Executive Summary

GP Pharmacist Collaborative Prescribing Pilot

This submission is for financial support to enable the Ontario Medical Clinic (OMC) and other General Practice's across the country to implement and evaluate a Pharmacist Collaborative Prescribing pilot that proposes to address the healthcare workforce shortage crisis in **regional, rural and remote Australia.**

Patients would be seen by the non-dispensing General Practice (GP) Pharmacist as part of a collaborative care model. Shared team based care, utilising the skill set of our existing workforce, is arguably the only way to address the healthcare workforce crisis in regional, rural and remote Australia, and lessen the gap between city and rural healthcare outcomes, however the full impact of this innovative model of care cannot be determined without financial support from the Commonwealth Government.

People living in regional, rural and remote areas have higher rates of hospitalisations, mortality and injury. Poorer access to primary health care services, compared with those living in metropolitan areas is one of the major reasons for this disparity.

Since the inception of the non-dispensing GP Pharmacist role, there have been a myriad of benefits documented for patients and GP's alike, alongside a major economic analysis showing a proposed benefit-cost ratio of 1.56. Improvement in patient adherence to medicines, reduction in total number of medications per patient, improvement in medication knowledge for the GP and process measures such as time saving for the GP are just a few.

Our experience at OMC is that the non-dispensing GP Pharmacist can do so much more. A significant proportion of the appointments made by patients to General Practice are for the management of a patient's chronic health condition. So much of what the patient requires in those appointments is well within a GP Pharmacists skill set and it can be argued that in fact, medication management of chronic disease is more a pharmacists area of expertise than the GP themselves.

Legislation needs to change to allow for pharmacists to be funded in General Practice, in areas of workforce shortage (regional, rural, remote), to be able to prescribe (PBS prescriber number) and refer for pathology (MBS provider number) to take the burden from our GP's who are already at breaking point.

The positive 1.56 benefit-cost ratio of the economic analysis of a proposed policy to integrate non-dispensing pharmacists into General Practice commissioned by the Australian Medical Association (AMA) in collaboration with the Pharmaceutical Society of Australia (PSA) in 2015, conducted independently by Deloitte, did not include the benefits that would be seen if pharmacists were able to prescribe and refer. This 4 year pilot program will extend on this work.

The requirements of the pharmacist prescribing pilot have been calculated at $2.85 million across the 4 years inclusive of the development of Prescribing Guidelines, training and clinical evaluation of the pilot.

"If we leave the medical workforce as it is at the moment… we are going to leave a large amount of our population behind with easily preventable and avoidable harm that will come to them because of the distributional issues that underlie our workforce."

Professor Jennifer May, Director of the Department of Rural Health at the University of Newcastle

THE PROBLEM

People living in regional, rural and remote areas have higher rates of hospitalisations, mortality and injury compared with those living in metropolitan areas. Poorer access to primary health care services is one of the major reasons for this disparity. [i]

Rural and remote populations rely more on General Practitioners (GPs) to provide health care services, due to less availability of local specialist services. For this reason, GPs are frequently managing complex, chronic illness which in metropolitan areas would be managed by secondary care specialist services.

There are fewer GP's as geographical remoteness increases. Data in the below tables reflects the distributional inequities[ii]:

Table 1. FSE* GPs per 100,000 people across each State/Territory

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUS
Major cities	104.7	99.9	113.9	94.8	109	NA	77.1	NA	103.5
Inner regional	107.1	103.3	109.8	101.4	78.2	97.9	NP	NA	104.2
Outer regional, remote and very remote	NP	NP	96.8	77.9	85	84.2	NA	54.9	89.9

*1 FSE is a 37.5 hour working week, NP: data not published, NA: data not available

Our own local experience in Mildura, regional Victoria (MMM3) is significantly worse than what is reflected above. Our GP per 100,000 rate is one of the worst in the state when comparing like for like population size at 63 GP's per 100,000 in the same year data set as above. What we also know locally is that clinics in Mildura frequently serve the populations of surrounding areas such as Robinvale, a population which has historically been under-reported in census data, estimates are by as much as half. [iii]

Our clinic has lost 3 full time GP's over the course of the past 6 months. Two of these doctors were seeing high volumes of patients, upward of 50 each working day, 250 patients each week, the other was seeing about 125 patients each week. Extrapolated out, 625 patient appointment times each week have been lost over the last 6 months.

Each of those 625 patients are important to us, each of them waiting longer than their city counterparts to access care, potentially either going without care in that time or presenting to the emergency room for issues that could and should be dealt with in General Practice, both scenarios costing them their health, the tax payers money unnecessarily or both.

We know that the sooner a problem can be diagnosed and treated, or referred to another healthcare provider if necessary, the less likely the patient is to experience further complications that may result in hospitalisation.

Ultimately, if patients cannot access primary health care via their GP, they will self-present to our already bursting Emergency Departments (ED).

Not surprisingly, the AIHW data shows **rates of lower urgency ED presentations are markedly higher in regional areas, at 159 cases per 1000 people, compared to 92 in the cities.**

THE OPPORTUNITY

Evidence suggests that team-based care contributes to reduced hospital readmission rates and emergency department presentations.[iv] In Australia, the percentage of hospital admissions due to adverse drug events range from 5.6% in the general population to 30.4% in the elderly population.[v] Since the inception of the non-dispensing GP Pharmacist role in Australia, there have been a myriad of benefits seen and documented for patients and GP's alike.

GP Pharmacists work from within a General Practice to:

- collaborate as part of a patient's healthcare team to optimise medication therapy and achieve treatment goals
- support GPs to improve health literacy and deliver health promotion, empowering patients to work on medication self-management goals and share decision making with their regular GP
- provide medication management services, such as identifying and monitoring medication use in partnership with GPs
- deliver medication safety initiatives
- manage the stock-control systems for medicines already stored in the general practice, such as vaccines and emergency medicines.

Increasing the scope of practice of the non-dispensing GP Pharmacists to prescribe will properly reflect the role of GP Pharmacists as medication experts.

Pharmacist prescribing is an established practice in a number of countries including New Zealand, the United Kingdom, Canada and the United States of America.

An economic analysis of a proposed policy to integrate non-dispensing pharmacists into General Practice commissioned by the Australian Medical Association (AMA) in collaboration with the Pharmaceutical Society of Australia (PSA), conducted independently by Deloitte, showed very favourable financial outcomes for the tax payer. The results of the analysis demonstrated that the proposed policy would have resulted in financial savings of $544.87 million over the four years from 2015-16 to 2018-19. The policy would have delivered a benefit-cost ratio of 1.56, which means that every $1 invested in the program generates $1.56 of benefits.[vi]

This policy **did not include pharmacist prescribing** in the role of the GP Pharmacist. The 4-year pilot program we are proposing will extend on these cost savings and will significantly improve access to primary care for regional, rural and remote Australians.

A significant proportion of the appointments made for GP's by regional, rural and remote Australians are for the management of their chronic health condition. This may be for repeat prescriptions or pathology requests, to check their blood pressure or to optimise their medication management.

A GP Pharmacist has access to all of the patients file including their medical history, their medications past and present, their test results and communication from specialists. So much of what the patient needs in those appointments are well within a GP Pharmacist's skill set. In fact, it can be argued that, given that medication use is the number one intervention made in healthcare, the management of a patients chronic illness is more a GP Pharmacist's area of expertise than the GP themselves.

The intention of this pilot is to support the proposition that by expanding the scope of practice of a non-dispensing GP Pharmacist to include prescribing and referral and have this prescriber/provider number linked to rurality where workforce need is significantly greater, Australians outside of major cities will have improved access to primary care.

For the past 20 years, successive Australian governments (federal, state and territory) have supported establishment and expansion of the nurse practitioner (NP) workforce through government funded pilot projects, revision of national registration standards, revision of course accreditation standards, introduction of collaborative care arrangements – authorising nurse practitioners to use Medicare Benefits Schedule (MBS) consultation item numbers and use a wide range of MBS funded pathology tests and diagnostic imaging, prescribe certain PBS medicines and refer patients to medical specialists[vii].

Pharmacists have a much broader education in the area of medication management than NPs. Pharmacists are "generalists" by nature and education and should be afforded the same opportunities to contribute to primary healthcare.

One of the concerns generally raised regarding pharmacist prescribing is the lack of separation between prescribing and dispensing, both from a safety and pecuniary conflict of interest point of view. Until recently, there had not been a role which would adequately allow for this separation. However, with the inception of the non-dispensing GP Pharmacist role, whereby the pharmacist consults from the General Practice clinic, this separation can now be achieved.

What we propose is for pharmacists in General Practice, in Modified Monash Model (MMM) 3 and above, and in MMM 2 where the practice can demonstrate a workforce shortage, can apply for funding to be part of this pilot. These pharmacists will be able to prescribe (be awarded a PBS prescriber number) and refer for pathology (be awarded an MBS provider number) to take the burden from our GPs. We acknowledge that in some instances, State and Territory legislation or regulations would need to be amended in order to facilitate this pilot program, however these consultations are already underway.

Patients would be seen by GP Pharmacists under a collaborative care model, as shared team based care is arguably the only way we will lessen the gap between city and rural healthcare outcomes. We must utilise existing healthcare workers to their full scope of practice and work together to improve the health of our region.

PILOT PROGRAM

We recommend that the pilot program be designed so that:

- The GP Pharmacist is an AHPRA registered Pharmacist with at least five years' experience;
- The GP Pharmacist be currently employed in a General Practice setting;
- The GP Pharmacist hold Medication Management Review accreditation (this is desirable, but not essential);
- Only General Practice's located in Modified Monash Model (MMM) 3 and above, and in MMM2 where the practice can demonstrate a workforce shortage, may apply to participate in this pilot;
- Clinics are responsible for enrolling patients in the pilot program, on advice and approval from the patients usual GP; and
- The patient will have at least one chronic health condition.

The pilot should run for a period of four years, to allow adequate assessment of the longer term outcomes of this collaborative model of care.

Under this pilot program, the role of the GP Pharmacist would be to consult with patients in a shared-care capacity. The GP Pharmacist would:

- Prescribe repeat prescriptions of existing medication in a patient's regime;
- Alter doses of existing medication;
- Prescribe an alternative medication where there is an obvious inefficacy or intolerance to an existing medication in a patient's regime, where a diagnosis has already been made by the GP;
- Refer a patient for pathology to aid in medication management and monitoring.

The GP Pharmacist will require a PBS prescriber number and an MBS provider number in order to participate in the trial.

Success of the pilot should be determined by:

- Increased access to primary care, with patients enrolled in the pilot experiencing average or below average wait times;
- Patient and GP satisfaction with the model and care provided.

The pilot program should be managed by the Pharmaceutical Society of Australia (PSA). PSA, in consultation with the Department of Health and the Australian College of Rural and Remote Medicine, would identify potential clinics, and manage the grant application process.

PSA is the only Australian Government-recognised peak national professional pharmacy organisation representing all of Australia's 34,000 pharmacists working in all sectors and across all locations.

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 evidence-based healthcare service delivery by pharmacists. PSA provides high-quality practitioner development and practice support to pharmacists and is the custodian of the code of ethics, professional practice standards and guidelines to ensure quality and integrity in the practice of pharmacy.

PSA would also develop pharmacist prescribing guidelines and training to support GP Pharmacists participating in this pilot.

BUDGET IMPLICATIONS

This proposal will require a budget allocation of $2.85 million over four years. This is based on the pilot running across five clinics, with an FTE for the GP Pharmacist of 0.6 each, based on a consultant pharmacist salary of $140,000.

This also includes funding for administrative support, the development of pharmacist prescribing guidelines, the design and delivery of 3x online eLearning modules, and a clinical evaluation of the pilot program.

	2022-23	2023-24	2024-25	2025-26	Total
GP pharmacists	$578,480.00	$578,480.00	$578,480.00	$578,480.00	$2,313,920.00
Development of guidelines	$350,000.00	-	-	-	$350,000.00
Training and support	$152,600.00	-	-	-	$152,600.00
Clinical evaluation	-	-	$6,000.00	$6,000.00	$12,000.00
					$ 2,838,520.00

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[vi] Deloitte Access Economics. Analysis of non-dispensing pharmacists in general practice clinics. Barton, ACT: Deloitte, 2015.

[vii] RACGP Nurse Practitioners in primary healthcare 2022, viewed 02 January 2022, https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/health-systems-and-environmental/nurse-practitioners-in-primary-healthcare