the intern and the pharmacy and not paid solely to the pharmacy as per current arrangements. (see Paragraphs 20,33)

7. PSA **recommends** that the PhARIA measure of remoteness be brought in line with the classification system (Australian Standard Geographical Classification) used by other health professions.(see Paragraphs 29-34)

BACKGROUND: RURAL PHARMACY

8. **Quality Use of Medicines.** Pharmacy practice in Australia is firmly underpinned by Australia's policy on the Quality Use of Medicines (QUM).[1] In the context of this policy, the role of pharmacists relates not only to medicines use and management but also in providing advice on non-drug management where appropriate, providing support and information, and working across the whole spectrum of health from maintenance of good health to management of ill health. PSA recommends that QUM must underpin and inform the development of all rural health service strategies

9. There have been numerous studies which demonstrate and confirm that pharmacist interventions in all populations result in improved patient health outcomes, improved medication adherence, reduced hospitalizations and reduced healthcare costs.[2, 3]

10. Rural patients have higher incidences of chronic disease than their urban counterparts. Together with lifestyle factors, long term medicine treatment is usually needed to prevent or reduce disease progression and thereby minimise or delay negative outcomes of ill health. Clinical pharmacists can assist with medication adherence through simplification of medication regimens, education for self-management and ongoing support and monitoring. Improving medication adherence is often complex and multifactorial and requires interventions at the system, provider and patient level. Pharmacists have a role to play at each of these levels. They can empower individuals, assess patient needs and tailor solutions, and to maximise the benefits arising from the health system by promoting timely and

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[1] Department of Health and Ageing. The national strategy for quality use of medicines: Executive summary. Canberra: Commonwealth of Australia, 2002.

1. Baran, R.W., et al., *Improving outcomes of community-dwelling older patients with diabetes through pharmacist counseling.* American Journal of Health System Pharmacy, 1535. **56**(15): p. 1535-9.

2. Roughead, E.E., et al., *The effectiveness of collaborative medicine reviews in delaying time to next hospitalization for patients with heart failure in the practice setting: results of a cohort study.* Circulation: Heart Failure, 2009. **2**(5): p. 424-8.

equitable access to medicines and QUM education of consumers and health professionals. [4]

11. **Pharmacy Workforce.** Pharmacists are accessible health professionals, employed in community pharmacies and hospitals. Australian Institute of Health and Welfare Labour Force [5] data indicates that, in common with other health professions, pharmacists are maldistributed across different parts of the country with 72% located in the major cities.

12. Previous pharmacy workforce studies have not clearly defined rural workforce distribution and have not accommodated the rapid increase in the number of pharmacy graduates. There has been a doubling of pharmacy graduates since 1997. A key factor in the growth of graduates has been an expansion in the number of pharmacy schools, several of which are located in rural areas. It is likely, therefore, that Australia will soon have an adequate supply of pharmacy graduates entering the workforce, however, the profession now needs assistance to develop and implement measures that will ensure these graduates are distributed throughout rural, regional and remote areas and not over-represented in capital cities as at present.

13. Pharmacist demographic data from the Australian Health Practitioner Regulation Agency (AHPRA) annual report 2010-2011 confirms that currently (at 30 April 2011) there are 7,627 pharmacy students registered and that pharmacy is the health profession with the largest proportion of young practitioners. The increase in pharmacy workforce provides the opportunity for expanded roles for pharmacists in primary health care.

14. **Ownership Models**. In a 2009 report on rural and remote pharmacy, the Australian Pharmacy Council (APC) identified a number of regulatory and other impediments which limit access to pharmacy services in rural and remote locations. For example, the APC reported that "current ownership and remuneration models for pharmacists inhibit the number of pharmacists in remote areas."[6]

15. **Remuneration Arrangements.** The APC report also recommends that the remuneration arrangements for remote pharmacists should be changed to

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3. Davidson, P.M., et al., *Improving Medication Uptake in Aboriginal and Torres Strait Islander Peoples.* Heart, lung & circulation, 2010. **19**(5): p. 372-377.

[5] Human Capital Alliance. Analysis of secondary data to understand pharmacy workforce supply: Initial supply report. 2008: 32.

[6] Australian Pharmacy Council. Remote/Rural Pharmacists Project; final report. Sydney. APC, 2009: 7.

provide for direct payment of clinical services.[7] PSA **recommends** that an assessment be undertaken of flexible mechanisms to directly remunerate pharmacists located outside the capital cities for the provision of clinical pharmacy services (for example, through the Medicare Benefits Schedule, or Practice Incentive Payments) directly remunerate pharmacists for the provision of clinical pharmacy services. PSA believes that this would also encourage many young pharmacists to pursue primary health care roles in rural areas.

16. The APC report notes that remote pharmacists can play an important role in enhancing QUM "if innovative models of practice are implemented, legal impediments removed and recognition is given to the uniqueness of remote health care provision."[8]

17. Specific recommendations[9] to achieve this objective arising from the APC report are as follows.
    a. registering remote health clinics as pharmacy outstations, so that pharmacists may dispense in these locations;
    b. remunerating remote pharmacists for clinical services through MBS item numbers;
    c. allowing appropriately credentialled pharmacy technicians at remote depots/outstations to provide Pharmacist Only Medicines and dispense Prescription Only Medicines under a pharmacist's supervision through video conference or similar technology such as telepharmacy;
    d. pharmacists to be remunerated for telehealth patient/health professional consultations;
    e. Commonwealth Government to employ, and suitably remunerate, a pharmacist for each remote Aboriginal Health Service.

18. PSA believes that there is considerable scope for greater integration of pharmacists into primary health care teams. In this regard, PSA supports the recommendation of the National Health and Hospitals Reform Commission (NHHRC) to improve "the way in which general practitioners, primary health care professionals and medical and other specialist manage the care of people with chronic and complex conditions through shared care

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[7] Clinical pharmacy services include (but are not restricted to) medication reviews, medication management, education and chronic disease management.

[8] Australian Pharmacy Council. *Op cit*: 8.

[9] Australian Pharmacy Council. *Op cit*: 8-9, 12-13.

arrangements in a community setting."[10] This recommendation has particular applicability in non-metropolitan areas.

19. In order for greater integration of pharmacists into the primary health care teams to occur pharmacists need to be incorporated into existing team-based remuneration arrangements or other flexible payment structures made available for the provision of clinical pharmacy services. This would enable pharmacists to work in rural and remote settings where the community pharmacy model is not viable.

20. **Attracting and Supporting Rural Interns.** PSA supports current incentive schemes, such as the Rural Pharmacist Intern Incentive, (under the Fifth Community Pharmacy Agreement) to provide a higher payments to more remote pharmacies. That is incentives should increasing on a sliding scale with remoteness. (see Paragraph 33). In recognition that interns undertaking rural placements incur additional costs not faced by their metropolitan counterparts, PSA believes that this incentive payment should be split between the intern and the pharmacy and not paid solely to the pharmacy as per current arrangements.

21. **Aboriginal Health**. PSA welcomed the recent Senate Community Affairs Committee's Inquiry into the effectiveness of the supply of PBS medicines to remote Aboriginal Health Services. PSA supports the Committee's recommendations, particularly the recommendation that remote Aboriginal patients need to have direct access to the services of a pharmacist. PSA **recommends** the Commonwealth Government employ, and suitably remunerate, a pharmacist position in each remote Aboriginal Health Service.

22. With the reduction of pharmaceutical wholesale margins, rural and remote pharmacies are worried that wholesalers will close a number of their regional depots, resulting in delayed delivery times for medicines, and pharmacies being forced to increase stock holdings of medicines and thus becoming less financially viable as a business.

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[10] National Health and Hospitals Reform Commission. A healthier future for all Australians: final report. Canberra, NHHRC, 2009: 19.

PSA'S RESPONSE TO THE SENATE INQUIRY

Factors Limiting the Supply of Health Services and Pharmacists to Small Regional communities

23. Pharmacists are primarily employed in community pharmacy and hospital pharmacy in rural and remote areas. Implementation of flexible remuneration pathways would facilitate more pharmacists being involved in the delivery of clinical pharmacy services and preventive health care, rather than limited to access and supply of medicines.

24. Pharmacists could be recruited to rural and remote areas if remuneration for delivery of clinical services, medication education and primary care was available. Flexible remuneration pathways would facilitate employment of clinical pharmacists through Medicare Locals into community health, Aboriginal Health Services and GP surgeries, allowing integration of patient care, improved medication adherence, and prevention of medication misadventure. It would maximise support for doctors and other health professionals who are often in short supply in rural areas.

The effect of Medicare Locals in rural areas

25. Rural Medicare Locals will target services to the local primary health care needs of their communities and be responsible for their population health outcomes. They will provide links between government jurisdictions and health service providers, and encourage collaborative care models. Medicare Locals offer pharmacists the opportunity to integrate with other health professionals and potentially could subsidize clinical pharmacy services to areas where there is no accessible pharmacist.

Current incentive programs for the recruitment and retention of pharmacists in rural areas

26. **Pharmacist retention:** To be able to recruit and retain pharmacists in rural environments it is important that mentoring, professional development and attractive work and business incentives are available to pharmacists.

27. The Pharmacy Guild of Australia manages DoHA funding for the following rural programs under the 5th Community Pharmacy Agreement.

a) Continuing Professional Development (CPD) Allowance
b) Emergency Locum Scheme
c) Student Placement Allowance
d) Rural Pharmacy Maintenance Allowance
e) Rural Pharmacy Intern Incentive

f) Rural Pharmacy Scholarship Scheme
g) S100 Pharmacy Support Allowance

29) On November 8th, 2011, the Pharmacy Guild of Australia announced that only pharmacies located in PhARIA 2-6 will be eligible for the programs. Previously regional PhARIA 1 locations were deemed eligible. These changes to incentive eligibility will result in many rural and regional pharmacists being unable to access funding incentives , making rural practice in regional centres and rural areas less attractive.

30) Without rural support allowances to pharmacies and students in PhARIA 1 regional centres there will be greatly reduced numbers of students able to undertake rural or intern placements in rural areas and this will impact on future pharmacist recruitment and retention in rural Australia. Interns in regional centres will be unable to claim CPD support allowances to travel to urban centres where their intern training is delivered.

31) Changes to the eligibility of PhARIA 1 pharmacists in regional areas to access CPD travel allowance is likely to make regional practice more expensive and less desirable. It may well mean that regional pharmacists are less likely to attend conferences, and mix with their peers and mentors.

32) The PhARIA system was designed to provide a comprehensive, standardised measurement of the physical and professional remoteness of pharmacies throughout Australia, for use in the determination of rural and remote pharmacy allowances. The Pharmacy ARIA is a composite index, which incorporates measurements of general remoteness, with a professional isolation component. A '9 pharmacies rule' was added, resulting in centres with 9 or more pharmacies being reclassified into PhARIA 1 regardless of their location. The PhARIA classification system does not differentiate between urban, rural and regional PhARIA 1 locations.

33) PSA **recommends** that there be a sliding scale of incentives, with the incentives increasing with degree of remoteness.

34) PSA **recommends** that the measure of remoteness applying to pharmacy should be the same as for other health professions. The Australian Standard Geographical Classification system used by medicines and other health professions is preferable to the flawed PhARIA system. There is little or no justification for pharmacy to be classified differently than other health professions.

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