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18 March 2005

The Secretary
Senate Community Affairs Reference Committee
Suite S1 59
Parliament House
CANBERRA ACT 2600

Dear Sir/Madam

Inquiry into Services and Treatment Options for Persons with Cancer

Thank you for the opportunity to provide a submission to the Inquiry into Services and Treatment Options for Persons with Cancer.

Outlined in the attached submission are some of the areas in which The Pharmacy Guild of Australia believes community pharmacy might become involved in order to enhance the delivery of services and treatment options for persons with cancer in Australia.

You will note from our submission that our comments specifically relate to the issues where we have particular interest and where we believe community pharmacy would be engaged and utilised to achieve best practice outcomes in the management of treatment options for persons with cancer.

I trust that you will give consideration to the issues raised in our submission and that our proposals will be reflected in your final recommendations. We look forward to hearing from you of the outcome.

If you require further information or any clarification, please do not hesitate to contact me.

Yours sincerely

Stephen Greenwood
Executive Director

Encl.

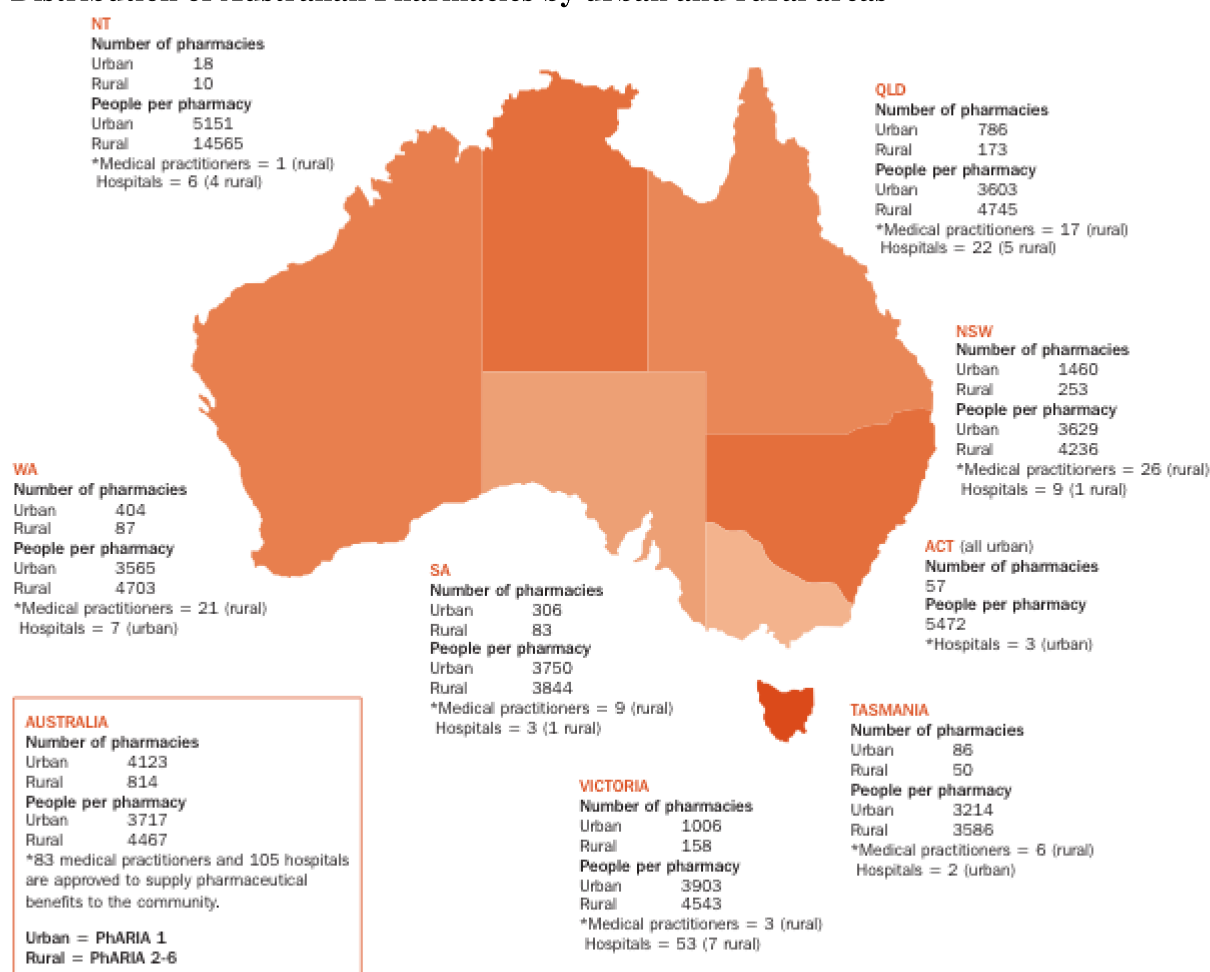
INQUIRY INTO SERVICES AND TREATMENT OPTIONS FOR PERSONS WITH CANCER

Introduction

The Pharmacy Guild of Australia is an employers' organisation servicing the needs of independent community pharmacies. It exists for the protection and betterment of its members and to maintain community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of drugs, drug management and related services.

Community pharmacy offers a highly accessible network of primary health care providers providing quality advice and service. Pharmacies exist in well spread out and accessible locations, are computerised and often operate over extended hours seven days a week in urban, rural and remote areas. Each man, woman and child visits a community pharmacy 14 times each year, in metropolitan, rural and remote, hospital and indigenous community settings.

Distribution of Australian Pharmacies by urban and rural areas [1]



[1] Dept of Health and Ageing Annual Report 2003-2004 (page 104)

In recent years pharmacists' roles have continued to expand from dispensing medications with an increased emphasis on working with other health care professionals to give services to the public as part of the health care team. There is an ever-increasing body of evidence to demonstrate that community pharmacists can and do perform countless activities that benefit patients and doctors, save money for the purchasers of health services and enhance the delivery of primary health care services.[2]

Community pharmacists currently provide an array of services, which extend well beyond the provision of prescription medicines and as such, pharmacies are often the first contact point of the primary health care system for many people. These services also include:

- Provision of information about medicines and health conditions;
- Provision of up to date and locally relevant information on other health care services and resources;
- Participation in community health, preventative health and other public health services;
- Distribution of public health information and educational materials;
- Referral to a General Practitioner or Hospital Emergency Services; and
- Referral to other appropriate allied health professionals where required; eg community health nurses, mental health services, drug and alcohol rehabilitation facilities etc.

In the UK, pharmacists have become involved in a wide range of health promotion and screening services including areas such as cardiovascular, diabetes, cancer, mental health and HIV/AIDS. Moreover, surveys have demonstrated that pharmacies are recognised as centres for the provision of such services and that these services are acceptable to clients.[3]

Community pharmacists maintain links with local general practitioners, and Divisions of General Practice within their local area as part of their ongoing commitment to and participation in the local community and as a provider of primary health care.

Australia's National Health Strategy has identified the vital role that community pharmacists play in health care provision, through reducing medication costs and improving the health outcomes of patients, particularly those with complex needs.

Pharmacy is well placed to assist consumers towards self-management of their conditions. People living with chronic illnesses and their carers form a major client group of community pharmacists. For clients seeking support in autonomous self-management of a chronic condition, as identified in the ***National Health Priority Areas*****,** the role of the pharmacist is crucial in providing medications, access to testing or screening procedures that assist in the monitoring of conditions.

[2] Issues Paper two: The Value of Professional Pharmacist Services – A compilation of national and international literature encompassing research published between 1990 and 1998
[3] Therapeutic drug monitoring in community pharmacy – feasibility study, Maguire, T. & J. McElnay (1993)

Recommendations

1. The Pharmacy Guild of Australia recommends that as part of the patient care reform, the Australian Government establish a program for community pharmacists to provide domiciliary pharmaceutical care to patients who are able to access specialist cancer drugs/treatment in their homes;

2. That a program for pharmacists to provide medication management of palliative care patients at home be established; and

3. That the range of medications used in palliative care listed on the Pharmaceutical Benefits Scheme (PBS) be broadened to assist in providing wider access to medication at an affordable price for people who wish to remain in the community during the terminal phase of their illness.

Recommendation 1

Home Care Administration of Cancer Therapy – assistance in monitoring of specialist cancer drugs for outpatients at home

Proposed Model

This is a concept based on the successful public health care delivery models for the management of different disease conditions such as Asthma, Cardiovascular, Diabetes, HIV/AIDS etc.

The proposed model is based the **Collaborative Drug Therapy Management (CDTM)**[4] in which the pharmacist's activities are integrated with those of other health care providers in developing a patient-centred practice. CDTM is practised any time the pharmacist works with the physician and other members of the health care team and shares responsibilities for patient outcomes. In this model, it is essential to establish good communication links between individuals involved in the patients' treatment and to establish clear and well-understood practice agreements.

The model would also build upon the **Enhanced Primary Care (EPC) Program** by linking the patient with a chronic disease to their usual pharmacist. It could also link with existing public health programs, to enable Government to target consumers with specific disease state to encourage them to seek assistance.

Following the patient's consent to participate in the program, an individualised EPC Care Plan would be developed in collaboration with the physician, GP, pharmacist and the patient who requires chemotherapy suitable for administration at home. The pharmacist would then regularly meet with the patient to assist in managing his or her treatment plan. Review and monitoring of the treatment care plan would be undertaken through short (up to half an hour), ongoing face-to-face sessions between the patient and pharmacist in the patient's home.

[4] (i) Trends in Collaborative Drug Therapy Management, Karen E. Koch (2000)
(ii) Helping pharmacists provide disease-based pharmaceutical care, Meade, V. (1995)

During these visitations, the pharmacist would assist the patient in **monitoring and managing the symptoms of their cancer therapy** by:

- providing counselling, advice and treatment support;
- ensuring that prescriptions for patients are understood and the medicines are used appropriately t optimum effect;
- providing advice on medicine delivery systems;
- reinforcing information provided to ensure compliance with the treatment regimen in order to achieve optimum results; and
- providing resources, education and referral.

Following these sessions the pharmacist would provide ongoing feedback of the patient's progress to the specialist and the GP in a consistent and predetermined manner.

Benefits of the model

This program makes effective use of the EPC items such as case conferencing, health assessment and multidisciplinary care planning while alleviating some of the most negative impacts of the chronic illness on the patient's functioning, their emotions and their interpersonal relationships. [5]

This model provides convenience, regularity and informality. It is a very cost-effective and is a sustainable model of service delivery because it develops and extends already existing services and structures. It utilises the service of the patients' usual pharmacist, the most accessible and trusted of health care providers, to assist them in managing their cancer therapy at home. It also assists the specialist and the GP in their primary care coordination role.[6]

For rural pharmacists this is a particularly important role, since community pharmacies in smaller rural and remote centres have become the focal point for the community in seeking reliable advice and referral, particularly in towns without a hospital or GP. This model of care delivery would enable rural pharmacists to provide pharmacotherapy support to cancer patients in their homes.

Through the Third Community Pharmacy Agreement, the links with General Practice have been strengthened by the placement of pharmacist facilitators in Divisions of General Practice. These facilitators are employed to facilitate collaboration between local pharmacists and GPs in the delivery of Home Medicines Reviews. It is envisaged that the facilitators will enable GPs and pharmacists to collaborate on a wide range of other primary health care initiatives, such as home-based cancer therapy. This mechanism in the longer term will enhance inter-professional relations and patient health.

[5] Impact of medication regimen reviews performed by community pharmacists for ambulatory patients through liaison with general medical practitioners, Ines Krass & Carlene Smith, (2000)
[6] Targeted medication reviews: patients in the community with chronic pain, Rhona W. Read & Janet Krska (1998)

Rationale

Healthcare challenges

The changing health care needs of an evolving population demand new approaches to providing care. Changing technology and products require new criteria to determine appropriateness, not just efficacy and safety.

There is a need for improved communications and interaction between the patient and all members of the care team as more and more patients are requesting appropriate information regarding their therapeutic options. There is a strong correlation between patient satisfaction and measures of quality of life. Even minor improvements in a treatment can have an impact on a patient's sense of well-being.[7] There is also a need to refocus on patients' needs, essentially promoting a "patient-centric" environment that supports improved physician/patient relationships.[8]

A review of the literature[9] suggests that pharmacists are well placed to take a more direct and active role across the continuum of care. Pharmacists are able to identify specific pharmacotherapy information for particular populations as participants in an early warning system regarding patients whose conditions can result in emergency room visits, hospital admissions, and high costs. Pharmacists can intervene to ensure there is optimal care and to prevent unnecessary services, thus playing a pivotal role in supporting physicians in achieving best clinical and cost outcomes.

At a time when the cost of healthcare is increasing rapidly, it is imperative to ensure that the type of care provided adds value to patients and is cost effective for Governments. Effective ways of providing continuity of care need to be explored to respond to escalating healthcare costs and as a method for enhancing the service provided to the patient.

Specific issues relating to cancer

Since 1990, cancer care has been performed in the outpatients setting, with increasingly complex care provided to patients. Chemotherapy has been one of the major cancer treatment modes for several decades: the other three are surgery, radiation, and immunotherapy. Most cancer patients receive a combination of chemotherapeutic agents. While many agents are indicated for a variety of primary tumours, similarities exist in the toxicities clients experience and the appropriate management strategies. [10]

[7] Many Ways to Better Support Cancer Patients, Christiana Sessa (2000)
[8] Trends in Managed Care Pharmacy: Preparing for the Future, Joseph Eichenholz (2001)
[9] Issues Paper two: The Value of Professional Pharmacist Services – A compilation of national and international literature encompassing research published between 1990 and 1998
[10] Supporting the Home Care Client Receiving Chemotherapy, Berman AJ, (1999)

The newer chemotherapy agents have helped to achieve more extended survivals and more cures. This has led to higher expectation of physicians by their patients and vice versa, and a greater demand from the health care givers by patients to receive more complex treatments according to a home-based schedule.[11]

Pain Management

Patients in the community with chronic pain may have poor pain control and use both prescribed and alternative therapies, often inappropriately, to try to optimise pain relief. Hence, relief of cancer pain should be an integrated component of comprehensive care for all cancer patients. Appropriate pain relief will facilitate anticancer therapy and improve survival.[12]

Many patients' medicine use can deviate from that prescribed, and a high proportion also use alternative medicine. Patients with chronic pain may be in need of improved pharmaceutical care because of lack of pain relief and lack of understanding of pain management, the potential for drug interaction and adverse effects.[13] Thus, patients will benefit from management by a multidisciplinary primary care team involving a pharmacist. Pharmacists have an important role to play in chronic pain management particularly in the provision of drug information to patients and medication reviews in a home setting.

Distress management

Distress presents itself in cancer patients as a *continuum*: from mild distress to severe forms that may then lead to depression, anxiety, and crisis. Cancer distress may result in more frequent visits to the doctor's office and to the emergency room, poor decision making by the patient, refusal or interruption of potentially curative treatment, and dissatisfaction with traditional care.[14] National Comprehensive Cancer Network, USA has acknowledged the need to recognise, document and monitor distress and has established standards of distress care similar to pain management.

According to these guidelines, screening and management of distress should be started as soon as possible, optimally at diagnosis or at the beginning of the specific cancer treatment. As part of the healthcare team, pharmacists will be in a position to provide screening and monitoring of distress and if necessary, referral can be made to mental health professionals or social work professionals.

[11] Standards of Care for Cancer Patient Distress, Jeffery Weber (2000)
[12] Management of pain in cancer patients, Michael Levy, (2000)
[13] Potential roles of the pharmacists in chronic pain management: a multidisciplinary perspective in primary care, Rhona W.Read & Janet Krska (1998)
[14] Standards of Care for Cancer Patient Distress, Jeffery Weber (2000)

Benefits of appropriate distress management

The benefits deriving from effective management of cancer distress are similar to those achieved by pain management. These include:

- better adherence to treatment;
- more effective patient-physician communication;
- lower stress levels;
- improved quality of life;
- prolonged survival; and
- more effective care provided by the oncology team.

Nutritional Issues

There is a growing body of evidence to support the role of nutrition in the prevention of cancer and in regressing or reducing effects of chemotherapy and radiation induced toxicity and weight loss.[15] Physicians and pharmacists face many questions from their patients concerning the use of supplemental nutrients during radiotherapy to protect normal tissues against the effects of radiation. The pharmacist's role in providing advice on nutritional approaches as important adjuncts to therapy will add value to the overall treatment plan.

Advantages of home-based chemotherapy

A number of researchers have shown that patients prefer home-based chemotherapy to hospital-based treatment. The diagnosis of cancer imposes a devastating sense of loss of control over a patient's life and home chemotherapy allows patients to become active participants in administering their own therapy, providing an opportunity to regain some of that control.[16]

Parents of paediatric oncology patients have reported that home treatment has helped them to cope, enabled them to feel more in control and to learn more about their child's illness and treatment. Consequently, home treatment is perceived as less stressful than hospital treatment and all have reported benefits to family life.[17]

The health care system can pose barriers to effective pain relief in the form of practical constraints. The lack of transportation to the physician or pharmacy and the lack of a home caregiver to assist with administering drugs pose major obstacles to pain treatment.[18] Pharmacists providing domiciliary pharmaceutical care can effectively overcome these barriers and as a result improve the quality of life for the patient.[19]

[15] Spotlight on Radiation Oncology: New Therapies and Aftercare, Avraham Eisbruch, & Zvi Symon (2000)
[16] Home Chemotherapy: Basic Concepts, Catania PN (1999)
[17] Safety, Efficacy, and Acceptability of Home Intravenous Therapy Administered by Parents of Paediatric Oncology Patients, Hooker L, Kohler J, (1999)
[18] Chronic Pain: Treatment Barriers and Strategies for Clinical Practice, Myra Glajchen (2001)
[19] (i) The benefits of in-home pharmacy evaluation for older persons, HsiaDer, E., L. Rubenstein et al. (1997)
(ii) The Medication Reduction Project: combating polypharmacy in South Dakota elders through community-based interventions, Schrader, S., B. Dressing et al. (1996)

Reported advantages for chemotherapy at home include: [20]
- the elimination of travel;
- reduction in treatment in associated anxiety;
- reduction in the burden on carers and family; and
- the ability to continue other duties.

Costing

It is anticipated that the cost in running the program would be linked to Care Plans developed by GPs. Pharmacists would require specific remuneration to reimburse them for time spent in assisting in patient monitoring and discussing concerns with the patient's GP. The actual costs would obviously need to be modelled through a demonstration pilot process.

It is anticipated that savings as a result of fewer preventable adverse drug effects and interaction, improved patient compliance, reduced hospitalisation would offset the cost of pharmacist remuneration.[21]

The future of chemotherapy-in-the-home programs in Australia will depend on whether patient preferences are deemed to offset any potential costs. Moving chemotherapy into the home would provide a less costly strategy for the expansion of a chemotherapy service without compromising patient outcomes.[22]

Recommendation 2

Palliative Care – Medication Management of Palliative Care Patients at Home

Community Pharmacist's role in Palliative Care

Community pharmacists can make valuable contributions in the provision of palliative care to terminally ill patients.

As palliative care is aimed at offering the highest possible level of comfort to the patient during the last phase of his/her life, technical and prolonged treatment should be avoided if possible, allowing the patient to lead as normal a life as possible. Home treatment is very often possible, and should be preferred, as it is more comfortable for the patient. Patients wishing to stay with their families for as long as possible should be encouraged to do so, and the pharmacist, along with all other health professionals, can support the patient, and family members, in making the situation more acceptable, and in taking the right decisions. [23]

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[20] A Randomised Crossover Trial of Chemotherapy in the Home: Patient Preferences and Cost Analysis, Rischin D, White MA, Matthews JP, et al (2000)

[21] (i) Cost savings and avoidance from clinical interventions, Munro, W., Kunz et al. (1997)
(ii) Expanding the roles of outpatient pharmacists: effects on health services utilisation, costs, and patient outcomes, Beney J, Bero LA, Bond C (2000)
(iii)Creative reimbursement, Ukens, C. (1994)
(iv) Clinical outcomes research in pharmacy practice, Cooper, J. (1997)

[22] Home or Hospital? An Evaluation of the Costs, Preferences, and Outcomes of Domiciliary Chemotherapy, King MT, Hall J, Caleo S, et al (2000)

[23] World Health Organisation 2002

The increasing need for palliative care in the community and patient preference for death at home is well documented.[24] [25] [26] [27] On average, terminally patients will spend 90 per cent of their final year at home, under the care of the family doctor and primary health care team.[28] More than half of patients with terminal illness express the wish to remain at home as long as possible and, if possible, to die there.[29]

Due to the combination of severe illness and emotional difficulties, the delivery of good palliative care presents a complex challenge to all concerned. As the most accessible health care professional for patients, their carers and families, the community pharmacist should be an integral member of all interdisciplinary palliative care teams. Good palliative care depends enormously on teamwork and effective symptom control.

Most of the patients in need of palliative care already have a long trusted relationship with their regular community pharmacist. In the difficult circumstances of palliative care, this relationship becomes even stronger. Pharmacists are aware of the valuable contribution they can make, particularly in medicines management; that is, helping to manage an efficient service so that patients get the medicines they need promptly and are given clear guidance on their use. This requires both traditional and expanded pharmacist activities, including a variety of clinical, educational and support roles.

Provision of effective medications for symptom control

Pharmacists can improve the cost effectiveness of pharmacotherapy for symptom control in palliative care through patient-specific monitoring for drug therapy outcomes recommending alternative drug products and dosage forms, minimising duplicative and interaction medications, compounding medications extemporaneously, improving drug storage and transportation, and educating staff, patients and families about the most efficient ways of handling and using medications.

Medication regime for patients in the last stage of their life should be optimised as much as possible in aiming for maximum comfort. The pharmacist can help to identify the best pharmacotherapy solution, in terms of cost and effectiveness including specific products/devices and preparations needed in palliative care.

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[24] Field D. Sociological perspectives on health, illness and health care: Palliative care for all. Pp 192-209. 1998 Oxford Blackwell Science Ltd

[25] National Council for Hospice and Specialist Palliative care services. Needs assessment for Hospice and specialist palliative care services: From philosophy to contracts. Occasional paper No 4 Dec 1993

[26] Higginson IJ. Ch 2 Quality, costs and contracts of care. The future for Palliative care: Issues of Policy and Practice. Ed Clark David 1993. Buckingham. Open University Press.

[27] Townsend J, Frank AO, Fermont D, Dyer, Karran O, Walgrove A, Piper M. Terminal cancer care and patients preference for place of death: a prospective study. BMJ 1990; 301:415-417.

[28] Main P. The Practitioner, April 1993: 321-324

[29] Townsend J, Frank AO, Fermont D et al. Terminal Cancer Care and Patients' Preference for Place of Death: a Prospective Study. BMJ, 1990; 301:415-7

Medication history/ documentation

The pharmacist has a computerised record of the full history of the medications previously dispensed in his/her pharmacy for use by the patient. Patients often move between care settings such as hospital, hospice and their own home and accurate records of the patient's medication should be transferred between these settings. Pharmacists maintain patients' medication profiles and monitor all prescription and non-prescription medication use in terms of their safety and effectiveness.

The Pharmacy Guild has recently commissioned a research project titled "Facilitating Quality Use of Medicines (QUM) between Hospital and Community Settings". The project aims to improve medication management for people as they move to or from hospital back to the community or between different institutions. Specific interventions include:

- Provision of dispensing data on admission to hospital;
- Provision of discharge and medication summaries to the patient and their local doctors;
- The development and co-ordination of care plans to assist medication management;
- Education for the patient about their medicines; and
- Home visits after discharge from hospital.

Ensuring compliance

Advice from pharmacists to patients and carers about drug dosage, administration and anticipated side effects can aid compliance. Pharmacists seek to ensure that all patients and families/carers understand and follow the labelling directions provided with medications and provide devices and equipment to assist with accurate measurement of liquid dosage forms. Pharmacists advise patients about the role and potential toxicity of alternative and complementary therapies. Pharmacists can visit patients' homes to communicate directly with patients and carers and to make necessary assessments. To assist with a safe self-administration of medication, pharmacists can provide and, where necessary, fill compliance aids or dose administration aids such as dosettes or blister packaging.

Provision of extemporaneous compounding of non-standard dosage forms

Pharmacists can also assist in the formulation and preparation of medicines for people with swallowing difficulties. Pharmacists communicate with pharmaceutical manufacturers to determine the availability of non-standard dosage forms. Medication compounding needs include the preparation of dosage forms to ease administration (eg. concentrated sublingual solution, topical medications), flavouring medications, eliminating or adjusting ingredients that patients cannot tolerate, and preparing or changing drug concentrations.

Safe disposal of all medications after death

Pharmacists are able to assist families with the removal of the medications remaining in patients' homes in compliance with the relevant State and Territory Regulations using the Return of Unwanted Medicines (RUM) Scheme.

Recommendation 3

More equitable access to medications for people with a terminal illness being cared for in the community

In 2004, several medications used in palliative care were listed on the Pharmaceutical Benefits Scheme (PBS).[30] These medications were previously only available freely through acute care settings or at a non-subsidised rate for people in the wider community. The Pharmacy Guild acknowledges that this now provides some access to medications at an affordable price for people who wish to remain in the community during the terminal phase of their life and will help ensure that quality of life for theses people is maintained through appropriate pain management and symptom relief.

However, the Guild is concerned that the preparations which may be prescribed for patients receiving palliative care currently listed in the Schedule of Pharmaceutical Benefits[31] is not adequate and needs refinement for the following reasons.

Restricted access

The Schedule allows provision for increased maximum quantities and up to 3 repeats on the *initial* authority prescription and is intended to provide up to 4 months' therapy in total.

Although most general practitioners treat relatively low numbers of patients requiring palliative care in a community setting, the requirement to seek an authority to prescribe may act as a barrier to timely initial access for particular urgent relief medications. If a general practitioner treats a patient at home without access to the up-to-date PBS prescribing information, the authority process may not be followed and as a result pharmacist is not able to dispense the item as a PBS subsidised medicine creating unnecessary hardship for the patient and the family.

The Schedule defines a patient receiving palliative care as: *"a patient with an active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life"*. Given this definition, it is appropriate that the method of access be made less restrictive to enable appropriate access and quality of service for those patients requiring palliative care treatment.

To this end, the Pharmacy Guild recommends that the *initial* supply be prescribed "without" authority and that the requirement to seek authority only apply in cases of *ongoing* treatment. This should also include patients who are receiving care under a hospice system or under the care of a palliative care team.

[30] Department of Health and Ageing Annual Report 2003-2004 (page 148)
[31] Schedule of Pharmaceutical Benefits for Approved Pharmacists and Medical Practitioners (1 April 2005 Edition)

Issue of Listing

There are medications that are not specifically registered on the Australian Register of Therapeutic Goods (ARTG) for palliation but registered for other use and indications. For example, *ketamine* is registered as an anaesthetic agent for diagnostic and surgical procedures that do not require skeletal muscle relaxation. *midazolam* is registered for conscious sedation prior to short surgical, diagnostic, therapeutic or endoscopic procedures and for induction of anaesthesia. However these medications are commonly used for the care of palliative care patients. Such anomalies should be rectified by listing such medications on the ARTG and the PBS.

Dual listing of medicines used in palliative care should be made possible. For example, *morphine oral* solutions and *morphine injections* should be listed both in the “white” section and the “palliative care” section. The listing in the palliative care section should allow quantities and number of repeats appropriate for palliative care use including use in syringe drivers.

The pharmaceutical companies should be encouraged to apply for listing on the PBS of those medications that fall into this category. Alternatively, organisations such as the Cancer Council Australia or Palliative Care Australia should be encouraged to make application for such a listing in the best interest of patients requiring palliative care treatment in the community.

Issue of Education

The Guild believes that there needs to be better education about drugs that are listed on the Schedule of Pharmaceutical Benefits to general practitioners, pharmacists and practice nurses. This would assist in situations such as prescribing of laxatives for palliative care patients where constipation is a problem[32]. It is best practice that laxatives should be prescribed in the first instance in conjunction with other medications for palliative care patients so that constipation does not become a problem. The PBS listing for palliative care patients should also be revised to allow prescribing before constipation is a problem for the patient requiring palliative care.

The Guild is aware that a number of projects are currently being conducted in the area of health professionals training in relation to management of palliative care patients. The Guild believes that the results of these projects will assist health professionals in achieving better outcomes for patients in the delivery of medication management and other palliative care services in the community. Brief information on these current projects is as follows.

[32] Schedule of Pharmaceutical Benefits for Approved Pharmacists and Medical Practitioners (1 April 2005 Edition)

Opioid Medication in Palliative Care – GP Resource Project

Palliative Care Australia (PCA) has been engaged by the Department of Health and Ageing to develop an education and training program in opioid medication management which will support general practitioners and practice nurses in the management of pain for palliative care patients. A representative of the Pharmacy Guild is participating in the project as a member of the Steering Group for this initiative.

Improving Medication Management of Palliative Care Patients: Enhancing the Role of Community Pharmacists Project

Monash University College of Pharmacy is conducting this project funded by the Department of Health and Ageing through the Third Community Pharmacy Agreement. The key element of this project is the development, implementation and evaluation of a flexible, problem-based educational program in palliative care, including medication management, directed at community pharmacists in both urban and rural Australia, to empower them to contribute more effectively in this area.

Conclusion

Community pharmacists have a well-defined role and are well-placed to assist the care team to provide maximum comfort to a patient in need of cancer therapy and palliative care, based on the rational and optimal use of medication and other products. A multidisciplinary approach involving community pharmacy will help deliver improvements in co-ordination of cancer and palliative care services.

This will also benefit patients' families. This model of service delivery in a community setting, making effective use of case conferencing, health assessment and multidisciplinary care planning, would provide convenience and flexibility. It is also a very cost-effective and sustainable model of service delivery because it develops and extends already existing services and structures. It also assists the general practitioner and pharmacist in their primary care coordination roles.

Australia's National Health Strategy has identified the vital role community pharmacists play in the provision of health care. International literature also shows that pharmacists' interventions provide huge savings to the health care system and enormous benefits to the consumer. The Pharmacy Guild of Australia is willing to assist all Governments in initiatives where community pharmacy is engaged and utilised to achieve best practice outcomes in the delivery of services and options for treatment for persons with cancer.