Concerns about Clinical Pharmacy Funding – based on letter sent to PSA 8th August 2018

The Small Pharmacies Group has raised important questions about the GP practice model in the past. We would like it to be noted that we still feel that many of these questions have not been adequately answered. For example, it has never been explained to us why there is a need to insert a second pharmacist into a patient's health journey whereas such duplication is generally discouraged when it comes to GPs, specialists etc. Furthermore, the question lingers about how a practice pharmacist resolves the problem of our daily need to consult directly with the patient's prescribing GP. In the meantime, however, new questions have arisen regarding this model. In this letter we will focus our attention on these new matters of concern.

AJP has recently reported on the results of Chris Freeman's 2017 survey of 43 Australian pharmacists working in general practice.[i] According to this AJP article, the survey found that there were "a significant number of referrals of patients to their community pharmacy for services such as MedsChecks, DAAs and HMRs."

We have not yet seen the research to be able to assess it fully, but it would seem to us that these results must be treated with caution given that we are not currently operating in the context of a funded model for practice pharmacists.

It is interesting to compare Freeman's results with an independent review of the UK clinical pharmacist in GP practice pilot program in the UK (which is a government funded program).[ii] In this review, researchers surveyed 78 GP sites where 373 pharmacists were employed as part of the NHS England scheme. This study found that "most CPs [Clinical Pharmacists] undertook patient facing work, focusing on complex medication reviews…For 70% they classified this as a major part of their role".[iii]

If practice pharmacists were to be funded by the government here would there still be the same flow-on benefits to community pharmacy in terms of increased medicine reviews that were seen in Freeman's survey?

PSA is strongly advocating for government funding for practice pharmacists. It is not clear exactly what funding model the PSA envisages but it would appear that an MBS style model is one option that is being pursued. We are concerned that the Pharmacist in GP model together with a potential MBS access can prove to be quite detrimental to the existing Community Pharmacy network in Australia if funding is diverted from CPA to MBS by the government to fund this. It is quite probable that GP surgeries would like to capture as much of the MBS funding available before the patient leaves the surgery, including any funding through their 'in-house' pharmacist, blocking community pharmacists and pharmacies from access. PSA seems to envisage that direct to patient activities would only occupy a small amount of a practice pharmacist's time. However, patient related activities are the activities most likely to attract new government funding

and it is therefore hard to escape the conclusion that surgeries will push practice pharmacists towards funded services to make the position viable.

In the UK there have been deliberate and systematic cuts to community pharmacy funding with a lack of increasing funds and/or types of professional services for community pharmacy. At the same time, considerable amounts of funding have been invested in the GP pharmacist model. There is a limited timeframe on the government funding for practice pharmacists in the UK and that funding will eventually wind up. While there seems to be support from GPs in terms of the clinical aspect of the role, there has been acknowledgement that it is not particularly cost effective.[iv] If pharmacists are not kept on in this role, once government funding is reduced/ceased, the question arises as to where these pharmacists will find employment given that the UK community pharmacy sector has contracted.

What guarantees does the PSA have that this is not part of the agenda of the Australian government? There are notable voices such as Stephen King, the Grattan Institute, and Consumers Health Forum to name a few that appear to be thinking along these lines of a pharmacy model that splits dispensing and advice: a low cost, high volume, discount dispensing model with minimal government support, alongside government funding for embedded pharmacists in a range of settings. Where does this leave community pharmacy? Are we willing to risk our existing strong network of community pharmacies that provides access and clinical services to our communities across Australia for this alternative model that has the potential to block funding to community pharmacy and shift clinical pharmacy services away from CP and into GP practices?

Assuming there is a finite pot of public money for clinical pharmacy services – where should this money be spent? This is a question for both the PSA and the Guild. We believe that the two organizations must work together to develop a strategic plan regarding remuneration for clinical services – what services need to be government funded (what services have the highest priority) and where and how should such funding be apportioned.

In the view of many small community pharmacy owners very careful decisions need to be made about how much money should be kept within community pharmacy to ensure its ongoing viability and to make certain that the clinical capabilities of our existing network of community pharmacists are being used to their very best advantage for the benefit of Australian patients. The PSA must recognize the significant personal investment that pharmacy owners (many of whom are members of the PSA) make to facilitate the system that Australians currently enjoy. As you know, SPG does not accept the view that clinical pharmacy services are better delivered from a GP surgery. There is no evidence to show that co-location of a pharmacist in a GP practice is essential to achieve the health outcomes and certainly no studies to show that delivery of such services in a GP setting provides better health outcomes and is more cost effective than delivery in a community pharmacy as no comparative studies have been undertaken. Given that the public purse is

finite and that we already have a strong existing network of community pharmacies across Australia, surely it makes sense to direct the bulk of clinical service funding towards community pharmacy?

Thorough consideration must also be given to the type of funding mechanism that is used to fund clinical pharmacy services. There are obvious problems with the current system of payment for HMRs and Medschecks as funding caps and service provision rules mean that some patients are missing out. There are also problems with "fee-for-service" models such as MBS style payments as such systems can easily be abused by unscrupulous providers. Such models incentivize throughput rather than health outcomes. There is a need to design a payment system that encourages best practice. We also need a payment model that addresses the issue of health disadvantage and ensures that government money is being spent on the patients who need it most.

Lastly, we feel compelled to raise concerns about the Workforce Incentive Program that was announced in the last budget. Members of SPG were not aware that PSA was pursuing this measure and are concerned by the apparent lack of consultation. Both PSA and the government have suggested that community pharmacies can be contracted to provide these services. However, if community pharmacy is placed in a position where it must tender for these services to GP surgeries we are likely to see a similar pattern as to what has happened with aged care - a race to the bottom to provide the cheapest service. How is this good for community pharmacy or for patients? It is also foreseeable that PSA's model may lead to script channeling back to the community pharmacy providing services. How does PSA propose to address this problem?

PSA claims that it wants a collaborative approach, yet policy is being developed without consultation with community pharmacy. In this regard it is worth noting that one of the identified shortcomings of the UK pharmacist in GP practice pilot program is that there are "poor or no links to community pharmacy" on a policy level.[v] Some stakeholders "felt that a big weakness was lack of engagement with community pharmacy in the process".[vi] For those who are worried that the model may worsen rural workforce shortages, this study also identifies that "the clinical pharmacist in general practice role is already causing variance and potentially gaps in the wider pharmacy workforce".[vii]

In conclusion we would like to reiterate the need for greater transparency and more careful and collaborative strategic planning between the PSA and the Guild when it comes to mapping out the future of clinical pharmacy services – in terms of what services should be funded, who should be delivering them, where they should be delivered and how they should be funded. If the two organizations could find some common ground on these matters our profession and Australian patients would be so much the better for it. We understand that the PSA wants to see pharmacists working to their full potential and think that the Guild needs to open itself up to the PSA's input in designing clinical services. But at the same time the PSA must acknowledge that there are legitimate concerns about the embedded pharmacist model and allow for more open debate about its merits and shortcomings - it is not reasonable to describe legitimate concerns as "baseless

fear mongering."[viii] PSA must also recognize that their relentless pursuit of alternative models for the delivery of clinical pharmacy services is an ongoing disappointment to the pharmacies around Australia who are already working very hard to deliver these services often without remuneration and who are willing and ready to do more if only there was appropriate support from our representative bodies.

[i] https://ajp.com.au/news/we-have-waited-far-too-long-for-this-to-occur/
[ii] Clinical Pharmacists in General Practice: Pilot Scheme Independent Evaluation Report: Full Report June 2018 https://www.nottingham.ac.uk/pharmacy/documents/generalpracticeyearfwdrev/clinical-pharmacists-in-general-practice-pilot-scheme-full-report.pdf
[iii] Clinical Pharmacists in General Practice: Pilot Scheme Independent Evaluation Report, p.18
[iv] Clinical Pharmacists in General Practice: Pilot Scheme Independent Evaluation Report, e.g. p.20
[v] Clinical Pharmacists in General Practice: Pilot Scheme Independent Evaluation Report, p. 76
[vi] Clinical Pharmacists in General Practice: Pilot Scheme Independent Evaluation Report, p. 78.
[vii] Clinical Pharmacists in General Practice: Pilot Scheme Independent Evaluation Report, p. 30.
[viii] https://ajp.com.au/news/we-have-waited-far-too-long-for-this-to-occur/