Professor Nick Shaw

25th August 2005

Health Workforce Study
Productivity Commission
PO Box 80
Belconnen ACT 2616

Dear Sir/Madam

Thank you for the opportunity to respond to the Productivity Commission Health Workforce Study Issues Paper, May 2005. I am pleased to provide some input into this study from the consolidated thoughts and ideas of our academic staff at the School of Pharmacy, The University of Queensland (UQ). Please do not hesitate to contact me if the School can provide any further assistance.

We have grouped our responses under two major areas that encompass several of the key issues the Productivity Commission report raised, namely:

- clarification of stakeholder objectives;
- ways to better align incentives, improve co-ordination and promote good regulatory practice
- possibilities for extending the use of 'market-friendly' mechanisms within the regulatory framework
- the scope to better align and/or simplify fiscal gate-keeping mechanisms
- opportunities to meet core health workforce objectives in new ways

Workforce supply and retention issues

As one of the three major Schools of Pharmacy in Australasia (others of similar size and research strength being at Monash University and The University of Sydney), we have a responsibility not only in the education of future pharmacy professionals, but also in the continuing education of practising pharmacists and in research in all aspects of our profession. We are concerned with the workforce supply for our pharmacy profession, as well as retention and retraining for the health workforce. We also believe that multi-professional, integrated healthcare will improve health outcomes, and we are committed to addressing inter-professional care in education and research.

In terms of relevant literature on this topic:

- There has been 'A study of the demand and supply of pharmacists, 2000 – 2010' (available at www.guild.org.au/public/researchdocs/demandssupply2003.pdf), which raises many of the issues highlighted in the Productivity Commission paper and gives some recent factual information about pharmacist workforce issues. Other

issues, such as changing work practices are also detailed and the Commission may find these of interest.

- In the UK, a series of papers concerning a recent pharmacist census has been published (Hassell K, Shann P. Pharmacy workforce census. Overview of main census findings. Pharmaceutical Journal 2003 (1st March); 270: 314-315, with 6 further detailed articles published between May and October 2003 in the Pharmaceutical Journal: http://www.pjonline.com/noticeboard/series/nationalworkforcecensus.html). These may also be of interest to the Commission.

These studies and others, and evidence from practice, indicate a large, international workforce shortage of pharmacists. This has led to 100% employment rates for our graduates, and increasing salaries for employed private sector pharmacists (the public sector has been slow to respond to this and has, anecdotally, lost many good pharmacists to overseas positions and to other professions. In turn, these factors have been influential in creating significant demand for Pharmacy programs at Universities, with the opportunity of 100% employment and relatively high salaries being viewed as very attractive to students and their families. Currently, at UQ, we have about 8-10 applicants for each undergraduate Bachelor of Pharmacy degree program place.

The above factors , coupled with economic constraints within the University sector and significant competition for the best students, have led to new Pharmacy programs being introduced at Universities that have not traditionally offered programs in the Health Sciences. There is an accreditation process for Pharmacy degrees and Schools of Pharmacy that is organised by the New Zealand and Australian Pharmacy Schools Accreditation Committee (NAPSAC), which is a Committee of the Council of Pharmacy Registering Authorities Inc. NAPSAC and its evaluators assess whether a degree course offered by a School of Pharmacy will produce graduates with the requisite knowledge, skills and competencies. We are firmly of the opinion that the quality of education, and the continuity of research in all Pharmacy disciplines, should not be compromised in efforts to increase workforce supply.

A problem that has already arisen with the new Schools of Pharmacy is that of supply of good quality, suitably qualified, academic pharmacists. It is vital for the sector as a whole that we can recruit and retain suitable academic pharmacists to maintain quality education and research. The intake into pharmacy programs has increased dramatically, but care needs to be taken that the quality of pharmacy services (and eventually health outcomes for consumers) will not suffer because of an inability of these newer programs to maintain educational quality. A pharmacy qualification can now be obtained via a number of different pathways: the traditional Bachelor of Pharmacy (four-year, undergraduate) degrees are most commonly offered, but some pathways offer more options to full fee-paying students. For example, students can complete a three-year HECS-funded Bachelor of Pharmaceutical Sciences followed by a fee-paying Masters of Pharmacy, or enrol in a six-semester fee-paying Masters of Pharmacy. It is important that all these offerings are accredited by NAPSAC before graduates can be registered as pharmacists. The discussion on page 42 of the Issues Paper is relevant to these points.

Also of relevance are the “re-entry” programs offered by a number of education providers. These are designed for pharmacists who have had periods out of practice, to

enable them to update their knowledge and skills. At UQ, we regularly offer such programs for pharmacists. We also offer coursework Masters degrees (Clinical Pharmacy, Pharmaceutical Sciences) to enable pharmacists to upgrade their skills in specific areas. There is the facility to offer recognition of prior learning in these programs to enable accelerated progress for appropriately skilled pharmacists. We encourage and support the development of multi-disciplinary programs to address the development of skills across a range of health professionals. We are also in strong agreement with the concept of competency-based rather than time-based registration, and would be very supportive of any such moves for pharmacy. The Pharmacists Board of Queensland has recently sought stakeholder comments and feedback relating to recency of practice and the continued registration of pharmacists.

International shortages of pharmacists are also likely to impact on Australia's health workforce. Currently, there are some countries with mutual recognition of pharmacy qualifications, but extending this to other specified pharmacy programs could possibly be of assistance. Great Britain is cancelling their mutual recognition of pharmacist registration and this may have a positive impact on Australia's workforce, as it will lead to fewer young Australian pharmacists travelling and working in the UK. The flipside is that Australia will also become less attractive for British pharmacists. The net effect will only be determined over time.

We believe that the 2002 Australian study of Pharmacy workforce could benefit from updating with new information concerning the developing roles for pharmacists (further discussed below), the increased output of pharmacy graduates and the effects of changes to the mutual recognition across national boundaries.

Services offered by the pharmacy workforce

Services offered by pharmacists have changed greatly over time. No longer should pharmacists be solely performing the technical aspects of the dispensing supply function. Pharmacists are now performing, and being paid for, services extending well beyond the supply of medicines. Any moves to extend such cognitive service roles, and particularly to influence and encourage multi-disciplinary practice in healthcare would be very much welcomed.

One issue that has not been raised in the discussion paper about funding mechanisms is the importance of arranging payments for each member of health care teams. Payments should be claimable through MBS channels for each health care practitioner participating in integrated service delivery (for example, GPs have an Enhanced Primary Care item number for case conferencing, unlike the other practitioners). In a similar vein, an anachronism has arisen in the payment for Home Medicines Reviews by pharmacists. The community pharmacy receives the payment for this, even though it is the accredited pharmacist (who may or may not be the pharmacy owner) who performs the healthcare service. In revising incentives, it would be important to ensure that the payment is actually delivered to the team performing the service. Integrated care options, using pharmacists as a hub, has certainly worked as a good model in rural and remote locations, and there are other examples of pharmacists working in teams, in multidisciplinary practice, which should be actively encouraged.

Another mechanism to improve practice is the more effective use of technology and technical support. There are various on-line options now available (particularly with the recent implementation of pharmacist subsidy for broadband access and subscription), including that of connecting with other health professionals, linking to consumers who have location difficulties and connecting to larger centres (such as Universities) to receive clinical advice and support. Other technical assistance not yet used to best capacity is that provided by dispensary technicians. If technical staff were supervised and used appropriately, considerably more pharmacist time would be freed up to provide cognitive services.

Pharmacists are society's experts on drugs and therapeutics and it is evident that their skills, knowledge and training are sometimes not most effectively used by healthcare systems around the world or in Australia. Cognitive service provision involving pharmacists has been discussed elsewhere, but there are also moves internationally to broaden the roles that pharmacists play in the healthcare environment. Pharmacists have long asked why, with their extensive knowledge of pharmacology and therapeutics, they have not been able to prescribe a defined range of medicines. This question has now been positively answered in a number of territories including the UK and Canada, where pharmacists have been empowered to make prescribing decisions without having to refer to a doctor on every occasion. A research project, due to report shortly, has been proposed various models by which patients can better access prescription medicines, and we would commend this report to the Productivity Commission for further investigation and implementation studies. The study has been undertaken by researchers at UQ and Monash University. Models, whereby pharmacists have a more active role in the drug selection process, have the potential for generating cost savings and for freeing the time of doctors both in hospital and community sectors. Importantly, such processes have the potential to improve patient experience through better access to care, better quality of care and improved patient safety.

Students at University are often exposed to new and different models of practice developed with them interactively during their training period. However, when they enter practice and discover that older, traditional, models of care are still being used and incentives for new practice are not there, they risk becoming disillusioned and abandoning the profession, or they may revert to the pre-existing practice. It is essential that, if new models of practice are to flourish, incentives are provided to ensure their coherent and widespread implementation.

If the School can be of any further assistance please do not hesitate to contact me.

Yours sincerely

Professor Nick Shaw
Head, School of Pharmacy