The Pharmacy Guild of Australia

SUBMISSION

Productivity Commission: Productivity Inquiry

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National Secretariat

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ABOUT THE GUILD

The Pharmacy Guild of Australia (the Guild) is the national peak organisation representing community pharmacy. It supports community pharmacy in its role of delivering quality health outcomes for all Australians. It strives to promote, maintain and support community pharmacies as the appropriate providers of primary healthcare to the community through optimum therapeutic use of medicines, medicines management and related services. Community pharmacies are the most frequently accessed and most accessible health destination, with over 462 million individual patient visits annually and the vast majority of pharmacies open after-hours, including on weekends[1].

Owned by pharmacists, community pharmacies exist in well-distributed and accessible locations, and often operate over extended hours, seven days a week in urban, regional, rural and remote areas. They provide timely, convenient and affordable access to the quality and safe provision of medicines and healthcare services by pharmacists who are highly skilled and qualified health professionals. 88% of people in metropolitan and regional areas have access to at least 1 pharmacy within a 2.5km radius.[2]

The network of over 5,800 equitably distributed community pharmacies plays a pivotal role in the delivery of the National Medicines Policy, by ensuring timely access to safe, effective and affordable medicines under the Pharmaceutical Benefits Scheme (PBS) for all Australians. Quality Use of Medicines is an important pillar of Australian National Medicines Policy, with community pharmacy having a vital role supporting ageing Australians who are at high risk of medication misadventure due to multiple co-morbidities and complex medicine regimens.

[1] PBS Date of Supply, Guild Digest, https://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0

[2] The Pharmacy Guild of Australia 2020

GUILD RESPONSE TO TERMS OF REFERENCE

Recommendations

TOR 1

1.1 Commonwealth and State and Territory governments reform health policies and regulations to enable all healthcare practitioners to work to their full scope of professional practice.
1.2 Commonwealth and State and Territory governments further incentivise the employment of health professionals in regional, rural and remote Australia.

TOR 2

2.1 State and Territory governments amend regulations and establish funding arrangements to enable pharmacists to fully contribute to the National Immunisation Program alongside other healthcare practitioners.
2.2 Commonwealth revise budgets and widen the eligibility criteria for the rural pharmacy workforce schemes, provide greater Commonwealth Supported Places funding for pharmacy students, and include pharmacy students in tertiary debt-waiving schemes.

TOR 3

3.1 State and Territory governments remove regulatory barriers limiting the range of vaccines and ages for which pharmacists can administer vaccines.
3.2 Comprehensive regulatory and business impact assessment be conducted prior to implementing significant changes to digital health technologies and workflows.
3.3 PBAC to recommend the list of medicines in the Emergency Measures (Schedule 1) be maintained in permanent Continued Dispensing and complementary emergency supply arrangements, adopted nationally and by States and Territories.
3.4 Community pharmacies be authorised to provide a greater range of Point of Care and supervised testing services to the general public.
3.5 Administrative payments be increased to a commensurate level for pharmacists and improve payment timeframes to match MBS timeframes.

TOR 4

4.1 Reform the electronic prescribing system as a critical digital infrastructure including establishing a funding model that is fair, equitable and recognises all users and beneficiaries of the system.

TOR 5

5.1 Commonwealth and State and Territory governments to implement the Guild’s recommendations in its submission to the Productivity Commission’s Study of Vulnerable Supply Chains.
5.2 Include pharmacists on the Medium Long-Term Strategic Skills List (MLTSSL) to encourage international pharmacists to migrate to Australia, to address the critical shortage of pharmacists.
5.3 Greater transparency and community pharmacist representation on Commonwealth committees relating to medicines including the PBAC, the Primary Health Reform Steering Group and ATAGI.

TOR 6

6.1 Intergovernmental collaboration to be systemised through a COAG-like forum to promote consistent policy, regulation and programs.

6.2 Remove funding limitations such as service caps on Community Pharmacy Programs from Community Pharmacy Agreements to enable more equitable patient access to healthcare.

6.3 Continue funding small businesses to transition out of the pandemic through programs such as the Regional Recovery Small Business Support Program.

6.4 Commonwealth and State and Territory governments to reform primary health care for patients with alcohol and other drug issues by:

- Authorising pharmacists to administer Long-Acting Injectable Buprenorphine;
- Establishing collaborative prescribing models for Schedule 8 medicines for opioid replacement therapy;
- Funding a National Opioid Dependence Treatment (ODT) Program under the PBS.

6.5 Invest in preventive health initiatives in community pharmacy including assessment and treatment of common conditions within scope of practice, and rolling out mental health first aid through community pharmacies nationally.

TOR 1. Analyse Australia's productivity performance in both the market and non-market sectors, including an assessment of the settings for productive investment in human and physical capital and how they can be improved to lift productivity.

Guild Response

Productivity in the primary health care sector can be enhanced by ensuring all health care practitioners are working to their full scope of practice. This requires the relevant health professions identifying and enhancing the professional and competency standards for their particular profession and for policy and law makers to ensure health policies and regulations enable full scope of professional practice.

The prime responsibility of community pharmacies is to deliver best practice in primary care and medicine use. Community pharmacies play a critical role in ensuring access to and the quality use of medicines and other pharmaceuticals. This includes both prescription and non-prescription medicines, therapeutic devices and associated support services – including for subsidised schemes such as the Pharmaceutical Benefits Scheme (PBS), the Repatriation Pharmaceutical Benefits Scheme (RPBS), the National Diabetes Services Scheme (NDSS) and increasingly, the National Immunisation Program (NIP).

Community pharmacies provide a range of services that support the quality use of medicines, including services subsidised as part of the Seventh Community Pharmacy Agreement (7CPA) such as Dose Administration Aids (DAA), Staged Supply and medicines reviews such as an in-pharmacy MedsCheck, Home Medicines Review (HMR) or Residential Medication Management Review (RMMR). Community pharmacies also are a common and convenient destination for an extensive range of primary health care services such as – vaccinations, assessment and treatment for common ailments (e.g., coughs and colds, aches and pains, eye, ear and skin conditions, hay fever, cold sores, hair lice), baby care, first aid care, skin care, sports care and the supply of independent living and mobility aids.

In providing these services, community pharmacies often operate with extended trading hours during evenings, weekends and public holidays, including in many regional locations. In rural and remote areas, the pharmacist may be the only primary health care provider in the community. More and more we are seeing 24-hour pharmacies being established in major cities, often supported by State Government funding and services.[3] This makes community pharmacies the most accessible primary health care provider in the country, and they are critical to increasing timely access to the health system.

As the public awareness of the range of services that a community pharmacy can offer increases, so does the uptake and satisfaction with the accessibility and convenience of pharmacists as primary health care professionals and integral members of a person's health care team. Australia's health system is under enormous pressure and requires all health professionals to work together and to their full scope to ensure we are meeting the needs of the Australian population.

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[3] Better Health Channel Victoria, Victorian Supercare Pharmacies, https://www.betterhealth.vic.gov.au/health/servicesandsupport/victorian-supercare-pharmacies

Scope of practice

The Guild has commissioned a report conducted by EY (yet to be published) , that quantifies health-related and economy-wide benefits of pharmacists working to their full scope of practice across ten acute, chronic and vaccine-preventable conditions. The evaluation framework has considered reduced healthcare costs to the broader health system, productivity gains arising from reduced absenteeism and presenteeism and improvements in health-related quality of life through reduced time in ill-health and improved medication adherence. Preliminary economic analysis indicates that if pharmacists were authorised to work to their full scope of practice across these conditions it would generate the following quantitative benefits in the next financial year:

- a total dollar benefit of $4.15b;
- of which, a total productivity dollar benefit of $751m arising from reduced absenteeism and presenteeism; and
- a total time-saving benefit of 5,800,000 consultations in primary care, 38,000 hours in emergency services, and 346,000 days in hospital care.

If States and Territories could enact regulatory amendments to authorise these activities, it would be a significant investment in the human capital of a key part of the health sector. The economic analysis conducted by EY does not take into costs arising from this regulatory amendment. As such, the cost may include remuneration and/or payment models, additional pharmacists training programs, and cost associated with modifying premises to provide services at a pharmacy. Each State and Territory regulatory body will require additional considerations of costs based on the current practice, local guidelines, and available infrastructure. The full report will be forwarded to the Productivity Commission once published.

Community pharmacies need to be supported to provide such services. Increasingly we are seeing reports of community pharmacies being overstretched by administrative requirements, a lack of staff or the training requirements for new staff and continuous professional development. In addition, long hours of availability and stress are commonplace among community pharmacy staff as they remain open to meet their communities' needs.

Flexibility in regional, rural and remote areas

Regional, rural and remote flexibility must also be addressed in order to lift productivity, including creating incentives for individuals to work in these locations. The health needs of patients vary widely across regions with higher burden of disease being associated with a lower socioeconomic demographic and increased rurality. There is a great need for custom-made variations in the allocation of resources and workforce across regional, rural and remote areas, and a more flexible approach to funding and models of healthcare in these areas would lift productivity.

Guild Recommendations

1.1 Commonwealth and State and Territory governments reform health policies and regulations to enable all healthcare practitioners to work to their full scope of professional practice as stipulated by the respective registration Board.

1.2 Commonwealth and State and Territory governments further incentivise the employment of health professionals in regional, rural and remote Australia.

TOR 2. Identify forces shaping Australia's productivity challenge as a result of the COVID-19 pandemic and policy response.

Guild Response

As communities went into lockdown to reduce the spread of COVID-19 from early 2020, community pharmacy was recognised as a critical service provider and remained exempt from lockdown requirements, remaining open to provide their communities with continuous access to medicines and pharmaceutical services.

COVID-19 has seen a number of policy and regulatory changes to increase the capability and productivity of community pharmacies to assist their communities, including:

- Recognition by all States and Territories and the Commonwealth for pharmacists to administer COVID-19 vaccines for adults and children; and despite a late start for community pharmacy involvement (from 12 July 2021, some 5 months after the program started in February 2021), at the time of writing, community pharmacists have administered over 6 million COVID-19 vaccines.

- Recognition by the Therapeutic Goods Administration for community pharmacies to not only supply COVID-19 rapid antigen tests, but to conduct point-of-care testing for the public[4].

- Changes to Commonwealth, State and Territory legislation to enable community pharmacies to substitute medicines (including PBS and TPBS medicines) according to a Serious Scarcity Notification[5] published by the TGA to manage medicine supply disruptions.

- The extension of expanded Continued Dispensing arrangements (covering the whole PBS/RPBS General Schedule) that had been implemented by the Commonwealth and States and Territories in response to the 2019/20 bushfires. This interim extension is currently in place until 30 June 2022 and enables community pharmacies to supply a standard PBS pack of medicine in the absence of a prescription to ensure a person's treatment is not disrupted because they cannot practically renew their prescription[6]. It has recently been announced that expanded Continued Dispensing arrangements will be made permanent, however the list of medicines that can be dispensed is significantly smaller than is currently accessible under the Continued Dispensing Emergency Measures. This risks interruption of care for patients if they are unable to obtain a prescription from their doctor and have run out of their medication.

- The introduction by the Commonwealth of a Home Medicines Service supporting the home delivery of PBS and RPBS medicines and other pharmaceuticals, ensuring people who were in quarantine, isolation, or avoiding public exposure can access their medicines[7].

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[4] COVID-19 point-of-care tests | Therapeutic Goods Administration (TGA)
[5] https://www.tga.gov.au/serious-shortage-medicine-substitution-notices
[6] https://www.pbs.gov.au/pbs/news/2020/03/continued-dispensing-arrangements-covid-19
[7] https://www.health.gov.au/sites/default/files/documents/2020/03/covid-19-national-health-plan-home-medicines-services-information-for-consumers.pdf

- The implementation by the Commonwealth and States and Territories of exemptions that recognised image-based prescriptions (e.g. faxed versions) as a valid prescription for dispensing and claiming purposes[8]. This was discontinued on 31 March 2022 for community-based prescribing with the increased availability of electronic prescribing.

- An exemption by the Commonwealth for patient signatures for PBS and RPBS prescriptions and NDSS items to minimise the risk of COVID-19 transmission between pharmacy staff and patients.

These policy and regulatory changes demonstrate the potential of the community pharmacy network when not constrained by regulatory limitations regarding vaccination and other areas within pharmacists' scope of practice.

From a productivity perspective, it should be noted that such advances required collaboration between Commonwealth and State and Territory governments. The supply of medicines is highly regulated involving the TGA (Commonwealth) for registration and general regulations, States and Territories' regulatory access within their jurisdictions, and the Departments of Health and Veterans' Affairs regulating access to subsidised medicines via the PBS and RPBS respectively. Prior to the pandemic, it took significant periods of time to standardise arrangements across the country. This was seen with the original limited Continued Dispensing arrangements which were implemented by the Commonwealth in 2012, and at various times in the States and Territories from 2013 to 2017.

Similarly, authorising pharmacists to administer influenza vaccines took many years to be implemented in all jurisdictions, and Queensland remains the outlier for authorising pharmacists to administer as part of the National Immunisation Program (NIP). By contrast, the urgency associated with COVID-19 saw the Commonwealth and States and Territories working together to quickly enable the above changes so arrangements have been mostly consistent across the country.

COVID-19 impacts on workforce

The community pharmacy workforce has been affected in various ways by the COVID-19 pandemic which may have impacts on ongoing productivity in the sector. Firstly, pharmacists and pharmacy assistants have experienced high levels of anxiety regarding individual health and safety and have been dealing with angry and abusive consumers due to medicine shortages or supply restrictions. Medicines shortages have been a long-term problem but have recently been exacerbated by COVID-related disruptions.

Burnout of staff is a major issue with high workloads, long hours due to furloughing of staff, an inability to take leave due to domestic and international border closures which prevented locums from travelling to relieve staff, and a reduced workforce pipeline. This particularly affected pharmacies in regional, rural and remote areas. Border closures also had an impact on the ability of pharmacists in border regions to attend work or deliver patient services such as facilitating care in Residential Aged Care Facilities.

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[8] https://www.pbs.gov.au/pbs/news/2021/12/extension-to-image-based-prescription

Pharmacist shortages are now evident across all areas. Raven's Recruitment Pharmacy Market Report in November 2021 states that pharmacy is facing significant workforce challenges, and that during 2021, the number of positions available and time taken to fill has increased considerably across all regional, rural and metropolitan areas.[9] The following workforce planning measures are needed to avoid future undersupply of pharmacists:

- Increasing the budgets and fees to participants for the Rural Pharmacy Scholarship and Mentor Schemes, and Rural Student Placement Allowance scheme, and expanding the eligibility criteria from Modified Monash (MM) category 3 areas to include participants from MM 2 areas;

- Creating a new Experienced Pharmacist Incentive Program to enable rural pharmacies to recruit experienced pharmacists or retain interns as full-time employees following the end of their internships;

- Moving Pharmacy courses from the Commonwealth Supported Places Funding Cluster 2 to Funding Cluster 3, which would enable universities to fund more places for pharmacy students.

Pharmacists must be considered in any health professional workforce strategy. A pharmacy cannot operate without a registered pharmacist in attendance. There are multiple reports of pharmacies closing their doors or reducing hours due to the lack of availability of pharmacists to work. This impacts the community's access to medicines and pharmacy services putting health outcomes at risk. Recently there have been announcements by the government in support of the medical and nursing workforce, such as waiving HECS debts.[10] These solutions need to be considered in terms of the entire health workforce needed to work as part of a patient's healthcare team.

Guild Recommendations

2.1 State and Territory governments amend regulations and establish funding arrangements to enable pharmacists to fully contribute to the National Immunisation Program alongside other healthcare practitioners.

2.2 Commonwealth revise budgets and widen the eligibility criteria for the rural pharmacy workforce schemes, provide greater Commonwealth Supported Places funding for pharmacy students, and include pharmacy students in tertiary debt-waiving schemes.

[9] Raven's Recruitment (2021), The Pharmacy Salary and Market Report 2021.

[10] Australian Government Department of Health, HELP for Rural Doctors and Nurse Practitioners, https://www.health.gov.au/initiatives-and-programs/help-for-rural-doctors-and-nurse-practitioners

TOR 3. Consider the opportunities created for improvements in productivity as a result of Australia's COVID-19 experience, especially through changes in Australia's labour markets, delivery of services (including retail, health and education) and digital adoption.

Guild Response

The Guild highlights the following opportunities that have been created for improvements in productivity as a result of Australia's COVID-19 experience.

Scope of practice

As stated in the International Pharmaceutical Federation (FIP) Vision statement 2020-2025, "the COVID-19 pandemic has demonstrated the essential role of pharmacies and pharmacists in our communities and their ability to innovate healthcare solutions. We must ensure their role continues to be recognised beyond the pandemic."[11]

A 2014 report by the Grattan Institute stated that pharmacists are among the most trusted of all professionals, are found in most communities throughout Australia and are accessible to patients without a long wait. Yet, compared to several other countries, pharmacists in Australia are still not able to practise to their full scope of practice.[12] The main gaps are in areas such as the administration of vaccines, therapeutic substitution, prescribing and laboratory testing. Australia lags behind countries with equivalent economies and health systems such as Canada, the UK, Ireland, the USA and New Zealand where there are examples of these practices being undertaken by pharmacists, and Australia's COVID-19 experience has highlighted these opportunities.

In 2021 the Organisation for Economic Cooperation and Development (OECD) stated that the pandemic had highlighted the "importance of investing more to strengthen the resilience and preparedness of health systems".[13] In the same report, the OECD remarked that even before the pandemic community pharmacists were "increasingly providing direct care to patients (such as vaccinations, medicine adherence and chronic disease management support, and home medication review)" and that due to the pandemic "pharmacists have been given greater scope including extending prescriptions, enabling electronic prescription transfer and, in some cases, prescribing medicines for certain chronic conditions".

Pharmacists have the knowledge, skills and professional accountability to prescribe, dispense, administer and review medicines. Pharmacists are underutilised by legislative barriers currently limiting their scope of practice.

Policy and regulatory changes require collaboration between Commonwealth and State and Territory governments to enable community pharmacies to practice to their full scope, and such changes will increase the productivity of Australia's health system.

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[11] International Pharmaceutical Federation (FIP) Vision 2020-2025, Pharmacists at the heart of our communities

[12] Grattan Institute submission No 21 to the Victorian Legislative Council, Letting pharmacists do more, June 2014

[13] OECD (2021), *Health at a Glance 2021: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/ae3016b9-en

As mentioned in TOR1, the EY opportunity assessment report quantifies the economic and health outcome benefits of pharmacists working to their full scope of practice across ten conditions. Total productivity dollar benefits of $751m are estimated due to reduced absenteeism and presenteeism across these conditions and a total economic dollar benefit of $4.15b. These indicative benefits could be further extrapolated to provide quantification of the contribution across all conditions and activities that are within pharmacists' current scope of practice and require regulatory amendment to achieve.

Vaccinations

The significant impact of pharmacist administration on the uptake of the COVID-19 vaccine is an opportunity to increase overall vaccination rates across all vaccine preventable diseases for all ages. Pharmacists have demonstrated the quality and safe provision of vaccines to children and adults and should be enabled through regulatory amendments and funding arrangements to fully contribute to the National Immunisation Program, to greatly improve vaccination rates and potentially preventable hospitalisations.

Pharmacists have been administering influenza vaccines since 2014 (2016 for all States and Territories), but the range of vaccines available in pharmacies has been very limited as governments have been slow to allow pharmacists to administer more vaccines. Pharmacists are trained through State and Territory Department of Health endorsed training courses in vaccinating for a broader range of preventable diseases, but State and Territory legislation inhibits pharmacists from delivering certain vaccinations. Australia's COVID-19 experience has demonstrated that community pharmacists are capable of safely administering vaccines to adults and children, and that allowing community pharmacists to deliver the full range of vaccines to all ages will greatly improve vaccination rates for vaccine-preventable diseases, and potentially preventable hospitalisations. This intention is supported by the Commonwealth Government in Clause 12.2 of the Seventh Community Pharmacy Agreement which states that "a nationally consistent approach be adopted in relation to appropriately trained registered pharmacists administering vaccines included on the National Immunisation Program Schedule, as appropriate."[14]

Throughout the pandemic pharmacists have provided over 6 million COVID-19 vaccinations,[15] demonstrating their competency in managing vaccination services and therefore the regulatory barriers for limiting the range of vaccines and ages should be removed. Similarly, other non-vaccine injectables such as long-acting buprenorphine, denosumab and vitamin B12 are administered via intramuscular injection which is an administration technique that pharmacists are trained and competent to execute. Enabling pharmacists to utilise this skill for other injectable medicines (with appropriate disease based professional development) should be considered to maximise the contribution of this skilled workforce.

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[14] Pharmacy Guild of Australia, Seventh Community Pharmacy Agreement, https://www.guild.org.au/__data/assets/pdf_file/0028/93655/20200611-7CPA-signed-Agreement.pdf

[15] Pharmacy Guild of Australia, https://www.guild.org.au/news-events/news/2022/6-million-covid-19-vaccinations-delivered-through-community-pharmacies

Digital adoption

During the pandemic pharmacies have adapted to using a network of digital platforms required to provide vaccinations and other services such as the Australian Immunisation Register (AIR), Health Professional Online Services (HPOS), Provider Digital Access (PRODA) and My Health Record, proving their capability to leverage digital technologies when providing new services to their communities. During this period, community pharmacies have also responded to the adoption of new digital health policies, most notably being the implementation of electronic prescriptions (ePrescriptions) and electronic medication charts (eCharts) and Active Ingredient Prescribing (AIP).

Responding to all of these changes has not been without difficulty, and has placed, and continues to place a significant burden on the sector at a time when pharmacies have been fully engaged in other COVID-related responses, including vaccination and testing.

Electronic prescriptions (ePrescriptions) provide significant benefits for consumers and considerable benefits to prescribers. There are far less direct benefits for community pharmacy, and yet as the final interface between the health care system and the consumer for the provision of medicines, there has been a significant additional workload placed on community pharmacies.

The introduction of ePrescription tokens and the roll-out of the Active Script List (ASL) which is currently underway has meant a significant shift in the workflow within a community pharmacy. This has required investment in technology, in new hardware and software, and dispensary staffing resources. It has required significant investment in terms of direct financial outlay as well as indirect business costs which have not been recognised by Government through any additional remuneration. The new systems require significant time informing and educating patients without any recognition of the substantial time impost for such a service.

Likewise, the Department of Health expected Active Ingredient Prescribing (AIP) policy to be largely a policy for adoption by prescribers with little impact on pharmacy. Early into the changes it was evident that active ingredient prescriptions were being issued which could not easily be interpreted by pharmacists, requiring either clarification from the prescriber, increasing the workload of both pharmacists and prescribers, or potentially delaying patient access to their medicine if the prescriber could not be contacted. At worst, there was reported prescribing errors which could potentially result in the wrong medicine being dispensed to the patient.

The Australian Commission for Safety and Quality in Healthcare (ACSQHC) has been engaged by the Australian Government Department of Health to develop resources and identify exemptions to AIP requirements in the interests of patient safety, but there had been very little engagement with other stakeholders. At the behest of the Guild, the Department of Health formed a working group consisting of Department representatives, pharmacy and prescriber groups and medical software representatives to review identified issues with a view to software adoption and providing information to the ACSQHC for safety modifications, both of which took time to implement.

In light of the above, the Guild recommends that Governments at all levels undertake a more comprehensive process for assessing regulatory and business impacts in the future, prior to implementing or imposing significant changes in regard to digital health technologies and workflows.

Continued Dispensing

Continued Dispensing arrangements have enabled community pharmacies to assist Australians who have an urgent need of their regular medicine when they are without a valid prescription and are unable to attend a prescriber in a timely manner to obtain a prescription. The importance of Continued Dispensing has been demonstrated during the pandemic and the Guild is unaware of any safety issues or problems arising from the expanded measure. The arrangements implemented for COVID-19 have meant that community pharmacists have been able to assist people recently affected by the 2022 floods in Northern NSW and Queensland, as many of them had to evacuate urgently without time to collect valuables or personal items, including medicines. Additionally, there are other emergency situations, such as domestic violence, where patients are displaced from their homes and are unable to access a prescriber in a timely matter. Beyond the COVID-19 pandemic, natural disasters and other emergencies, patients will continue to experience ongoing challenges in accessing a prescriber in a timely manner due to an ageing population, increased incidence of chronic disease and workforce pressures.[16] This may be more pronounced in regional, rural and remote locations where inequitable access to healthcare is already an issue.

The provision for continued dispensing has just been made permanent from 1 July 2022[17], however the medicines that a pharmacist can supply under permanent Continued Dispensing arrangements has been significantly reduced compared to the current National Health (Continued Dispensing – Emergency Measures) Determination 2020. The Guild calls for the PBAC to recommend the list of medicines in the Emergency Measures (Schedule 1) be maintained in permanent Continued Dispensing and complementary emergency supply arrangements, adopted nationally and by States and Territories; this will deliver better health outcomes for patients, help prevent avoidable hospital presentations, and in some situations, save lives. It will also ensure that when patients are unable to access a prescriber in a timely manner or a future disaster hits, there is no delay in providing people with urgent access to their medicines.

Provision of rapid antigen tests (RATs)

Community pharmacies have delivered the COVID-19 Rapid Test Concessional Access (CRTCA) on behalf of the Australian government and National Cabinet, demonstrating the innovation and agility of the community pharmacy sector to implement and deliver urgent programs according to public health responses. The community pharmacy sector anticipated a need and strongly urged for policy changes to allow for the supply of self-test Rapid Antigen Tests (RATs), and when the business rules for this program were released, a digital system was rapidly put in place and the associated software platform ProjectCOVID[18] was quickly adopted by pharmacies. As at 25 March 2022, 5,500 pharmacies have supplied over 25 million RATs to eligible patients under this program, which 94 percent of pharmacies have participated in.[19]

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[16] https://www.aihw.gov.au/reports/australias-health/primary-health-care

[17] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/australian-pharmacy-professional-conference-2022-gold-coast

[18] GuildLink, ProjectCOVID, https://ng.guildcare.com.au/projectcovid

[19] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/australian-pharmacy-professional-conference-2022-gold-coast

COVID-19 Testing

Community pharmacies can play a greater role in providing Point of Care and supervised testing services to the general public, as demonstrated by their provision of COVID-19 Point of Care (PoC) tests and supervised RATs. Community pharmacists have administered these tests within pharmacies and in professional workplace settings during the pandemic, and the TGA has recognised pharmacies as providers of these tests along with other trained health practitioners.[20]

Medicine delivery

Community pharmacies have been providing the temporary COVID-19 Home Medicines Service since 2021 to deliver critical medicines to COVID-19 affected consumers.21 This has demonstrated the adaptability and capability of community pharmacies, and there will be a need for medicine delivery services in future times of crisis.

However, any programs funding medicine delivery services should be improved to ensure that the pharmacy administration time and incurred costs are supported with a reasonable, financially viable fee, so that all Australians, regardless of their location, financial situation, prescribed medicines or health condition can continue to access their medicines in times of crisis. For this program, funding criteria for home deliveries is limited to once per month per patient, however there may have been other deliveries outside of these, with costs either absorbed by the pharmacy or paid for by patient. We also note that the funding amount only covers the postage/courier costs and not the administrative costs incurred by the pharmacy, not recognising that some patients may require multiple deliveries per month, for example people who use weekly dose administration aids.

Administrative platforms

There are opportunities for improving administrative platforms.

We note that general practitioners (GPs) can utilise the Medicare Benefits Schedule (MBS) to claim payments for providing services, however community pharmacists cannot. This presents issues where pharmacies require payment for providing services such as COVID-19 vaccinations or participating in the Concessional RAT program. Fortunately, in these cases existing systems were able to be adapted at short notice to support the administration of pharmacist claiming and payments.[22]

Whilst the PBS Online administrative system is effective in certain aspects such as allowing real time claim feedback via an alert system, payment timeframes should be improved. Currently payment timeframes for PBS Online are within 2-9 days of pharmacist dispensing, compared with Medicare payments for GPs being processed within a more efficient 1-2 days. We also note that the National Diabetes Services Scheme (NDSS) Administrative payments are an insufficient $1 per transaction, and are paid monthly in arrears. Such payments should be increased to a commensurate level and paid to service providers within 1-2 days.

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[20] Therapeutic Goods Administration, Q&As - Conditions of supply for rapid antigen point of care COVID-19 tests, https://www.tga.gov.au/qas-conditions-supply-rapid-antigen-point-care-covid-19-tests

[21] Pharmacy Programs Administrator, COVID-19 Home Medicines Service, https://www.ppaonline.com.au/programs/covid-19-programs/covid-19-home-medicine-service

[22] Pharmacy Programs Administrator, COVID-19 Rapid Test Concessional Access (CRTCA) Program, https://www.ppaonline.com.au/programs/covid-19-programs/covid-19-rapid-test-concessional-access

Guild Recommendations

3.1 State and Territory governments remove regulatory barriers limiting the range of vaccines and ages for which pharmacists can administer vaccines.

3.2 Comprehensive regulatory and business impact assessment be conducted prior to implementing significant changes to digital health technologies and workflows.

3.3 PBAC to recommend the list of medicines in the Emergency Measures (Schedule 1) be maintained in permanent Continued Dispensing and complementary emergency supply arrangements, adopted nationally and by States and Territories.

3.4 Community pharmacies be authorised to provide a greater range of Point of Care and supervised testing services to the general public.

3.5 Administrative payments be increased to a commensurate level for pharmacists and improve payment timeframes to match MBS timeframes.

TOR 4. Identify priority sectors for reform (including but not limited to data and digital innovation and workforce skills) and benchmark Australian priority sectors against international comparators to quantify the required improvement.

Guild Response

We recommend that Commonwealth and State and Territory governments collaborate to make policy and regulatory changes to enable all healthcare practitioners to practise to their full scope. This should be a priority to improve efficiency and productivity in the health system as a whole. For example, in the primary health care sector, community pharmacists should be more involved in the following areas and governments should support investment in developing workforce skills in these areas.

- Managing non-complex common ailments
- Renewing prescriptions for chronic health conditions for stable patients
- Supporting self-management of many uncomplicated health conditions through pharmacist prescribing, preparing, monitoring and reviewing management plans (e.g., asthma management plan) & ordering appropriate health tests for conditions including UTI, dyslipidaemia, asthma, diabetes, CVD
- Vaccination for all ages for all vaccines as part of the NIP
- Travel care – including being able to prescribe preventable travel medicines (e.g. for malaria) and vaccines according to established clinical guidelines
- Pharmacist administration of (non-vaccine) injectable medicines, for example Long-Acting Injectable Buprenorphine (LAIB), depot medroxyprogesterone, vitamin B_{12}, denosumab
- Down-scheduling more appropriate Schedule 4 (S4) medicines to Schedule 3 (S3), which has previously been done for specific medicines including mometasone topical ointment for inflammatory skin disorders, triptans for migraine, and melatonin for insomnia. However, there have been missed opportunities such as the decision not to down-schedule the oral contraceptive (OC) pill.[23] Down-scheduling medicines to S3 improves patient access while requiring oversight and intervention by a pharmacist to ensure safe and appropriate use.

Australia's medicine scheduling system ensures that sufficient controls are in place to manage safety/misuse risks while enhancing patient access. Medicines are not a normal commodity and can be dangerous if used incorrectly or inappropriately, and it is therefore important to enhance their availability through community pharmacy. Productivity can be improved by supporting the training of pharmacy personnel including pharmacists and pharmacy assistants, and enforcing strict clinical governance and quality assurance measures through an accreditation system such as the Quality Care Pharmacy Program (QCPP).[24]

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[23] Pharmacy Guild of Australia, Oral contraceptive decision "regrettable", https://www.guild.org.au/news-events/news/forefront/v12n01/oral-contraceptive-decision-regrettable

[24] Quality Care Pharmacy Program, https://www.qcpp.com/

Digital Health

In regard to digital health, we recommend reforming the electronic prescribing system as a critical digital infrastructure. Currently the projected benefits and efficiencies of electronic prescribing are being experienced by patients and the Government from health sector savings, but are not being realised or experienced by community pharmacies. This needs to be addressed to ensure the sustainability of this heavily invested digital health initiative. The ongoing transition to electronic prescribing is occurring without financial support, has required community pharmacies to make major changes to clinical and business workflow, and has required significant re-investment into new pharmacy IT infrastructure.

We note that the Prescription Delivery Service (PDS) and Prescription Exchange Service (PES) are core components of the national digital health infrastructure providing for the exchange and delivery of essential prescription medicine information to clinicians and consumers, supporting patient medication safety and clinical decision making across many healthcare settings. This infrastructure increasingly supports clinicians to deliver primary care and harm minimisation, and any under-funding would compromise the integrity of the system and patient safety. Currently the Electronic Prescription Fee is funded at 15 cents per eligible prescription transaction.

The system must be supported by a funding model that is fair, equitable and recognises all users and beneficiaries of the system. The PDS/PES is an essential infrastructure for community pharmacists to dispense medicines to their patients and therefore should be officially recognised by government as essential infrastructure whereby all community pharmacies have equitable, cost neutral and transparent access to this national infrastructure, while at the same time enabling the PDS/PES to earn a return on their investment. We recommend reforming the electronic prescribing system by establishing:

- A transparent access regime to this essential infrastructure inclusive of required service and access standards by the PDS/PES for community pharmacy users;
- Transparent funding allowing a rate of return for the PDS/PES without having to resort to charging community pharmacies for costs not adequately covered in the funding or raising other charges and fees on community pharmacies for other services and products provided by the PDS/PES to potentially cross subsidise any shortfalls in funding received from the Government.

The Guild’s position is that future utility of this program must not come at a cost to any user of the system, including prescribers, pharmacies and patients. Also, the ongoing governance of the system should be characterised by collaboration between all system participants and enablers including providers, consumers, governments, regulators, funders, and industry.

Guild Recommendations

4.1 Reform the electronic prescribing system as a critical digital infrastructure including establishing a funding model that is fair, equitable and recognises all users and beneficiaries of the system.

TOR 5. Examine the factors that may have affected productivity growth, including domestic and global factors and an assessment of the impact of major policy changes, if relevant.

Guild Response

Multiple factors have affected productivity growth, including the following domestic and global factors.

Supply Chain Disruptions

Community pharmacies encountered multiple supply chain disruptions during the pandemic. Factors driving these disruptions included shipping delays, difficulties in and competition for procurement, labour shortages due to quarantine and isolation measures, and manufacturing problems. A lack of local manufacturing capability is also a key factor in driving such disruptions, with estimates of the proportion of medicines imported in Australia at over 90%. It is noted that Australia has very little capacity to manufacture active pharmaceutical ingredients for most products on the WHO's Model List of Essential Medicines.[25] This is also the case for most developed countries, and many have moved to address this issue – for example the Pharmaceutical Manufacturing in America initiative "is increasing the ability within the U.S. to manufacture the consumables used in vaccine production and the raw materials and other ingredients required to manufacture life-saving drugs and vaccines".[26.]

These disruptions caused community pharmacies to not have access to the full range of PBS medicines, which decreased productivity in the sector. A series of measures were introduced including the TGA's Serious Shortage Medicine Substitution (SSMS) process aiming to cover gaps in supply. The TGA Medicines Shortage Working Party, consisting of all elements of the supply chain, worked together to implement the following measures to cover gaps in supply:

- Limits for the supply of some prescription and non-prescription medicines (pharmacists dealt with verbal and sometime physical abuse while trying to uphold limits);

- Scheduling amendments for high demand medicines such as salbutamol and hydroxychloroquine, and;

- Establishing the Serious Shortage Medicine Substitution (SSMS) process ('therapeutic substitution'). The model implemented is a complex process involving TGA notification on each occasion, implication under State and Territory laws, and substituted medicines are not generally covered by the PBS. It does not recognise the professional expertise of pharmacists.

[25] Institute for Integrated Economic Research Australia,
[26] https://www.medicalcountermeasures.gov/barda/influenza-and-emerging-infectious-diseases/coronavirus/pharmaceutical-manufacturing-in-america/

The Guild submitted a response to the Productivity Commission Study of Vulnerable Supply Chains in April 2021[27], and recommendations included the following:

- *Through the Pharmacy Guild of Australia, community pharmacists must be formally recognised for inclusion in emergency, disaster and pandemic planning and preparedness by governments, as well as response and recovery measures impacting community pharmacies;*

- *The Therapeutic Goods Administration should continue the Medicine Shortages Working Party on a permanent basis for the coordination and implementation of management strategies to maintain equitable and reliable access to pharmaceuticals by Australians with the capability to escalate activities during a crisis;*

- *Regarding new or altered PBS policies or regulations, the Australian Government should consider any implications on the supply chain, and on the competitiveness of Australia in the global medicines market so that Australia is not disproportionately affected at times of global shortage of individual medicines.*

- *The Australian Government should enable pharmacists to work to full scope of practice through autonomous therapeutic substitution to manage either national or regional medicine supply disruptions and to optimise patient care.*

- *Enable the pharmaceutical supply chain to work together on an ongoing basis and not just during an emergency, to plan for and manage supply issues and ensuring equitable distribution, including through amendments to distribution arrangements and the Community Services Obligation (CSO).*

- *National stockpiling requirements should be reviewed and aligned, including routinely reviewing the lists of critical medicines maintained and monitored by the Therapeutic Goods Administration (TGA) and aligning the National Medical Stockpile with these lists. It should also include funding sponsors to maintain a minimum level of stock within their pre-distributor facilities of 'Medicines where interrupted supply could result in serious health consequences'.*

- *There should be greater investment by governments in technology and data analytics to better manage pharmaceutical supply disruptions, including more timely identification of potential risks and implementation of management strategies along the supply chain.*

[27] Productivity Commission, Submissions to Study of Vulnerable Supply Chains, Pharmacy Guild of Australia, https://www.pc.gov.au/__data/assets/pdf_file/0007/275524/sub016-supply-chains.pdf

Workforce Challenges

As previously mentioned, the community pharmacy sector is facing significant workforce challenges, and during 2021 the number of positions available and time taken to fill has increased considerably across all regional, rural and metropolitan areas. Continued shortages in finding pharmacists for permanent roles has increased demand for locums to backfill these roles.

Pharmacists are currently on the Short-Term Skilled Occupation List (STSOL) which does not provide sufficient incentive for overseas trained pharmacists or employer sponsors as the eligible visa classes are temporary and do not lead to permanent residency. Due to professional registration requirements including examinations and extensive periods of supervised practice, the lead time for an overseas pharmacist to work independently does not always justify the cost to the pharmacist or their employer. Pharmacists should be included on the Medium Long-Term Strategic Skills List (MLTSSL) to encourage international pharmacists to migrate to Australia, which is one strategy in addressing the critical pharmacist shortage we are currently experiencing.

Health System Efficiency

During the pandemic, medical practitioners and allied health practitioners utilised Telehealth MBS items, which was aimed at protecting vulnerable patients and those self-isolating due to COVID-19. It also allowed medical practitioners and allied health professionals to maintain patient consultations where clinically appropriate without the risk of being exposed to COVID-19. However community pharmacies remained open and accessible to provide face to face healthcare services such as blood pressure monitoring and other point of care testing, and vaccinations. This provides a current example of how community pharmacies can contribute to the efficiency of the healthcare system by providing services to their full scope of practice, and would require appropriate and commensurate funding.

There is an international trend toward the broader user of community pharmacists to increase resilience in healthcare systems. As previously noted, in 2021 the OECD stated that the pandemic had highlighted the “importance of investing more to strengthen the resilience and preparedness of health systems”.[28] The OECD also stated that even before the pandemic community pharmacists were “increasingly providing direct care to patients (such as vaccinations, medicine adherence and chronic disease management support, and home medication review)” and that due to the pandemic “pharmacists have been given greater scope including extending prescriptions, enabling electronic prescription transfer and, in some cases, prescribing medicines for certain chronic conditions”.

By ensuring optimum accessibility and usage of all parts of the healthcare infrastructure and workforce, these changes improve the productivity and effectiveness of the healthcare system in the countries in which they are implemented. Australia continues to lag behind international trends with respect to implementing full scope of practice for community pharmacists.

Full scope of practice

The report mentioned in TOR1 estimates that pharmacists working to full scope of practice across the ten conditions examined can provide a total time-saving benefit of 5,800,000 consultations in primary care, 38,000 hours in emergency services, and 346,000 days in hospital care, thus contributing to the efficiency of the broader health system.

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[28] OECD (2021), *Health at a Glance 2021: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/ae3016b9-en

Committee Representation

In order to improve productivity for the health system, and in particular for primary care, the Australian Government and the Departments of Health and Veterans' Affairs must recognise the value and contribution from the community pharmacy network and ensure adequate representation on the committees and advisory bodies which make policy recommendations relating to community pharmacies and their patients. The Guild highlights the following committees.

- **The Pharmaceutical Benefits Advisory Committee (PBAC)** consists of a range of health, economics and consumer representatives appointed by the Minister for Health. The current membership of the PBAC is predominantly made up of specialist and general practice medical officers. There is one pharmacist represent, one industry representative and two consumer representatives. While ostensibly established to assess and make recommendations for the listing of a pharmaceutical benefit onto the PBS, the PBAC is also used as a consultative committee for PBS-related policy matters.

  The Guild is concerned with both the lack of transparency with decisions relating to such policy matters and also whether the make-up of the committee is adequate to be considering matters outside its original scope. With only one pharmacist representative, amidst a plethora of medical practitioners, there is little if any advice from the front-line pharmacists that manage emergency supply situations.

- **The Primary Health Reform Steering Group**[29] was established in October 2019 'to provide independent advice on the development of the Primary Health Care 10-Year Plan'. The group of 13 is chaired by GPs and consist of three other GPs as well as consumer and allied health representatives. Despite community pharmacy being the most accessible and most accessed primary health care provider with a network that covers all regions of Australia, there is no community pharmacy representation on the group.

- **The Australian Technical Advisory Group on Immunisation (ATAGI)** is the body responsible for advising the Minister for Health on the National Immunisation Program and other immunisation issues.[30] It should also be noted that the listing of a vaccine on the NIP requires a recommendation from PBAC, hence the inclusion of the PBAC Chair and deputy Chair as ex-officio members.

  Despite the role that community pharmacy plays in immunisation significantly increasing since the roll-out of the COVID vaccine in which community pharmacies have administered over 6 million vaccines to adults and children around the country, there is no community pharmacy representation on ATAGI. Noting the expert advice required from immunologists and epidemiologists for such a group, a community pharmacist representative would be able to provide the practical expertise and perspective of community pharmacy that the general practice, nurse practitioner and consumer reps provide for their sectors.

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[29] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/primary-health-reform-steering-group-established

[30] ATAGI, https://www.health.gov.au/committees-and-groups/australian-technical-advisory-group-on-immunisation-atagi

State and Territory Impediments

- The delays in implementing policy and regulatory changes at state level can result in non-standardised arrangements across the country. This not only affects patient access to services which will vary according to where they are, but it can be very confusing for providers, particularly in border locations. Examples include the slow pace, and incremental steps of policy change in the vaccination space to enable pharmacists to administer COVID-19 vaccines, which caused considerable unnecessary delays in the vaccine roll out.

  For example, at the time of writing, intern pharmacists, pharmacy students and dispense technicians in Victoria can reconstitute COVID-19 vaccines and label syringes for administration, whereas in other States and Territories they cannot. We note that jurisdictions which amended legislation to 'all ARTG registered COVID vaccines to all approved ages' enabled timely and practical implementation of vaccination services for each vaccine and age group as they were approved by ATAGI.

- Significant variability in vaccination legislation between States and Territories creates inequities and inefficiencies for vaccinating community pharmacies. For example, pharmacist vaccinators in all States and Territories except Queensland have access to NIP-funded influenza vaccines from this year. The National Centre for Immunisation Research and Surveillance (NCIRS) tracks these legislative discrepancies.31

- We highlight that the original Continued Dispensing instrument was recognised inconsistently, and years apart for some States and Territories, which created unnecessary barriers to patient access to medicines:
  - Commonwealth – recognised in 2012
  - ACT, NSW, SA, TAS, VIC, WA – recognised in 2013
  - NT – recognised in 2014
  - QLD – recognised in 2017

COVID-19 Rapid Test Concessional Access Program

- Community pharmacies are delivering a temporary Rapid Test Concessional Access program, which began in late January 2022 for a three-month period, which has now been extended until 30 June 2022. Patients with an eligible concession card can access up to 10 RATs through participating community pharmacies for free. This program has enabled millions of vulnerable patients to continue engaging in their regular activities while protecting themselves and their contacts from COVID-19.

- Additionally, States and Territories have various schemes for providing RATs to patients that could impact the Commonwealth program. Patient access to RATs is a priority, however policymakers should also ensure that any overlapping programs do not inadvertently affect businesses that may have invested in purchasing RATs to participate in a particular program. For example, a recent announcement by the Western Australian government that all households in WA can receive free RATs[32] has resulted in WA pharmacies being left with unsold RAT stock at a significant cost.

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[31] NCIRS, https://www.ncirs.org.au/sites/default/files/2022-02/NCIRS%20Information%20Sheet-%20Vaccines%20from%20community%20pharmacy_24%20Feb%202022%20update_Final.pdf

[32] Western Australian Government, COVID-19 coronavirus: WA free RAT program, https://www.wa.gov.au/government/covid-19-coronavirus/covid-19-coronavirus-wa-free-rat-program

Guild Recommendations

5.1 Commonwealth and State and Territory governments to implement the Guild's recommendations in its submission to the Productivity Commission's Study of Vulnerable Supply Chains.

5.2 Include pharmacists on the Medium Long-Term Strategic Skills List (MLTSSL) to encourage international pharmacists to migrate to Australia, to address the critical shortage of pharmacists.

5.3 Greater transparency and community pharmacist representation on Commonwealth committees relating to medicines including the PBAC, the Primary Health Reform Steering Group and ATAGI.

TOR 6. Prioritise and quantify the benefit of potential policy changes to improve Australian economic performance and the wellbeing of Australians by supporting greater productivity growth to set out a roadmap for reform.

Guild Response

The Guild highlights the following policy changes that would improve Australian economic performance and wellbeing by supporting productivity growth.

Scope of practice

Productivity in the primary health care sector can be enhanced by ensuring all health care practitioners are working to their full scope of practice. Community pharmacists in Australia do not currently practise to their full scope because they do not have the legislative authority to do so. This means they are unable to contribute to the healthcare system at an optimum level, in accordance with their acquired and assessed competencies. Because the existing pharmacy university program facilitates the necessary competencies, the impact of legislative authority changes would quickly achieve a scale that would impact access to quality health services and improved health outcomes significantly.

To effectively utilise the Australian pharmacy workforce and empower pharmacists to reduce preventable hospitalisations, a legislative approach to facilitate the full scope of pharmacy practice across all patient presentations (acute conditions, chronic conditions and vaccine-preventable conditions) is required. COVID has clearly demonstrated how the Commonwealth and State and Territory governments can collaborate to implement consistent policy and regulatory changes, and this collaborative approach must be systemised moving forward through the appropriate intergovernmental forum replacing COAG.

Changes to funding

Another barrier to pharmacists working to full scope of practice is current funding arrangements for services. Pharmacists largely rely on a fee-for-service remuneration model for services, where the patient bears the full cost; even though the equivalent service is Government funded in other healthcare settings. Enabling pharmacists to access adequate funding will allow pharmacies to offer a wider range of services to patients, leading to equitable access to services for the community.

A prime example of this is access to National Immunisation Program (NIP) funded vaccines (e.g. the influenza vaccine). People eligible for NIP-funded vaccines may choose to get vaccinated at a community pharmacy due to easy access and convenience, however they incur an out-of-pocket fee for the patient as pharmacists in most jurisdictions are unable to provide vaccines under the NIP, where other healthcare professionals can. We note that this challenges the government policy intent of universal access for all Australians, and disadvantages those eligible patients from accessing the vaccine at a time and place of their choice.

Another example is the limited caps on services for many of the Community Pharmacy Programs such as MedsChecks and Staged Supply, resulting in community pharmacies being unable to claim for more than a certain amount of services per month. [33] This impacts the level of patient access to these programs and ultimately patient health outcomes.

Continue supporting small business in regional and rural areas

Commonwealth and State and Territory Governments have funded various initiatives to support small businesses through the pandemic, and this should continue throughout Australia's transition out of the pandemic and into the future. For example, in late 2020 the Regional Recovery Small Business Support Program offered specialised small business financial counsellors to help rural and regional businesses navigate the path to recovery.[34] The program made it easier for eligible businesses to access immediate support and to receive ongoing assistance in developing long-term plans to maintain their viability.

We highlight the added costs and risks of doing business in rural and regional areas, which is currently recognised by the Commonwealth Government through their funding of the Rural Pharmacy Maintenance Allowance (RPMA). The RPMA program provides an allowance to eligible rural pharmacies with the aim of supporting improved access to PBS and RPBS medicines for patients in regional rural and remote areas. In many small towns, the local community pharmacy is the only health infrastructure, and it is critical that they are given adequate support to sustain their service to patients. The Commonwealth must continue to adequately fund the RPMA program into the future.

Supporting disadvantaged and vulnerable consumers

Governments should invest in policy that will support disadvantaged and vulnerable consumers including Aboriginal and Torres Strait Islander consumers, those with a disability, and those in aged care amongst others. This is needed in both the primary and acute healthcare sectors.

Primary healthcare reform

There must be appropriate recognition of the core, and specialist, skills and competency of all primary health care professionals including community pharmacists and the contribution they can provide to achieve primary healthcare reform. This requires significant culture change to pivot towards a truly integrated, collaborative team that a patient chooses to be involved in their health care. An effective primary health care system should be a coordinated, patient-centred health care system that is responsive and tailored to meet the specific needs of individuals and communities. It needs to provide equitable, accessible and affordable care to ensure patients can engage with the system regardless of their socioeconomic status, location or health status.

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[33] Pharmacy Programs Administrator, Staged Supply Program, https://www.ppaonline.com.au/programs/medication-adherence-programs-2/staged-supply

[34] Pharmacy Guild of Australia, Help for small regional businesses, https://www.guild.org.au/news-events/news/forefront/v10n18/help-for-small-regional-businesses

Supporting patients with alcohol and other drug-related issues

We note that Victoria has led the way in authorising pharmacists to administer Long-Acting Injectable Buprenorphine (LAIB) and this should be replicated in all jurisdictions. Governments should also invest in collaborative prescribing models for Schedule 8 medicines for opioid replacement therapy (ORT), to allow pharmacists to undertake dose titration, treatment continuation and screening under a shared care plan with the patient's prescriber. This is within pharmacists' scope of practice and would reduce the burden on the specialist workforce, particularly in regional, rural and remote Australia.

The Guild also recommends that the Commonwealth Government fund a National Opioid Dependence Treatment (ODT) Program under the PBS. Prescribing and dispensing of prescriptions for ODT medicines should be aligned with that of other PBS medicines, to ensure that treatment is accessible and affordable for this patient cohort. Approved pharmacists would be remunerated for dispensing the prescription as a pharmaceutical benefit, inclusive of daily dose management for oral ODT or in-pharmacy administration (or delivery to the patient's clinic) of injectable ODT. Patients would pay the relevant PBS co-payment for one month of treatment. This would make treatment accessible and affordable, and would help address the current opioid epidemic.

Preventive health

Commonwealth and State Governments should invest in the following policy initiatives in preventive health which community pharmacies can readily undertake:

- Targeted health promotion campaigns/ health checks/ screening campaigns;
- Navigation of healthcare system via referral pathways;
- Assessment and treatment of common conditions within scope of practice;
- Screening and risk assessments;
- Community pharmacies becoming immunisation centres;
- National rollout of mental health first aid through community pharmacies, especially in rural and remote regions.

Productivity will be best achieved by building the capacity of the health workforce, both current and emerging. Recognising core competencies of all healthcare professionals including interprofessional collaboration and understanding of the health system, as well as allowing practitioners to work at full scope, will help to fulfil Australia's Preventive Health Strategy and help disadvantaged and vulnerable individuals navigate the health system.

The above policy changes would support productivity growth in the primary healthcare sector and thereby improve Australia's economic performance.

Guild Recommendations

6.1 Intergovernmental collaboration to be systemised through a COAG-like forum to promote consistent policy, regulation and programs.

6.2 Remove funding limitations such as service caps on Community Pharmacy Programs from Community Pharmacy Agreements to enable more equitable patient access to healthcare.

6.3 Continue funding small businesses to transition out of the pandemic through programs such as the Regional Recovery Small Business Support Program.

6.4 Commonwealth and State and Territory governments to reform primary health care for patients with alcohol and other drug issues by:

- Authorising pharmacists to administer Long-Acting Injectable Buprenorphine;
- Establishing collaborative prescribing models for Schedule 8 medicines for opioid replacement therapy;
- Funding a National Opioid Dependence Treatment (ODT) Program under the PBS.

6.5 Invest in preventive health initiatives in community pharmacy including assessment and treatment of common conditions within scope of practice, and rolling out mental health first aid through community pharmacies nationally.

TOR 7. Revisit key recommendations and themes from the previous five yearly review in light of the above, where relevant.

Guild Response

No comment.