The Pharmacy Guild of Australia

Submission to the Review of the Existing Supply Arrangement of PBS Medicines in Residential Aged Care Facilities and Private Hospitals

Part C – Supply Arrangements of PBS Medicines in Residential Aged Care Facilities

January 2009

1. INTRODUCTION

The PBS was established in 1948 as a mechanism to provide timely, reliable and affordable access to life saving medicines for all Australians. While an extremely effective public policy mechanism – one that is envied around the world – it is a system structured around ambulatory patients and its regulatory and operational requirements do not reflect the different requirements and procedures for medication management in other settings such as residential aged care facilities and private hospitals.

For this reason, as part of the Fourth Community Pharmacy Agreement, it was agreed that the Pharmacy Guild of Australia (the Guild) and the Commonwealth would 'undertake a review of the existing PBS supply arrangements in the context of residential aged care facilities and private hospitals.'

The proposed objectives/outcomes of the review are as follows:

- In the context of the Fourth Agreement and subject to the Review, identify and address areas which may achieve better productivity and efficiency whilst maintaining QUM and reflecting the role of community pharmacy.

- Consider and make recommendations to the ACC which may include but are not limited to:

    - changes to the National Health Act and relevant regulations aimed at improving the efficiency and effectiveness of PBS supply (including through community pharmacy) to aged care residential facilities and private hospitals; and
    - identification of new models of PBS supply to residential aged care facilities and private hospitals.

Healthcare Management Advisors (HMA) has been engaged to undertake the Review, including conducting extensive consultations with key organisations, dissemination of a discussion paper and facilitation of workshops open to stakeholders, healthcare providers and consumers in each state and territory.

The Guild believes this Review represents an exciting opportunity to achieve better productivity and efficiency in the residential aged care and private hospital sectors, while maintaining quality use of medicines, and reflecting the role of community pharmacy. The Guild has prepared two separate Submissions that address Parts B and C of the HMA Discussion Paper – private hospitals (part B) and residential aged care facilities (part C). This particular Submission addresses Part C.

The Guild believes the introduction of administrative practice changes in the area of PBS supply to residential aged care facilities, some of which could be relatively minor, will deliver greater efficiency in this vital sector of care, reduce Commonwealth costs, reduce business expense, and most importantly improve patient outcomes.

Patients in these facilities are generally being treated for chronic conditions over a period of months, if not years, are often visited by their treating physician infrequently and rely on their pharmacist to ensure continuity of their treatment. Ensuring this continuity of treatment often places an extraordinary administrative burden of community pharmacists due to the nature of the PBS system.

2. SOLUTIONS

The Guild considers the following six key elements as essential factors which need to be addressed as part of any solution regarding PBS supply to residential aged care facilities

National Network

Australians, no matter where they live be it urban, rural or remote, must have equitable access to PBS services regardless of whether they are an ambulatory patient, a patient in a private hospital, or a resident of an aged care facility. The solutions proposed for changed PBS supply must be implementable across Australia. No pharmacy should be disadvantaged from any new arrangement that may be introduced. Moreover, any new solution, or adapted solution, needs to be systematically incorporated into pharmacist training. This will occur through incorporation into the programs at Australia's 16 pharmacy schools and through continuing education for pharmacists.

- **Infrastructure**

Any solution must take into consideration any infrastructure costs. While more efficient processes can occur with investment in infrastructure, this must be taken into consideration in any reimbursement model. That infrastructure investment may be prohibitive enough to impact on the first key element of 'national network' being achieved. The system solutions for changed supply must be scalable as a pharmacy may take on more beds in residential aged care facilities. Pharmacies should not be required to change systems based on scale without consideration and reimbursement of cost.

- **Access to Advice from Suitable Health Professionals**

The terms of reference for this Review address the importance of Quality Use of Medicines. The Guild wishes to reinforce this point. Any solution suggested from this review process must ensure a collaborative multidisciplinary approach where there is a balance between the necessary referral to a health professional and the inability for logical efficient processes to be implemented. RACFs are currently burdened with processes where a health professional's sign-off is a rate determining step and an efficient process cannot be achieved. The Guild is concerned that with the corporatisation of RACFs there is sometimes servicing of facilities via pharmacies from a large distance away due to a signed central contract. It is the Guild's view that QUM is compromised. The Guild recommends that the review consider the potential development of a mandatory set of minimum service standards applicable to all pharmacies. The existing Quality Care Pharmacy Program standards could form the basis for these standards.

- **Consideration of True Total Cost**

The search for solutions must involve consideration of total costs – be it time taken for health professionals to communicate, resource materials or the cost of infrastructure. The existing arrangements mask these significant hidden costs and make no attempt to remunerate any health professional involved in providing professional services in a residential aged care facility.

- **Program Longevity**

Many new systems fail because they are not incorporated within existing structures. Any suggested solution needs to be incorporated easily into pharmacy practice and that of other health professional involved in the care of residents in a residential aged care facility where the supply of PBS medicines is indicated. As well, because of the movement of staff across the pharmacy sector, that solution needs to be simple. There also needs to be a lead in period to allow the profession to be brought up to speed on any new measures, and consideration must be given to the improved efficiencies and resident outcomes that result from any change that might be implemented.

- **IT Infrastructure and Monitoring**

Community Pharmacy has a track record of being quick to adopt new IT developments and programs. This review presents an opportunity to maximise the benefits of such IT efficiencies. The IT programs must allow for auditable processes to be introduced to ensure there is appropriate monitoring of PBS supply arrangements.

3. DETAILED COMMENTS ON HMA'S PART C DISCUSSION PAPER

The Guild's commentary on HMA's Part C Discussion Paper follows the structure of that paper. We begin by considering the 'factors and issues related to the supply arrangements of PBS medicines in RACFs' (Section C1 of the discussion paper). We then provide comment on the 'opportunities to enhance PBS supply in RACFs – description of the proposed options' (Section C3 of the discussion paper). Throughout this commentary, any sections of text quoted from the HMA discussion paper are italicised to make it easy to follow. We have not commented on all sections and have maintained the numbering from the discussion paper. Guild comment is in regular text.

C.1 FACTORS AND ISSUES RELATED TO THE SUPPLY ARRANGEMENTS OF PBS MEDICINES IN RACFs

As a general rule, RACFs negotiate arrangements with community pharmacies to supply medications for residents. These medications are usually ordered and debited to the resident's account, so that the resident is not required to pay for medications every time a medicine is provided.

Payment for the supply of PBS medicines is entirely the responsibility of the resident (or their nominated financially responsible person) and thus all medication accounts for residents are managed by the pharmacy and not the RACF. It is the resident's responsibility (or their nominated financially responsible person) to settle their accounts with the pharmacy at the appropriate time. It should be noted that PBS quantities do not always match the cycle of supplying a Dose Administration Aid.

The RACF usually assumes responsibility for providing the pharmacy with a valid PBS prescription.

This is not the case for most pharmacies providing pharmacy services to RACFs. In fact, most RACFs now specifically include a clause in the service agreement with the pharmacy that expressly removes this responsibility from the RACF. Responsibility explicitly resides with the pharmacy to obtain PBS prescriptions from the resident's doctor.

The basic steps in the supply of PBS medicines to a resident in RACF are:

- *medical practitioner writes an order for medicine on the resident's medication chart (paper based/computerised form);*
- *medical practitioner must also write a prescription for PBS-listed medicines (paper based/computerised form);*

Achieving this in a timely fashion represents the core of the problem with PBS supply in RACFs. Typically, doctors write the prescription sometime later in their surgery, in many instances following a reminder from the pharmacist that the prescription is owing in order for this PBS medicine to be supplied for the resident's use in a timely manner expected by the staff at the RACF. Additionally, a doctor has no way of knowing when a script or subsequent repeat is exhausted. The introduction of medication continuance by pharmacists would alleviate this problem. The reason prescriptions are written by the doctor back at the surgery is for completeness of the history of this resident. At the RACF the doctor will makes notes in the resident's progress notes, complete the order by writing on the medication chart and then once back at the surgery will generate a prescription when completing notes in the history maintained at the surgery. None of the annotation from the RACF is transferrable to the doctor's history – which a doctor must maintain.

- *medical practitioner must seek Authority approvals as required and enter details on PBS prescription;*

Due to the absolute requirement of an authority being approved prior to dispensing, this results in delays before the resident will be able to receive such PBS medicines as typically the same process is undertaken by the doctor – the authority is sought once the doctor is back at the surgery and then supplied to the pharmacy for subsequent dispensing.

- *pharmacy dispenses medication after receiving a valid PBS prescription;*

In the majority of cases this does not happen – pharmacists are frequently required to dispense the medication from the medication chart or on a phone order before the prescription has been written by the doctor and definitely prior to receiving the prescription. In many cases a prescription is faxed to the pharmacy. Some RACF staff or medical practitioners will fail to send the actual prescription believing that they have completed their task by sending it by fax.

- *pharmacy may pack the resident's medications in a dose administration aid (DAA); and*
- *pharmacy may dispense medication for emergency situations prior to receipt of PBS prescription, but the prescription must be received within seven days of the order.*

1. PRESCRIPTION TIMING

Stakeholders advised that as a general rule, a medical practitioner makes the decision to initiate medication whilst visiting a RACF resident. The medical practitioner makes an order for the drug to be administered by writing the medication on the resident's medication chart. There is also a request/requirement to write a PBS prescription to facilitate supply of that same drug from the pharmacy.

As stated above, doctors typically write the prescriptions at a later time in their surgeries. It is also not uncommon for doctors to telephone or fax to the pharmacy a change in a resident's medication order based on changes made to that particular resident's medication chart during a visit to the RACF.

In certain circumstances pharmacies that supply medications to residents in RACFs are required or requested to dispense PBS medications prior to the receipt of a valid PBS prescription.

As stated above, this statement reflects the norm rather than the exception as prescriptions are not written at the time of visiting the resident, rather once the doctor has returned to the surgery.

- *these matters are not conducive to promote collaboration between pharmacies, RACFs staff and medical practitioners.*

This is certainly true – pharmacists who provide pharmacy services to RACF's spend many hours following up prescriptions from doctors. This does not promote good relations between the professions and can be detrimental to patient wellbeing due to unavoidable delays in being able to provide required PBS medicines (e.g. items requiring an Authority or Controlled Drugs). The proposed move to a system based on the medication chart will go a long way to resolving this. Alleviating the anxiety experienced by the health professional involved would most definitely contribute to encouraging greater participation of the same health professionals in RACF's.

3. USE OF DOSE ADMINISTRATION AIDS

- *different PBS medicines had different dosage requirements, packs sizes or medicines may be exhausted over different durations of treatments resulting in the requirement to design a number of variations of DAAs;*

The Guild understands that nearly all DAAs are now supplied based on a weekly supply cycle and NOT dependent on the pack size of the medicine.

- *following changes in residents' health conditions, the medical practitioner may need to alter the medications regimen to ensure optimal patients care. Generally a new DAA is packed and the previous one is to be destroyed, thus generating a wastage of sometimes expensive medicines.*

Wastage is certainly a concern and has cost implications for the PBS. Some of the current packing systems exacerbate the problem, especially those that are multi-dose rather than unit dose. The Review provides an opportunity for this to be addressed. It is a significant Quality Use of Medicines issue.

6. ADMINISTRATIVE ARRANGEMENTS

- *there may be circumstances where the condition of the medicine is compromised because of the storage conditions between the time it leaves the pharmacy and the time it is received at the RACF.*

This is a significant problem which can occur in particular with mail order and third party supplies of medications. The Guild believes this could be addressed via its proposed minimum standards.

C3. OPPORTUNITIES TO ENHANCE PBS SUPPLY IN RACF – DESCRIPTION OF THE PROPOSED OPTIONS

Option 1: Prescription-less system using current PBS structure

For the purposes of this discussion paper, the term 'prescription-less' describes a system or option which operates without the use of a written PBS prescription (as defined by the NHA and the National Health (Pharmaceutical Benefits) Regulations (1960).

Under this option it is proposed that the resident's medication chart (which may be paper-based or held electronically) could be used as both an order to the pharmacy for the supply of PBS medication and the record of delivery and administration of the medication to the resident.

The supply of PBS items listed as requiring an approved Authority prescription would need to follow the existing dispensing process.

Currently, medication charts do not fulfil the requirements of a PBS prescription.

The medication chart could form one central document which meets the needs of the resident, medical practitioner, pharmacist, nurse, RACF and MA by providing:

- *an order from the medical practitioner to the pharmacist to dispense a medication;*
- *documentation of the supply of the medication by the pharmacist to the resident;*
- *an order from the medical practitioner to the nurse to administer a medication;*
- *documentation of each dose of medication administered to the resident;*
- *verification of the claim made by the pharmacist to MA for the supply of a PBS item; and*
- *a permanent record of all medications prescribed, dispensed and administered to a resident forming part of that resident's medical records.*

The Guild fully supports this proposed option. Furthermore, the Guild believes that the adoption of this solution alone would go a long way to addressing the concerns and frustrations felt by doctors, pharmacists, nurses and staff of RACFs. This option would also benefit residents as the delay experienced in supply of some regular (chronic) medicines would be removed with the establishment of a medication continuance process that the pharmacist would be initiating for the life of the medication chart. The administrative burden, particularly for the pharmacy, associated with ensuring that a valid PBS prescription is available would be significant. Many community pharmacies that provide pharmacy services to RACFs are required to employ additional staff just to cope with the workload associated with ensuring all required prescriptions are received from the doctor in a timely manner.

The introduction of a solution that negates the need for a written PBS prescription in addition to a medication chart would also have the advantage of increasing the number of GPs who would be willing to work in the area of RACFs.

The Residential Aged Care sector has not moved to a standard chart unlike the hospital sector, however there are a few medication charts that are now commonly used across the sector. This standardisation is unlikely to occur in the foreseeable future. The Guild however sees the need to migrate to a new format where standard segments are included on all charts no matter the design in order to satisfy the ability to have the medication chart recognised as a replacement for a separate PBS prescription.

The Guild also believes this option could be supported by further IT system changes whereby quality use of medicines is maximised and an audit trail can be assured. On dispensing an item for a resident from a medication chart, the pharmacy software would have a 'check box' for the pharmacist to tick indicating the patient is a resident in a RACF. (An additional step could also be included where the unique identifier allocated to all Commonwealth funded residents of aged care facilities is entered into the dispensing system.)

Option 2: Authority application by pharmacist for approved indications

The Authority prescriptions should be written where applicable for the listed drugs and indications.

Under this option, it was proposed that the pharmacist could make the Authority application where required. This process could be similar to that currently in place for public hospitals participating in Hospital Reforms whereby an application for Authority approval for supply of oncology drugs listed on the PBS is made by a pharmacist.

The Guild fully supports this option. This could operate in a manner not dissimilar to the streamlined authority system.

Option 3: Authority application by pharmacist for increased quantity

Under current PBS arrangements, if a medical practitioner considers that the maximum quantity or the number of repeats of a PBS item is not sufficient for a resident's requirements, a medical practitioner may apply to MA seeking an approval for increased maximum quantity or the number of repeats (an Authority PBS Prescription Form must be filled in). The provision of increased quantities and repeats on authority PBS prescriptions is intended to provide approximately one month's therapy which may be repeated (if clinically appropriate) to provide six months' therapy in total.

Approval for increased quantities and repeats is only granted where the reason for the PBS prescription is consistent with the indications published in the PBS schedule.

Under this option, it was proposed that a pharmacist could be given the right to obtain the Authority approval for increased quantities and repeats from MA.

The Guild fully supports this option recognising that the provision of increased quantities can remove difficulties for patients due to the constraints of the safety net 20 day rule especially with the increased use of DAAs is this sector.

Option 4: Collaborative prescribing-pharmacist

This option could allow pharmacists to provide the documentation to facilitate continuing administration and supply of a RACF resident's established medication when admitted to a private hospital. This model would not permit the initiation of therapy by a pharmacist.

This option could be performed as part of a care plan prepared by the medical practitioner in collaboration with the resident, the pharmacist and the nurse. The pharmacist could determine the resident's current medication regimen by following a process of medicines reconciliation. This requires an accurate medication history from the resident through direct interview and additional information such as a current medication profile, obtained from the resident's community pharmacy and/or medical practitioner.

Once the pharmacist has identified the resident's regular medications, this detail would be documented on the resident's medication chart. This entry by the pharmacist would become the order for dose administration and supply.

Because this option is intended to allow an established therapy regimen to continue during the course of a resident's admission to hospital, the quantity of medication dispensed from these orders should be defined in line with the Australian Pharmaceutical Advisory Council (APAC) Guiding principles to achieve continuity in medication management. The sufficient amount of medicines could be supplied by the pharmacist to the resident to carry them through to the next appointment or to complete the course of treatment. The pharmacist also would give the resident and/or their carer sufficient instructions about how to obtain supply of continuing medicines.

Further ethical consideration should be given whether there should be separate pharmacists involved in collaborative prescribing and dispensing.

The pharmacist could submit a claim for payment for supply of PBS items made in this way to MA in the usual manner.

The Guild fully supports this option and furthermore the Guild believes that the adoption of this solution alone would go a long way to addressing the concerns and frustrations felt by doctors, pharmacists and staff in RACFs. There is also potential for an improvement in outcome for the resident as the continuation of medication prescribed would be seamless and without the interruptions often experienced at this stage.

The Guild would prefer this be referred to as medication continuance as the word prescribing is sensitive to many in the medical profession. The word continuance better describes the process.

This option would allow pharmacies to provide the documentation to facilitate continuing administration and supply of a resident/patient's established medication when in a RACF. This option would not permit the initiation of therapy by a pharmacist but would be performed as part of a care plan prepared by the medical practitioner in collaboration with the patient, the pharmacist and the nurse. Any medication chart provided by the pharmacist would include only medicines that have been previously documented and signed by the doctor.

The Guild fully supports this option and notes that an analysis of the roles of pharmacists overseas provides a useful context for consideration of this option. Internationally, the concept of expanding a pharmacist's role to incorporate continuance of supply is not a novel or radical one. In fact, pharmacists in the United States, the United Kingdom, Canada and New Zealand are able to legally prescribe a range of medicines previously only prescribed by medical practitioners.

This obviously constitutes a far more advanced scenario than is being proposed here, however it is noteworthy that, relative to these other developed nations, the role of Australian pharmacists remains very limited. Consistent with this point, Dr Lisa Nissen, Senior Lecturer in pharmacy at the University of Queensland contends that:

> "Pharmacists are the most over-trained and under-used professionals in the health system. Chronic medications such as the oral contraceptive pill, antihypertensives, diabetes and asthma drugs could be supplied on an ongoing basis by pharmacists."[1]

[1] Australian Pharmacist – Volume 27 Number 4 April 2008 p273

Emmerton et al's 2005 review of the international literature[2], detailing the various models of pharmacist prescribing, also confirms the comparatively restricted capacity of pharmacists in the Australian community pharmacy setting. The paper points to eight models of pharmacist prescribing and includes 'Collaborative prescribing models' (involving a cooperative practice relationship between pharmacists and physicians).

> 'Under this model the doctor diagnoses and makes initial treatment decisions for the patient, and the pharmacist selects, initiates, monitors, modifies and continues or discontinues pharmacotherapy as appropriate to achieve the agreed patient outcomes. The doctor and pharmacist share the risk and responsibility for the patient outcomes.
>
> Informally, clinical pharmacists in public and private hospitals have practised collaborative prescribing to some extent throughout the past 25 years. Examples of collaborative prescribing by hospital pharmacists in Canada and the USA include aminoglycoside and pharmacokinetic dosing services, anticoagulant therapy adjustment and chemotherapy antiemetic management. By 2001, 27 American States had some form of legislation that allowed collaborative practice between pharmacists and physicians. In Minnesota, pharmacists may provide medicines for first dosages and in emergencies. Collaborative models are being considered in Canada for pharmacists' prescribing, including initial drug selection or adjustments.
>
> A study has been undertaken to demonstrate the appropriateness of prescribing and monitoring by hospital pharmacists. Evidence also supports that provision of cognitive services by community pharmacists improves patient health outcomes and possibly reduces health care costs. An Australian hospital study found that a significant proportion of doctors would welcome pharmacists making written comments in the medical record notes.'

Option 5: Collaborative prescribing-nurse practitioners

This option could allow nurse practitioners employed by RACFs to make orders on residents' medication charts within the parameters of their approval to prescribe under State/Territory Poisons Regulations. It could be performed as part of a care plan prepared by the medical practitioner in collaboration with the resident, the pharmacist and the nurse.

To incorporate these requirements would require amendment to the NHA.

These orders could be valid for administration of medication to residents as well as for the dispensing of medication by a pharmacist. Where the medicines ordered are PS listed items, supply by a pharmacist of these items prescribed by a nurse could be subsidised under the PBS and claimable from MA.

This option would allow nurse practitioners to make orders on a resident/patient's medication chart within the parameters of their approval to prescribe under State/Territory regulations. Once again this is another form of medication continuance, not true prescribing. The term 'nurse practitioner' needs to be fully explored but the Guild prefers to leave it to other authorities to judge the level of qualification that is required for a nurse to undertake prescribing. The nurse practitioner courses currently available in places such as the Queensland University of Technology Nurse Practitioner course have a sufficient rigour of training for those nurses to undertake PBS prescribing. As per the Guild's key principles as stated above, the full costs

[2] Emmerton, Lynne et al 2005 *Pharmacists and Prescribing Rights: Review of International Developments*

associated with nurse practitioners, including MBS costs, would need to be considered. The Guild believes a more efficient model is for pharmacists to undertake medication continuance.

The Guild is not aware there are currently any nurse practitioners approved to prescribe in the area of residential aged care. However, if nurse practitioners were to be approved to 'prescribe' in this sector, the Guild would be supportive of the proposed option, while recognising there would be additional costs associated with this.

Option 6: Funding of Cognitive Services

A Patient Medication Profile (PMP) is a detailed record of all or a resident's current medications. This facilitates continuity of care for residents when moving between health care settings and has been shown to reduce the chances of adverse medication incidents caused by inadvertent omission or doubling up of prescribed medicines.

Admission to a hospital generally lead to the changes to a resident's medication regimen and the provision of a PMP (or discharge summary) by the pharmacy at the time of discharge ensures that the resident, their carers and other health care providers are made aware of these changes.

Payment for provision of PMP is now available to community pharmacists as part of the Patient Medication Profile Program funded under the Fourth Agreement. However, funding under the PMP Program is only available when profiles are provided to community based patients.

This option could extend that framework to include the provision of PMPs by pharmacies to RACFs residents to improve the consistency of services provided across all RACFs.

Community pharmacies that provide pharmacy services to RACFs provide significantly more services than just the supply of medications. In the majority cases, these medications are supplied in a dose administration aid. This greatly increases Quality Use of Medicines and efficiency for the RACF staff, but adds significantly to the workload and costs of the pharmacy. This cost is expected to be borne by the RACF but in many cases this is not the situation with the total cost of supply of a DAA being borne by the pharmacy as a contractual obligation.

Furthermore, community pharmacies provide a number of other medication management services to RACFs, including developing policies for administration of over-the-counter medicines, drug usage reviews, and taking part in medication advisory committees, drug audits and in-service education sessions for staff as well as residents and through the provision of CMIs and PMPs.

This includes pharmacists making regular visits to the RACF, which is particularly important given the declining number of GPs opting to work in aged care. The supply pharmacist is an obvious resource for a RACF and greatly utilised as a drug resource. In fact the AMA claims that only 16 per cent of doctors routinely make aged care visits. An AMA survey of 750 GPs in July 2008 found doctors working in aged care facilities spent on average 13 minutes face-to-face with each patient, which required another 13 minutes to deal with the resulting paperwork.

This continuum of care provided by community pharmacies to RACFs needs to be given greater recognition than just ad hoc funding of individual programs. Recognition must be given to this specialised professional role, particularly since RACFs no longer receive specific funding to pay for services such as DAAs. Removal of this funding opens the way for pharmacists to take a more active role in providing QUM services to RACFs which will lead to improved patient outcomes.

Option 7: Contracts with General Practices

This option could work on a similar basis to the way in which RACFs currently engage with community pharmacy. A RACF could enter into a contract with a General Practice to provide medical services to the residents.

Generally this option could include:

- *a RACF could enter into a contract with a General Practice, preferably:*
  - *a practice containing multiple GPs to ensure suitable coverage can be provided; and*
  - *a local practice (where possible)*
- *the contract could include:*
  - *an allowance for a retainer to be paid to the GP service for service provision; and*
  - *service performance indicators around GP attendances at the RACF, frequency of medication reviews and number of 'owing' PBS prescriptions;*
- *the contract could contain clauses that set out agreed service provision parameters linked to the retainer payment;*
- *the RACF could be funded for the retainer payment (source to be identified); and*
- *consideration would need to be given regarding the resident's right to choose their GP (however, it is also acknowledged that such contractual terms may actually improve the regularity of GP attendance at RACFs).*

The Guild believes this proposal is outside the scope of this Review. The Guild does not support this proposal. We also believe contracts between an RACF and a particular general practice could restrict patient choice.