Role of Pharmacists in Healthcare Teams

POSITION STATEMENT

College position

Rural and remote communities deserve equitable access to excellent healthcare. ACRRM contends that the highest value care will extend from models founded on continuous, holistic, multidisciplinary care, with a rural generalist or specialist general practitioner at the centre of this care.

The College acknowledges and respects the important role that pharmacists play as members of the healthcare team, particularly in rural and remote communities where all team members work to a broad but safe scope of practice. Where there are proposals to extend pharmacist practice, the key principles of patient safety and continuity of care, appropriate training and credentialing, and transparency in the development of service models and their evaluation, must be applied.

ACRRM will only support extending the current role of pharmacists where this is undertaken in a team-based, collaborative arrangement under the leadership of the rural generalist or specialist general practitioner or practice.

Rural and remote communities should not be forced to accept a lower standard of care or accept that this standard is the norm or level of service which they can expect.

Policy should support and strengthen primary case based services models; prioritise high quality continuity of care of patients; and provide equity to people living in rural and remote Australia and Aboriginal and Torres Strait Islander peoples.

ACRRM welcomes the opportunity to progress initiatives in which pharmacists can work in effective partnerships with their rural generalist and specialist general practitioner colleagues together with other members of the primary health care team, to improve the patient journey and access to quality care for people in remote and rural areas.

Background

Rural Generalists (RGs) and specialist GPs (GPs) have a strong working relationship with their pharmacist colleagues and value their advice and expertise. In addition to the community pharmacy setting within their local community, they also work with pharmacists who are based in a range of other settings including hospitals, medical practices, aged care and other facilities where collaborative arrangements are already in place.

Extending the scope of practice provided by pharmacists has been proposed as a response to ongoing difficulties for consumers in accessing timely bulk-billed medical appointments for services such as vaccination; diagnosis and prescribing, especially for some commonly-occurring conditions. In rural and remote communities this is exacerbated by workforce maldistribution and resultant shortages.

In the view of the College, addressing medical workforce and practice funding issues to increase the number of RGs and GPs, especially in rural and remote areas, is the most effective response to the current access issues.

Arrangements which enable pharmacists to deliver basic vaccination programs are now well established. However there is a fundamental distinction in arrangements enabling vaccination by pharmacists and those enabling pharmacists to diagnose, prescribe and issue repeat medications. Provision of immunisation does not require a diagnostic skill set and vaccinations are administered as part of a fixed program which is closely regulated and for which there is a common national record in the form of the National Immunisation Register.

ACRRM contends that any proposal to extend the services provided by pharmacists to include a medical scope of practice contains significant inherent risks. To mitigate these, proposals must be developed in association with robust, transparent and extensive consultation involving all stakeholders including medical practitioners. Likewise robust and transparent governance mechanisms and monitoring and evaluation frameworks must be in place.

Proposals must be consistent with key principles based on the paramount importance of patient safety and high-quality continuity of care. **They should include appropriate safeguards including referral guidelines and protocols.**

Policy should support and strengthen primary care-based service models; prioritise high quality continuity of care for patients; and provide equity to people living in rural and remote Australia, including Aboriginal and Torres Strait Islander communities.

Rural and remote communities deserve equitable access to excellent healthcare It is widely evidenced that health systems based on a strong primary healthcare foundation are the most effective and efficient in terms of cost and health outcomes[1] including reduction in preventable hospital admissions[2] and that continuity of patient care leads to better mortality outcomes.[3]

ACRRM promotes a Rural Generalist approach which involves innovative care models in which all health practitioners are encouraged to work to their broadest scope in effective healthcare teams. These models must facilitate continuity of patient care and support cooperation, collaboration and innovation while maintaining the highest standard of patient safety within the rural and remote context.

These models can deliver and lead coordination of care in partnership with the local healthcare team (including pharmacists) and collaborate with remote and visiting consultant specialists as required.

There is growing health sector demand for aged care and the care of people with chronic and complex conditions. These people represent a high-needs health consumer group that should appropriately be targeted for the best possible medical attention and for whom ongoing healthcare monitoring and continuity of care is most important. For people with chronic health conditions, research demonstrates that missing more than two general practitioner appointments is linked to an eight-fold increase in all-cause mortality.[4]

It is important that a pharmacist does not independently assume key medical practitioner roles and especially without collaboration or communication with the patient's continuous care provider practice. This would lead to fragmentation of primary care and negative health outcomes. A clinical visit with a doctor involves diagnostic skills, diagnostic tools, capacity to examine and make sense of past history and past pathology. A pharmacist mediated episode of dispensing for the same condition cannot be regarded as comparable.

The primary focus for prescribing ongoing medications must be on the judicious treatment of the patient's medical issues and more holistic management though high-quality, continuous medical care. A collaborative and team-based approach will best support vulnerable populations and address a range of complex issues, including polypharmacy.

Extending pharmacist services must not compromise national standards with respect to patient safety and quality care, including separation of the roles of prescribing and dispensing.

National quality and safety regulators have developed compliance regimes for medical practitioners which deem the minimum acceptable standards for provision of medical services. These include extensive requirements for training, continuing professional development and ongoing skills credentialing; together with certification; professional liability cover; and the regulatory requirements for accreditation for medical surgeries. These requirements should equally apply to pharmacists if their roles re extended beyond their current scope of practice.

Infrastructure requirements must also be considered, including pharmacy facilities that are equivalent to a private general practice consulting room. This includes appropriate privacy and examination facilities, together with access to a set of past clinical notes, the capacity to order investigations appropriately, and to follow up on those investigations and recall a patient if there is a problem and make appropriate referrals.

In order to prevent conflicts of interest in patient treatment, it is a fundamental principle of our health system to separate the roles of prescribing and dispensing medications. This has always been the consistent justification for opposition from pharmacy organisations to doctors establishing a dispensing role, even in communities where there is no pharmacist.

This principle stands to be significantly undermined should pharmacists be able to both prescribe and dispense medications. The College believes there are a range of positive approaches to addressing this issue. For example, ACRRM would support the inclusion of a pharmacist resident within a general practice or primary care facility, as part of the health care team. It is noted that pharmacists also already work in clinical roles in hospital facilities.

Extending the role of pharmacists must not jeopardise access to a wider range of health care services especially in the longer term

Access to appropriate care is a critical issue for patient health and well-being especially in rural and remote locations, where people generally have a poorer overall health status than their urban counterparts.

Rural Generalists are best positioned to deliver cradle-to-grave care for patients and their families. They also provide a range of other services, including hospital, after-hours and emergency care; community and public health; aged care and palliative care.

In order to maintain these services within the community, the local rural medical practice must be viable and sustainable. Any measures which erode the scope of practice of medical practitioners or detract from the overall value proposition of rural medical practice will potentially jeopardise access not only to general practice-based primary care, but also to the other services that these doctors provide. In the longer term, this will result in increased risk and overall decreased service both to patients and pharmacy customers, particularly in rural and remote communities.

Strategies to deliver services to rural and remote communities must prioritise patient safety. They must reflect and clearly communicate an intent to the people in these communities, which is that they deserve doctors to care for them as in cities. Strategies with the intention of cost-cutting or providing a band-aid response in rural and remote areas are likely to increase pressure on the already stretched local health services and place the safety of patients at risk.

Supporting Innovation and new Models of Care

ACRRM is dedicated to ensuring that people in rural and remote areas have access to high quality care that meets their medical needs, and a Rural Generalist approach in which all health practitioners are encouraged to work to their broadest safe scope in effective healthcare teams.

The College is receptive to innovation which leads to improved care for rural and remote communities. To assess this, any proposals would need to be developed and implemented in an open, transparent and independent manner with the application of appropriate scientific rigour to evaluate if it produces meaningful improvements in care.

ACRRM is open to collaborative participation in the development and evaluation of new standards and trials relating to extending the scope of practice of pharmacists where:

1. There will be no requirement to sign a confidentiality agreement, or reasonable policies regarding the ability to seek input from key College Councils and Committees; and
2. The review process will be open, ethical and transparent at all stages.

ACRRM would also require mutual agreement with respect to:

1. Appropriate ethical oversight and peer review by a range of health care professionals including medical practitioners
2. Independent third-party investigators, reporting to Revised Standards for Quality Improvement Reporting Excellence (SQUIRE) 2.0 guidelines
3. Clear and measurable endpoints
4. Pharmacist are trained to agreed clinically safe standards within a clearly defined scope of practice and within a collaborative health care model
5. Timely, independent and clinically relevant follow up on all patients where clinical trials are involved
6. Assessment of cost effectiveness of the model of care first and foremost from a patient safety perspective.
7. Procedural design and funding capacity for independent management of reporting and investigation of undesirable/ unexpected patient outcomes to an independent authority such as the Health Ombudsman

ACRRM would welcome the opportunity to progress initiatives in which pharmacists can work in effective partnerships with their Rural Generalist and specialist General Practitioner colleagues together with other members of the primary health care team, to improve access to quality care for people in remote and rural areas.

Find out more

If you have any queries relating to this Position Statement, please contact us by:

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Endnotes

1 Shi L, Starfield B, Politzer R, Regan J. Primary care, self-rated health, and reductions in social disparities in health. Health Serv Res. 2002 Jun;37(3):529-50. doi: 10.1111/1475-6773.t01-1-00036. PMID: 12132594; PMCID: PMC1434650.

2 Australian Institute of Health and Welfare (2018). Transition between hospital and community care for patients with coronary heart disease: New South Wales and Victoria, 2012–2015. AIHW Cat. no. CDK 9.

3 Pereira Gray D, et al (2017) Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open 2018;8:e021161.

4 McQueenie R, Ellis D, et al. (2019) Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study. BMC Medicine. 17:2

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live, and pay respect to their Elders past present and future.