Small Pharmacies Group
PO BOX 76
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The Pharmaceutical Society of Australia
Level 1
381 Royal Parade
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Thursday 27th October 2016

Dear Mr Demarte,

We are writing on behalf of the Small Pharmacies Group (SPG) regarding the proposal advanced by the Pharmaceutical Society of Australia regarding pharmacists in GP practices.

The Small Pharmacies Group has a membership of approximately 60 pharmacies across Australia in both rural and urban locations. We define a small pharmacy as one which dispenses less than 35,000 prescriptions per year or has an annual turnover below $1.5 million.

Our group has a number of concerns about the consequences for small pharmacies of the proposed PSA model of pharmacists in GP practices:

- PSA's prebudget submission 2016-17 outlines some of the services that a non-dispensing pharmacist in a GP practice might perform. We are particularly concerned about the services listed in the patient directed services list (p.11) that seem very similar if not virtual replications of the services that a community pharmacist can already (or could, if funded) provide. PSA's list on page 11 includes:
    - Providing in-practice referral based medicine reviews
    - Private consultations for medication based concerns
    - Documentation and patient follow-up on adverse drug events
    - Counseling on smoking cessation, lifestyle issues and medicine based activities
    - Assisting patients navigating the health system and medication changes between health settings

  Even some of the other listed services in PSA's prebudget submission (i.e. staff directed services and practice based quality assurance activities) are services which the local community pharmacy already regularly assists with. These include:
    - Responding to medicine queries
    - PBS queries
    - Sourcing medications

  - Specific medication concerns from GPs e.g. switching anticoagulants, antidepressants, opioid equivalence
  - Questions about medication formulations.

  Without clear demarcation of the roles that a pharmacist in a GP practice may serve in relation to the services performed within community pharmacy there is potential for many professional and clinical services that are currently offered in community pharmacy to be shifted to GP surgeries.
- If pharmacists in GP practices are to be paid a wage/salary (rather than a fee for service) we are wondering whether there would be any restrictions to prevent them from taking over even more services that are currently performed by community pharmacists (e.g. absence certificates, blood pressure monitoring, asthma inhaler technique demonstration).
- PSA is claiming that pharmacists in GP practice will provide benefits for community pharmacy. For example, in a recent email to members PSA claimed that this initiative would result in an "increased uptake of 6CPA-funded services in local community pharmacies e.g. MedsChecks, DAAs, HMRs, as the practice pharmacist raises awareness of, and creates referral pathways for these services". We are skeptical of this claim. We already possess anecdotal evidence indicating that the number of HMR referrals to local pharmacies has diminished where there is a pharmacist operating in a GP practice. We are concerned that this might also extend to other community pharmacy based services such as MedsChecks and Clinical Interventions. We are also finding it hard to reconcile how PSA can promote an expanded clinical role for community pharmacy (the 'Health Destination' model) but at the same time advocate for pharmacists performing very similar functions in surgeries.
- Pharmacists with overlapping functions to community pharmacists operating in GP practices can be highly problematic for small pharmacies that have worked hard to form good relations with their local surgeries and would like to develop that clinical link further. It is worth pointing out in this regard that small pharmacies often elect not to offer certain services in their pharmacies (e.g. vaccinations) so they do not undermine the viability of their local surgery. We do not think it is right (or an efficient use of taxpayer money) that surgeries should be given the opportunity and funding to hire a pharmacist in house whose role duplicates that of the nearby pharmacy.
- Large medical practices in urban areas, like the Camp Hill Medical Centre where Dr. Chris Freeman works, may see benefits to have a pharmacist on staff as the direct link to the 'local' pharmacy may not be as well developed, but it is an entirely different matter in smaller communities where there is quite likely much stronger and frequent collaboration between the local GPs and pharmacist(s).
- We do not think the PSA's model has taken adequate account of the implications for the already established and highly competent community pharmacy network in Australia and will undermine rather than complement this network. We are

concerned that this model has the potential to destabilize and marginalize community pharmacy and reduce us to performing merely a 'supply' function.
- We are also concerned that this proposal has the potential to drive a wedge between community pharmacy and GP surgeries creating a competitive environment that is divisive rather than collaborative and not actually patient focused and that it may therefore have precisely the opposite outcome to what is intended.

We consider that the PSA's model has merit in seeking to foster better links between pharmacists and doctors and in optimising pharmacists input into the health system, thus likely producing improved health outcomes for patients and hence government savings. However, we are opposed to the proposed payroll mechanism through GP practices and also question the necessity of this. As far as we know the PSA has not produced evidence to demonstrate that the actual co-location of a pharmacist in a GP practice is critical or superior in providing better health outcomes compared with a similar role for a pharmacist positioned in community pharmacy. On the contrary we contend that clinical pharmacists employed by a GP practice cannot be involved effectively in all NINE steps of the 'Medicines Management Pathway' as can a community pharmacy.[1]

In our opinion the PSA, AMA, and the Government need to adopt a much more collaborative and integrative approach with the Pharmacy Guild and community pharmacy more broadly in seeking to strengthen relationships between pharmacists and GPs for the benefit of Australian patients. We do not think that pharmacists co-located and funded through GP practices is the only or best way to achieve the desired outcomes. Instead, we propose that pharmacists who are employed in the community could take on the expanded role that the PSA envisages but have the model funded through community pharmacy not GP surgeries. We suggest that PTP funds from the 6CPA could be used to conduct trials. Pharmacies could be paid a federal government 'Pharmacy-Medical Practitioner Liaison Allowance', along with any other service fees e.g. Meds Checks, HMR's, Clinical Interventions, etc. The only stipulation may be that community pharmacies need to be patient-focused, rather than 'product at a price' focused, and development of Quality Care Pharmacy Program (QCPP) to fit this model may need to be considered. We consider that doctors should also be remunerated for the time spent consulting with pharmacists and receive incentives for referrals (in the same way they currently do for HMRs). We advance that this type of funded model would likely result in an increase in jobs for pharmacists, while also helping to address pharmacy workforce issues in terms of diversification of our clinical skills. Overall, we believe that this alternative model would help to strengthen and unify the profession as well as improving patient health outcomes and cultivating closer collaboration with GPs.

We have already written to the Pharmacy Guild regarding our views on this matter. We also look forward to hearing your response and how you think the issues that we have raised can be addressed.

[1] PSA Professional Practice Standards version 4 (2010) Appendix 1: The Medicines Management Pathway

Yours Faithfully,

The Small Pharmacies Group Steering Committee

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