The Pharmacy
Guild of Australia

31 July 2015

Mr Steve Irons MP
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Dear Mr Irons

Response to the House of Representatives Standing Committee on Health - best practice in chronic disease prevention and management in primary health care

As you are aware, The Pharmacy Guild of Australia is the national peak pharmacy organisation representing community pharmacy. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimal therapeutic use of medicines, medicines management and related services.

There is an ongoing need for genuine primary health care reform and the Guild welcomes the opportunity to provide a response to the House of Representatives Standing Committee on Health regarding best practice in chronic disease prevention and management in primary health care. What we are seeing are programs that come and go, lack scale and duplicate each other. Equipping all arms of the health system to work in a coordinated way towards common measurable health outcomes is vital to ensure ongoing affordability across the system. This will only be facilitated by better alignment and coordination within Federal Government through the Community Pharmacy Agreement and State/Territory Governments as well as with Primary Health Networks and with private health insurers.

There are over 5,450 community pharmacies in Australia offering a highly skilled network of primary health care professionals providing quality advice and service. Community pharmacies exist in well distributed and accessible locations and often operate over extended hours seven days a week in urban, rural and remote areas. Both well and sick people visit community pharmacy, providing an opportunity to engage people along the health spectrum and hard-to-reach populations who do not use other health services, particularly in rural and remote locations.

A health system weighted towards expensive episodic acute medical care is inefficient at dealing with the changing demographics and disease patterns that we're now experiencing in Australia – patterns that we will continue to experience for decades to come. The health challenges associated with this rising chronic disease burden and an ageing population require a coordinated multidisciplinary approach to care, where teams of health providers are supported to work collaboratively in the community setting, tending to people's health needs before they get to the point of needing hospital admission or requiring a resource intensive and costly level of primary health care. Effective referral systems between all health professionals where expanding skills are embraced rather than resisted, are fundamental to future reform. I have provided a small number of examples in which community pharmacy should be viewed as an opportunity for best practice in chronic disease prevention and management in primary health care.

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An opportunity to address medicines adherence issues

Adverse medicine events account for an estimated 190,000 hospital admissions per year. Costs to the health system are estimated at $660 million annually and 50% of these adverse events are avoidable. Further, medication adherence rates in Australia are low, averaging only 50-65%. This leads to poor outcomes, hospitalisations, and increased health care costs. An IMS Study in 2012 identified six main levers to lower overall health system costs and improve health outcomes: non-adherence to medicines; untimely medicines use; antibiotic misuse/overuse; medication errors; suboptimal generic use and mismanaged polypharmacy. This study estimated that a $6 billion avoidable cost opportunity, or 7.7% total health expenditure, exists in Australia across these areas with non-adherence contributing most to this figure.

There is ample evidence that a relatively modest investment in the quality use of medicines would significantly reduce unnecessary hospital stays and premature aged care facility admissions. Pharmacists already deliver medicine management services but there is a need for better coordination and collaboration across the acute and primary care system, with general practitioners and other health care providers, in order to address these alarming statistics. I highlight that, by ensuring that the medicine is prescribed and taken as envisaged when it was assessed and approved for listing on the PBS, a comprehensive community pharmacy program addressing prescribing, adherence and compliance issues would provide the full value of the community's investment in PBS medicines.

An opportunity for risk assessment and screening

An enhanced role for pharmacies in areas like screening, chronic disease monitoring, vaccinations, minor ailments, smoking cessation, wound and pain management would free up scarce doctor resources to allow them to better care for patients with more complex and chronic conditions. A comprehensive in-pharmacy health check service would assist in early identification of disease risk in order to encourage lifestyle behavioural changes and address identified risk factors, as well as enable referrals to other health professionals such as GPs where required. A health and wellness check may include blood pressure, cholesterol, blood glucose, body measurements, lung function, and kidney disease assessment and address lifestyle risk factors such as smoking, diet, sleep and exercise.

An opportunity for minor ailments

Primary health care reform must facilitate a greater focus on remunerating medical practitioners to manage chronic and complex conditions and better utilise and remunerate pharmacists on those areas where their skills and accessibility can achieve the most cost-effective health outcomes. Many people visit their GP as the first line of treatment for what are relatively minor ailments. These doctor visits represent an inefficient allocation of our scarce health resources. These minor ailment consultations are a major contributor to the fact that 23% of Australians in capital cities and 42% of Australians in other areas are forced to wait at least three days for a GP appointment. I highlight to the Committee a study commissioned by the Australian Self Medication Industry which found that 15% of all GP consultations involve the treatment of minor ailments. When projected nationally, this equated to 25 million GP consultations annually, or approximately 96,000 potentially unnecessary GP consultations per day.

Clinical interventions relating to minor and more serious conditions and situations are standard practice for community pharmacists. Pharmacists have an appreciation of their clinical limitations and scope of practice and are trained to identify situations where a seemingly minor ailment may indicate or lead to a more serious medical condition, resulting in referral to a medical practitioner. A structured minor ailments scheme that included a consumer education campaign to raise the awareness of the choices available, together with appropriate remuneration, would ensure a better allocation of health resources. It would also

provide greater convenience and more timely treatment for patients suffering from these ailments. Such a program exists in the United Kingdom where eligible individuals register with and use a community pharmacy as the first presentation for the treatment of common illnesses approved by the National Health Service. 2014 research from the UK Royal Pharmaceutical Society found that the cost of treating common ailments in community pharmacies was £29.30 per patient. The cost of treating the same problems in Emergency Departments was found to be nearly five times higher at £147.09 per patient and nearly three times higher at GP practices at £82.34 per patient. The minor ailments service is anticipated to save over £1billion each year.

Opportunity for care transition

I highlight that on admission to hospital, up to one in two patients have an incomplete medicine list provided, resulting in a medicine not being provided during the hospital stay. Add to this that 12% of patients have an error in their hospital discharge prescription, 73% of GPs do not directly receive discharge summary information, and 9% of patients are discharged from hospital with insufficient medicine supplies.

There is no funding for medication management services at this critical juncture. A coordinated approach is required involving the hospital pharmacist, the GP and the community pharmacist – with an agreed plan to check adherence and any other issues that may otherwise result in a high risk of readmission to hospital. Less than 2% of people leaving hospital receive a discharge plan, case conference or medication review within the first month after discharge. Further, data suggests that 30 days post-hospital discharge, 71% of patients visit their GP within a median time of 12 days, whilst 86% of patients visit their pharmacy within a median time of 6 days.

Opportunity for Point of Care Testing

Point of Care Testing (PoCT) technology offers consumers convenient access to fast, reliable and evidence-based testing. Anticoagulation therapies support in people with Atrial Fibrillation (AF) was the subject of a review commissioned by the Australian Government in 2012. Up to 400,000 Australians are thought to have AF currently and this number is expected to rise with an ageing population. A number of complications can arise from AF including a significantly higher risk of stroke, more severe strokes and increased risk of death following a stroke. This is managed by the use of warfarin, which, despite the potential benefits, is being used sub-optimally. Warfarin is a high risk medicine, but complications are reduced if the patient stays within the therapeutic treatment range. Internationally, anti-coagulation management services using PoCT through community pharmacy have led to improved anticoagulation control, a reduced frequency of warfarin-related hospital admissions, a lower frequency of drug interactions, and improved patient compliance and satisfaction. A number of community pharmacy based anticoagulation management services for patients on warfarin studies have been conducted in Australia with positive outcomes such as reduced rates of warfarin-related adverse events, better self-monitoring for appropriate consumers, and successful multidisciplinary care.

Opportunity for after-hours care

In recognition of the critical role that community pharmacy plays in local primary health care, the Guild has dedicated substantial human and financial resources to establishing a network at both the National and the State/Territory level to collaborate and foster relationships with individual Primary Health Networks (PHNs) and previously each Medicare Local. One example of where PHNs could work with pharmacists is in providing after hours care with the development of models at the local level. Community pharmacy's extended trading hours of evenings, weekends and public holidays, in which a community pharmacist must be on duty, makes it one of the most accessible health care service providers. Given that 80% of GP visits

result in the issuing of a prescription, it would be counterintuitive to enhance community access to GPs after-hours without addressing the expected pressure on pharmacy opening hours from a variety of factors.

In summary, community pharmacy transformation has already started in other countries and is referred to throughout this submission. Governments of nations with similar modern healthcare systems, similar patient and community health needs, and similar challenges in relation to community pharmacy viability are making greater use of community pharmacies and pharmacists. Community pharmacy in Australia is an essential, cost-effective and highly accessible health care destination. It has the capacity, skills and willingness to deliver a considerably broader set of services and functions for the Australian community, in collaboration with other health professionals, to improve health outcomes.

More detail can be provided on request in relation to any of the issues outlined above. The Guild has done considerable work in the development and costing of new and expanded programs and initiatives and would welcome any opportunity to provide further information. I encourage the Committee to see community pharmacy as an opportunity for addressing issues relating to best practice in chronic disease prevention and management in primary health care.

Yours sincerely

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