THE SOCIETY OF HOSPITAL PHARMACISTS OF AUSTRALIA

FEDERAL PRE-BUDGET SUBMISSION 2024-25

Introduction

The Society of Hospital Pharmacists of Australia (SHPA) is the national, professional organisation for the 6,100+ Hospital Pharmacists, and their Hospital Pharmacist Intern and Hospital Pharmacy Technician colleagues working across Australia's health system, advocating for their pivotal role improving the safety and quality of medicines use. Embedded in multidisciplinary medical teams and equipped with exceptional medicines management expertise, SHPA members are progressive advocates for clinical excellence, committed to evidence-based practice and passionate about patient care.

SHPA is pleased to present its 2024-25 Federal Pre-Budget Submission, promoting cost-effective solutions that enhance the efficiency and capacity of Australia's healthcare system. It calls for investment across three focus areas: scope of practice, workforce development and sustainability, and medicines access. Our recommendations aim to optimise patient care, improve medication safety, and provide equitable and affordable access to medicines for all Australians.

Background

Pharmacists as medicines experts operatively manage and clinically ensure the safe, efficient and effective use of medicines within Australia's hospital system. Hospital pharmacists are responsible for almost a quarter of all Pharmaceutical Benefits Scheme (PBS) medicines expenditure, accounting for just over $3 billion in expenditure from public and private hospitals each year.

Hospital pharmacists are skilled in providing clinical pharmacy services that enable the Federal Government to mitigate unnecessary health costs by reducing medication wastage, reducing medication-related harms, optimising medication use, decreasing patient length of stay in hospital and reducing hospital readmissions and their associated Medicare costs. The value of clinical pharmacy services is well-established in the literature, with an Australian economic analysis indicating a $23 return for every $1 invested in clinical pharmacy services.1

Pharmacists are able to alleviate pressures on medical colleagues by working to their full scope of practice. Pharmacy technicians also working to their full scope of practice through more efficient inpatient medication management systems and assisting in clinical support roles, enable pharmacists and nursing staff to spend more of their time delivering direct patient care and other clinical activities, ultimately improving patient outcomes and health system efficiency.

Increasingly, SHPA members are practicing outside of the four walls of a hospital, in non-dispensing, clinical roles, such as those in general practices, aged care facilities, and in Aboriginal Community Controlled Health Organisations (ACCHOs). Non-dispensing pharmacists practicing to their full scope within multidisciplinary teams, have yielded substantial economic and health benefits to Australia's primary care system. The highly specialised and evidence-based care being delivered by these pharmacists not only increases patient safety and satisfaction, but also increases the capacity of the primary care sector and reducing costs associated with preventable hospital admissions and specialist referrals.

SHPA welcomes the opportunity to partner with the Australian Government in implementing these solutions in a cost-effective and efficient manner, fostering advancements in the pharmacy sector for the benefit of patient care and Australia's overall health system.

For more information about our submission, please contact: Jerry Yik, Head of Policy and Advocacy, jyik@shpa.org.au.

LIST OF RECOMMENDATIONS IN SHPA'S FEDERAL PRE-BUDGET 2024-25 SUBMISSION

SCOPE OF PRACTICE

1. Fund the establishment of a **National Collaborative Pharmacist Prescribing Framework and National Pharmacy Technician Competency Framework**, developed and stewarded by SHPA to maximise the pharmacy sector's scope of practice, efficiency, timeliness, and quality of care.
    a. A **National Collaborative Pharmacist Prescribing Framework** would recognise pharmacists who are credentialed to prescribe in collaborative care settings, alleviating pressures on the healthcare system whilst improving medication safety and patient health outcomes.
    b. A **National Pharmacy Technician Competency Framework** would recognise the advanced skills and training of pharmacy technicians undertaking technician-led dispensing and medication supply functions, and support the development of the pharmacy technician workforce, increasing the capacity of pharmacists to perform alternative patient-facing clinical roles and alleviating pressures on the healthcare system.
2. **Embed non-dispensing pharmacists into primary care teams in general practices and residential aged care facilities** to enhance medication safety and quality use of medicines.
3. Fund the **expansion of the profession's well-recognised Standards of Practice Series** developed by SHPA, to guide the profession in delivering clinical, operational and specialty pharmacy services.

WORKFORCE DEVELOPMENT AND SUSTAINABILITY

4. **Fund private hospitals to provide SHPA's two-year Pharmacy Resident/Registrar Training Programs for pharmacists across Australia across 2025 and 2026**, to support workforce recruitment, retention and development, as well as enhance the capacity of this sector.
5. Provide **relocation funding and living allowances through Rural Health Workforce Australia for public and private sector pharmacists** undertaking SHPA's two-year Resident Training Program, addressing pharmacist workforce shortages in rural areas.

MEDICINES ACCESS

6. Transition to **independent five-year, nationally consistent Hospital Pharmacy Agreement for the public hospital pharmacy sector**, endorsed by and referenced into Clause A9 or A10 of Schedule A of the National Health Reform Agreement, with the Commonwealth, jurisdictional governments and SHPA as signatories.
    a. Implement Pharmaceutical Reform Agreements (PRAs) in New South Wales (NSW) and Australian Capital Territory (ACT).
    b. Enable public hospital pharmacies to supply PBS-subsidised medicines for inpatients.
7. **Improve First Nations equity of access to medicines and clinical pharmacy services, and support medication adherence** via;
    a. Enabling hospital pharmacists to supply medicines to Indigenous Australians under the Closing the Gap (CTG) PBS Co-Payment Program.
    b. Expanding the CTG PBS Co-Payment Program to include Section 100 medicines.
    c. Enabling Section 94 public and private hospital pharmacies to be Approved Service Providers.
    d. Integrating pharmacists within Aboriginal Community Controlled Health Organisations.

SCOPE OF PACTICE RECOMMENDATIONS

RECOMMENDATION 1

Fund the establishment of a National Prescribing and National Competency Framework established and stewarded by SHPA to maximise the pharmacy sector's scope of practice, efficiency, timeliness and quality of care.

a. A National Collaborative Pharmacist Prescribing Framework would recognise pharmacists who are credentialed to prescribe in collaborative care settings, alleviating pressures on the healthcare system whilst improving medication safety and patient health outcomes.

SHPA commends the Australian Government on its commitment to improving Australia's primary healthcare system whose limitations have placed undue pressures on the already stretched acute care system. SHPA welcomed the opportunity to provide feedback to the *Unleashing the Potential of our Health Workforce - Scope of Practice Review* in October 2023. SHPA's full submission can be viewed here.

SHPA stands as a well-established and authoritative entity, uniquely positioned to spearhead the establishment and stewardship of a National Collaborative Pharmacist Prescribing Framework. This framework would serve as a structured and formalised mechanism to officially recognise pharmacists who possess the necessary credentials to engage in prescribing activities within collaborative healthcare environments.

SHPA believes that all healthcare should be collaborative to achieve best patient health outcomes. SHPA has for years championed pharmacist-led prescribing practices in collaborative care settings – which have operated in Australian hospitals for over a decade – and invested in the specialty skills and recognition that are a cornerstone of safe, expanded scope of practice. SHPA recently also announced its National Credentialing program for Partnered Pharmacist Medication Charting (PPMC) as part of its Transformation 2024 agenda.

Theme 1 of SHPA's Pharmacy Forecast Australia 2023 report released in September 2023, focuses on expanding pharmacists and pharmacy technicians' scope of practice to support safer, more efficient, and cost-effective healthcare delivery. This includes the broadening of PPMC nationally and the expansion of practice for pharmacy technicians to achieve efficiency in medicines management and supply.

Expanding the scope of practice of pharmacists to include prescribing in collaborative care models offers a range of benefits to funders of the healthcare system, including the government. As medication experts, pharmacists are a more cost-efficient workforce who are able to reduce the need for specialist referrals and the frequency of visitations, whilst also mitigating errors that often lead to hospitalisation. Fundamentally, collaborative pharmacist prescribing will facilitate improved patient health outcomes, reduced long-term health conditions and associated expenses, improved healthcare system capacity and sustainability.

The significance of a National Collaborative Pharmacist Prescribing Framework lies in recognising and leveraging the unique skill set of pharmacists, enabling them to contribute directly to patient care through prescribing responsibilities. Pharmacists, with their extensive knowledge of medications, play a pivotal role in medication management, dosage adjustments, and therapeutic decision-making. By formally acknowledging and supporting pharmacists in this capacity, the framework ensures that their contributions are integrated seamlessly into collaborative care teams.

Funding would support the costs of convening an interdisciplinary working group with medical representation, including sitting fees, to guide the development of the National Collaborative Pharmacist Prescribing Framework. It would also support SHPA to allocate the resourcing necessary to develop and implement the Framework.

The calls for government funding to support this initiative reflects the commitment to advancing the role of pharmacists in delivering high-quality healthcare services. The National Collaborative Pharmacist Prescribing Framework acknowledging and harnessing the full potential of pharmacists in collaborative care settings, would lead to improved patient care, enhanced medication safety, and a more efficient and responsive healthcare system.

Cost of investment: $250,000 to fund the development of a National Collaborative Pharmacist Prescribing Framework

b. A National Pharmacy Technician Competency Framework would recognise the advanced skills and training of pharmacy technicians undertaking technician-led dispensing and medication supply functions, and support the development of the pharmacy technician workforce, increasing the capacity of pharmacists to perform alternative patient-facing clinical roles and alleviating pressures on the healthcare system.

To enable pharmacists to practice to their full scope and alleviate pressures on medical colleagues, the pharmacy technician workforce must likewise be supported to expand their scope of practice. In some hospitals in Australia, pharmacy technicians are expanding their scope of practice to support pharmacists and increase their capacity to perform more clinical and patient facing roles.

An example of this is the tech-check-tech model undertaken by many pharmacy technicians in the ACT, Victoria, Queensland and in South Australia. In this model, after successfully completing advanced training, pharmacy technicians can check the accuracy of a dispensed item against the corresponding prescription or medication order. A meta-analysis of accuracy checking proficiency demonstrated that pharmacy technicians demonstrated a higher level of accuracy than pharmacists (99.72% vs 99.27%).[2]

Internationally, expanded technician scope of practice has existed and advanced over many years, with pharmacy technician accuracy checking commonplace in hospitals and community pharmacies in the United Kingdom[3], Canada[4] and New Zealand[5].

As the role of pharmacists continues to evolve in hospitals, pharmacy technicians are increasingly participating in clinical roles under the supervision of pharmacists, as outlined in *SHPA's Standard of Practice for Pharmacy Technicians to support Clinical Pharmacy Services.*[6] Pharmacy technicians can document allergy statuses on medication charts and complete Best Possible Medication Histories (BPMH) for newly admitted patients in hospitals, allowing pharmacists to prioritise clinical tasks such as reconciling these medications and assessing them for appropriateness.

The benefits of a pharmacy technician completing BPMHs has been successfully demonstrated for surgical patients through a perioperative clinical support technician (PCST) role. Time taken for the pharmacist to complete a BPMH was shown to reduce by 25% if a PCST was involved.[7]

Nursing staff shortages have placed undue pressures on an already overstretched health system in Australia. Protecting nursing time should be a priority for the government. Pharmacy technicians working to their full scope of practice through more efficient inpatient medication management systems enables nursing staff to spend more of their time delivering direct patient care and other clinical activities, ultimately improving patient outcomes.

Ahead of the Tasmanian Health Service implementing the Bedside Medication Management (BMM) model a few years ago, an evaluation conducted by KPMG for the Tasmanian Health Service concluded that Tasmanian nurses 'waste' over 1,526 hours each week on reactively managing medication orders and supply for inpatients, time which could have been spent on delivering direct patient care.

The role of ward-based pharmacy technicians in the BMM model is to co-ordinate and streamline timely supply of medications, coordinate, and maintain appropriate storage of medications, as well as to remove ceased and unwanted medications from patient care areas. This ensures cost-saving medication stock management at a ward level, cost-savings by the return of unused medicines, timely supply of newly initiated medications, and reduces the risk of administration of expired or incorrect medications. Supplying medications in a timely manner also prevents missed doses from occurring, ensuring patient treatment is not interrupted, and fundamentally, supports the flow of patients through hospitals by preventing gaps in treatment.

In addition to SHPA's Technician and Assistants Specialty Practice Group, SHPA has recently established a pharmacy technician and assistants working group to help fast-track career development and recognition through the newly launched ANZCAP, and is undergoing Constitutional changes in 2024 to embed an elected Technician Director to the Board. Through these measures, SHPA

is able to ensure that the thousands of pharmacy technicians and assistants working across Australia's public and private hospitals and in all community pharmacy settings are represented, acknowledged and supported to continue the critical role they play in the nation's pharmacy workforce, to the benefit of the broader care team and Australian patients.

Formally recognising pharmacy technicians as registered healthcare professionals through the Australian Health Practitioner Regulation Agency (AHPRA) would ensure a standardised and regulated level of competency, enhancing the overall quality and safety of medication management in Australia. Registration through the Pharmacy Board of Australia (PBA) would support pharmacy technicians to further expand their roles and responsibilities, contributing significantly to the optimisation of pharmacy services, and would facilitate a clearer career pathway for technicians, fostering professional growth and specialisation. The establishment of a National Pharmacy Technician Competency Framework would support PBA in the registration process should this come to fruition.

Funding would support the costs of convening an interdisciplinary working group, including sitting fees, to guide the development of the National Pharmacy Technician Competency Framework. It would also support SHPA to allocate the resourcing necessary to develop and implement the Framework.

As a truly inclusive organisation that embraces the entire pharmacy profession, SHPA is well placed to develop, establish and steward a National Pharmacy Technician Competency Framework. This government supported framework would provide a structured pathway for recognising and enhancing the specialised expertise of pharmacy technicians, thereby bolstering the efficiency of technician-led dispensing and medication supply functions. Moreover, the framework would actively support the ongoing development of the pharmacy technician workforce, cultivating a pool of highly skilled professionals capable of adapting to the evolving healthcare landscape.

Cost of investment: $250,000 to fund the development of a National Pharmacy Technician Competency Framework

RECOMMENDATION 2

Embed non-dispensing pharmacists into primary care teams in general practices and residential aged care facilities to promote the safe and quality use of medicines, and to support high-risk patients, such as those transitioning between care settings, to improve the overall capacity of the health system and patient health outcomes.

Embedding pharmacists in general practices and residential aged care facilities not only aligns with the government's health priorities but also presents a tangible opportunity to strengthen the overall capacity of the health system, improve patient outcomes, and realise cost-effective healthcare delivery.

Theme 1 of SHPA's Pharmacy Forecast Australia 2023 report, as noted previously, focuses on expanding pharmacists and pharmacy technicians' scope of practice to support safer, more efficient, and cost-effective healthcare delivery. This includes adopting the successful multidisciplinary collaborative care models of practice used in the acute care setting and embedding non-dispensing, clinical pharmacists in GP practices and in various other primary care settings.

Non-dispensing pharmacists practising at full scope within multidisciplinary teams play a significant role in medicines optimisation and patient safety. Their integration into primary care teams is crucial to addressing the increasing barriers that patients face in accessing GP services, leading to delayed diagnoses and subsequent advanced disease progression, and fundamentally increased costs to the healthcare system.

An estimated 250,000 hospital admissions in Australia are medication related, with an annual cost of $1.4 billion to the healthcare system, and two-thirds of medication-related hospital admissions are potentially preventable.[8] This is largely reflective of the current shortfalls of primary care service delivery and the existence of legislative and funding barriers in the delivery of effective primary care and preventative care.

The integration of pharmacists into general practice is an example of healthcare practitioners working to their full or expanded scope within multidisciplinary teams in a primary care setting. This model has yielded substantial benefits including:

Medication management: General Practice Pharmacists (GPPs) support comprehensive medication management, identifying potential drug interactions and suggesting dose adjustments. Key feedback from several qualitative studies reviewing Australian GP perspective showed GPPs enhanced medication safety, strengthened by shared decision making and improved tackling of polypharmacy in the management of their patients.[9,10] This expertise aids in deprescribing unnecessary medications and ensures that the patient is on the most appropriate medication regimen.[11]

Chronic disease management: with an in-depth understanding of pharmacotherapy, GPPs complement the work of GPs in managing chronic conditions like diabetes, hypertension, and asthma, often leading to more optimised therapy and improved patient outcomes. A systematic review assessing the role of pharmacists in primary care services showed that pharmacist interventions led to positive effects on measures of blood pressure, diabetes, cholesterol, cardiovascular risk scores, and reduced inappropriate prescribing and medication-related issues.[12]

Preventative care: GPPs offer immunisation services, advice on lifestyle modifications, and preventative health screenings, thereby playing a significant role in preventive care, which is an essential focus of primary care. An evaluation into the clinical, economic, and organisational impact of pharmacist-led clinical activities including preventive care services in eight general practices in the Australian Capital Territory (ACT) showed that 50% of clinical activities had the potential for a moderate or major positive clinical impact on patients and 63% of activities had potential to decrease healthcare costs.[13]

Transitions of care: GPPs also support medication management at key transitions of care such as between the primary and acute care setting, when patients are at a high-risk of medication misadventures, as recognised by the Australian Commission on Safety and Quality in Health Care (the Commission) in their report on Safety Issues at Transitions of Care.[14] Changes made to a patient's medications during their hospital stay and often communicated to the patient and/or their carer at the point of discharge, can at times be an information overload at a time when the patient is vulnerable and recovering from their admission. GPPs ensures patients understand these changes and are taking their medications as intended upon discharge from hospital. A systematic review and

meta-analysis looking at the impact of community placed pharmacists during transitions of care showed 40% reduction in 30-day readmissions, with more active pharmacist involvement having a greater effect on 30-day readmission rates.[15]

This highly specialised and evidence-based care being delivered by GPPs not only increases patient safety and satisfaction, but also increases the capacity of general practitioners to see more patients whilst reducing costs associated with preventable hospital admissions and specialist referrals.

Similarly, embedding pharmacists in Aged Care facilities as recommended by the Royal Commission into Aged Care Quality and Safety: Final Report[16], is a solution to improving the quality use of medicines in this setting and provides equity of access to regular medication review and medicines optimisation for aged care residents and home care clients.

Australian evidence highlighted that embedded clinical pharmacist services in aged care homes can reduce medication-related problems, polypharmacy and adverse drug events, while also being cost-effective.[17] and anywhere where medications are being used, such as Aboriginal Health Services and prisons, will significantly improve the safe and quality use of medications and patient health outcomes in primary care.

Deprescribing, which is the process of stopping a medication or reducing its dose to improve the person's health or reduce the risk of adverse effects, is an important strategy for reducing unnecessary and inappropriate medication use in aged care residents. There is evidence that pharmacists can effectively identify medications that should be deprescribed, and implement and monitor deprescribing plans to ensure medications are safely withdrawn while minimising risk of adverse drug withdrawal effects.[18] This includes the deprescribing of psychotropic medications that are prescribed inappropriately in people older Australians and associated with falls and increased risk of mortality.[19]

These important pharmacist roles in GP practice settings and residential aged care settings to provide pharmacy care to patients, especially at the transitions of care will support safer and more appropriate medicines use. However, there is currently no consistent approach for these to be implemented and thus has resulted in limited uptake across Australia.

These roles and services should be designed, implemented and evaluated independently to ensure they are cost-effective. The government should consider establishing a separate "Medication Management Services Agreement" should be established with a broad range of stakeholders to enable the funding of medication management services. An alternative would be to fund these through the Medicare Benefits Schedule, Primary Health Networks (PHN) or other mechanisms that allow for independent service provision by a pharmacist.

RECOMMENDATION 3

Fund the expansion of the profession's well-recognised Standards of Practice Series developed by SHPA, that provide guidance to pharmacists and health professionals on the delivery of clinical, operational and specialty pharmacy services, to shepherd the profession as it expands its scope of practice to enhance the capacity of Australia's health system.

As the pharmacy profession advances and diversifies its role in not just acute but also primary care settings including community pharmacy settings, a robust framework of standards becomes increasingly essential to maintain consistency, excellence, and patient-focused care.

SHPA has been setting standards that drive best-practice for over two decades. The Standards of Practice Series includes over 20 Standards developed by SHPA across a range of clinical and non-clinical disciplines.

SHPA's renowned Standard of Practice for Clinical Pharmacy Services[20] is supported by a range of speciality Standards that define practice across specific disciplines in healthcare. These speciality Standards are imperative to the delivery of high quality specialised care and are designed to be read in conjunction with the Standard of Practice for Clinical Pharmacy Services.

SHPA's Standards of Practice Series serve as a benchmark and are widely utilised and well-referenced by a range of health professionals seeking guidance on medication management services in multidisciplinary settings. The Series draws on the collective expertise of SHPA members across all areas of practice and is based on research and the expertise of SHPA's Leadership Committees.

For example, the Standard of practice in geriatric medicine for pharmacy services, published in 2020, describes best practice clinical pharmacy care for geriatric patients across hospital, sub-acute, community and residential care settings. This Standard will be highly relevant to the forthcoming embedded pharmacists in aged care program.

Standards drive quality and set the baseline standard of care to ensure safety is prioritised at all times, whilst also promoting the highest level of quality care health practitioners and organisations should aspire to provide.[21] A fundamental component of Standards is to describe essential services, which are defined as services that reflect the full scope of contemporary practice, but to also define innovative, future-focused services and models of care.[22] As pharmacy practice in the community pharmacy setting becomes increasingly clinically-focused and specialised, with the advent of pharmacist-led clinics in this setting that will reduce the strain on other parts of the healthcare sector, there is a strong need for standards to guide these new and innovative services beyond existing standards.

SHPA is currently undertaking a comprehensive review of its flagship Standard of Practice for Clinical Pharmacy Services. By investing in the expansion of the Standards of Practice Series, the government ensures that the profession is well-equipped to meet the evolving demands of the healthcare landscape.

Funding the Standards of Practice Series developed by SHPA would facilitate their availability to a much broader audience as they will no longer have to remain as a SHPA member benefit sitting behind a paywall. They will be accessible to all health professionals across all health care settings seeking guidance on best practice medication management services, ultimately improving patient care.

Fundamentally, supporting the expansion of SHPA's Standards of Practice Series is an investment in the future of pharmacy practice across all healthcare settings, and, by extension, the broader health system. It serves as a strategic initiative that not only fortifies the professional capabilities of pharmacists but also contributes to the government's overarching objective of building a resilient, patient-centred, and efficient healthcare system for the benefit of all Australians.

Cost of investment: $300,000 per annum to support the ongoing expansion of SHPA's Standard of Practice Series

WORKFORCE DEVELOPMENT AND SUSTAINABILITY RECOMMENDATIONS

RECOMMENDATION 4

Fund private hospitals to provide SHPA's two-year Pharmacy Resident/Registrar Training Programs for pharmacists across Australia across 2025 and 2026, to support workforce recruitment, retention and development, as well as enhance the capacity of this sector.

Private hospitals play a pivotal role in the overall healthcare landscape, providing additional capacity and choice for Australians, and alleviating pressure on the already strained public health system. Private hospitals, often offering a diverse range of specialised and advanced clinical services, require a highly skilled and expert workforce to ensure the delivery of safe and quality care.

SHPA's Resident and Registrar Training Programs (previously known as the Foundation Residency and Advanced Training Residency Programs) are Australia's premier structured, formalised, supported and accredited national pharmacy training programs. By providing a structured and supported training environment, the Resident Training Program equips early career pharmacists with foundation clinical skills whilst the Registrar Training Program offers a pathway for speciality development for pharmacists with three to five years of foundation hospital experience, seeking to advance their practice towards *ANZCAP Registrar* status.

The economic impact of pharmacists undertaking these training programs is substantial, as well-trained pharmacists contribute to streamlined healthcare delivery, reducing medication errors, optimising therapeutic outcomes, and mitigating unnecessary healthcare costs associated with suboptimal pharmaceutical care. The value of clinical pharmacy services is well documented in literature, with an Australian economic analysis indicating a $23 return for every $1 spent on clinical pharmacy services.[23]

The private hospital sector, accounting for only 2% of all pharmacists undertaking SHPA's Training Programs, encounters distinct challenges in delivering training and education to their staff compared with the public sector. Unlike public hospitals, private facilities often operate within a more commercial framework, which can limit the resources allocated to comprehensive training programs. Financial constraints hinder the development of extensive educational initiatives and ongoing professional development opportunities for private hospital staff.

Additionally, the private sector face challenges in coordinating centralised training due to the diverse range of specialised services often offered by private hospitals. SHPA's Registrar Training Program offers 11 speciality Practice Area Pathways in addition to the common framework, and further pathways are currently in development.

The private hospital sector would greatly benefit from having their staff undertake training in some of these Practice Area Pathways which align with the specialised services they deliver, including:

- Surgery and Perioperative Medicine
- Oncology and Haematology
- Critical Care
- Mental Health
- Emergency Medicine

Ramsay Health and ICON Group are two major national private hospital groups that are currently accredited, or in the final stages of accreditation with SHPA to be eligible to deliver our training programs. St John of God Health Care is also accredited to deliver training in one of its major hospitals in Western Australia. All three of these organisations have expressed an eagerness to expand the training they currently deliver through SHPA, across the country, as a means of ensuring their patients receive the best possible healthcare, whilst supporting the recruitment and retention of their valued staff. However, cost is the common prohibiting factor.

Table 1 shows that, with sufficient support from the Federal government, Ramsay Health, ICON Group, and St John of God Health Care, are keen to provide a total of 96 additional positions for pharmacists undertaking SHPA's Resident and Registrar Training

Programs in 2025 and 2026. Funding would be used to cover the cost of the pharmacists, their training, and the clinical educator costs required to mentor candidates across the two-year duration of the program.

Fundamentally, health and economic outcomes are best achieved with a knowledgeable and skilled workforce, and these two-year training programs not only upskill the workforce and alleviate pressures on public hospitals, but also act as an imperative strategy to combat the recruitment and retention challenges facing the private sector.

Cost of investment: $24.2 million to support 96 additional private hospital pharmacists to undertake SHPA's two-year Resident and Registrar Training Programs across five jurisdictions in Australia in 2025 and 2026.

Table 1: Proposed Private Hospital Pharmacist Training Programs in 2025 and 2026

	Resident Training Program					**Registrar Training Program**				
Resourcing and Costing	**NSW**	**QLD**	**SA**	**VIC**	**WA**	**NSW**	**QLD**	**SA**	**VIC**	**WA**
Training positions with Ramsay Health	15	17		12		13	15	1	8	
Training positions with ICON Group	3	3		3	2					
Training positions with St John of God Health Care					2					2
Cost per 1 FTE pharmacist resident/ registrar training position per annum (salary, oncosts & professional development)	$107,704					$124,302				
Cost of 0.1 FTE Clinical Educator Pharmacist per pharmacist resident/ registrar training position per annum	$11,462					$11,462				
Total number of additional private hospital pharmacist resident/registrar training positions	57					39				
Total cost per training program per annum	$6,792,462					$5,294,812				
Overall cost of delivering each of the 2-year training programs	$13,584,924					$10,589,623				
Overall cost of investment	**$24,174,547**									

RECOMMENDATION 5

Provide relocation and living support via Rural Health Workforce Australia for pharmacists undertaking SHPA's two-year Pharmacy Resident Training Program, enabling a six-month rural hospital rotation, addressing workforce shortages in these areas.

Healthcare recruitment in regional and rural Australia poses a multifaceted challenge, one of which is the scarcity of healthcare professionals willing to practice in remote areas, leading to persistent workforce shortages severely impacting rural communities. Addressing this issue requires comprehensive strategies that incentivise healthcare professionals to work in rural areas, ultimately ensuring equitable access to healthcare services across the country.

According to the *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032*[24], addressing inequities of access to health services and poorer health outcomes among people in rural and remote Australia has been a strong focus for the Australian government. However, data from the National Health Workforce Dataset demonstrates that whether you look at pharmacy workforce statistics on a per capita or per 100 hospital beds metric, regional and rural Australia pharmacy workforce numbers are far below metropolitan pharmacy workforce statistics. Only 13% of the pharmacists currently undertaking SHPA's two-year Pharmacy Residency Program are practicing in a regional, rural, or remote hospital nationally.

Regional SHPA members have reported extreme difficulty in recruiting pharmacist positions in rural and regional areas, with recruitment often needing to go beyond three rounds of recruitment regardless of the role, and often being unsuccessful altogether. Some smaller rural and remote hospitals have recently undertaken the process of becoming SHPA-accredited residency sites as a means of bolstering their recruitment process.

Relocation funding and living allowances alleviate financial burdens associated with moving to and living in regional locations, making it more attractive for pharmacists to consider undertaking their training in these areas. This strategy ensures a steady influx of skilled pharmacy professionals into these underserved areas, directly combating workforce shortages and enhancing the overall healthcare infrastructure.

Large metropolitan public and private hospitals accredited to deliver SHPA's Residency Training Program, can partner with smaller regional and rural hospitals, and send their pharmacists to undertake a six-month rotation at these sites as part of their two-year training. This model, which already exists between The Alfred in Victoria and both Central Gippsland Health (Vic) and Alice Springs Hospital (NT), is a means of ensuring efficient workforce distribution and bolstering the capacity of regional healthcare facilities, whist also upskilling pharmacists practicing in metropolitan areas and enhancing their skills and experience.

Exposure to rural and regional practice in a six-month rotation not only enriches the skills and capabilities of participating pharmacists but also provides them with a firsthand understanding of the unique challenges and healthcare needs in these areas. This experience contributes to a more well-rounded and adaptable pharmacy workforce that is equipped to address the diverse healthcare requirements of regional communities.

SHPA therefore, calls for $8,000 relocation and living allowance per candidate, to be available for up to 50 pharmacists per annum, willing to undertake a six-month placement in a regional or rural hospital whilst completing their Residency Training Program through SHPA. By partnering with Rural Health Workforce Australia, the government can leverage existing networks and resources dedicated to rural healthcare professionals to support the pharmacist workforce in these areas. The onus would be on the metropolitan and regional or rural hospitals to form a partnership that facilitates these placements, whilst Rural Health Workforce Australia, with the support of the Federal government, would cover their relocation and living allowances.

Cost of investment: $400,000 per annum relocation and living support for 50 pharmacists to undertake a six-month rotation in a regional or rural hospital whilst completing SHPA's two-year Resident Training Program.

MEDICINES ACCESS RECOMMENDATIONS

RECOMMENDATION 6

Transition to independent five-year, nationally consistent Hospital Pharmacy Agreement for the public hospital pharmacy sector, endorsed by and referenced into Clause A9 or A10 of Schedule A of the National Health Reform Agreement, with the Commonwealth, jurisdictional governments and SHPA as signatories.

An independent five-year, nationally consistent Hospital Pharmacy Agreement is imperative for advancing the quality and sustainability of healthcare services across Australia. The existing healthcare landscape demands a comprehensive framework that ensures consistent standards, equitable access, and efficient delivery of pharmacy services within public hospitals. By endorsing and referencing this agreement into Clause A9 or A10 of Schedule A of the National Health Reform Agreement, as recommended by the Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025[25], we establish a robust foundation for collaboration between the Commonwealth, jurisdictional governments, and the SHPA.

This proposed agreement serves as a strategic pathway to harmonise and standardise practices, fostering a cohesive approach to pharmacy services that aligns with the evolving needs of patients and the healthcare system. By extending the agreement to a five-year term, the stability necessary for effective long-term planning, resource allocation, and continuous improvement initiatives can be provided. The inclusion of SHPA as a signatory underscores the importance of engaging pharmacy professionals in shaping policies that directly impact patient care.

Furthermore, this recommendation aligns with the principles of the National Health Reform Agreement, emphasising collaboration, quality improvement, and efficiency in healthcare delivery. By integrating pharmacy services into the agreement, we acknowledge the critical role that pharmacists play in patient outcomes and safety within the hospital setting. The independent and nationally consistent nature of the proposed agreement ensures that pharmacy services are tailored to the specific needs of each jurisdiction while maintaining a cohesive and standardised approach at the national level.

a. Implement Pharmaceutical Reform Agreements (PRAs) in New South Wales (NSW) and Australian Capital Territory (ACT) to achieve equitable access to Pharmaceutical Benefits Scheme (PBS) medicines, support safer discharges and transitions of care and ease reliance on primary healthcare systems.

Whilst hospital pharmacies only form 5% of the PBS approved suppliers, they account for just under a quarter of all PBS expenditure, which the Australian Government expended $17 billion from 1 July 2022 to the 30 June 2023. Hospital pharmacy also accounts for the majority of section 100 PBS medicines, often where complex and high-cost medicines are funded under. The expansion of PBS into public hospitals through PRAs has enabled hospital prescribers and pharmacists to prescribe and dispense PBS subsidised medicines to patients upon discharge from hospital, outpatients and patients receiving care from daytreatment services.

Access to PBS subsidised quantities of medicines is not afforded to Australians being discharged from public hospitals in NSW and ACT. SHPA understands that both NSW and ACT governments have formally written to the Ministers of Health of the current and previous governments, requesting establishment of PRAs. This has been recently reiterated publicly in the ACT's *Health Services Plan 2022-2030* and the NSW Government's *Response to the Inquiry into Public Hospital Access Block and Ambulance Ramping*.

PRAs have worked to achieve 'Ongoing access to medicines,' Guiding Principle 10 of the *Guiding Principles to Achieve Continuity in Medication Management*[26] document published late last year. They have supported the continuity of care for patients discharging from hospital back into the community by allowing for patients to be supplied the standard PBS quantity of one-months' supply of discharge medicines and eliminating the need for them to make an appointment to see their local GP for medicines post-discharge.

This contrasts with the patients being discharged from public hospitals in NSW and ACT who are currently supplied only 3-7 days' worth of discharge medicines, and are forced to seek an immediate GP appointment to access more medicines prescriptions for vital treatments that will prevent readmission to hospital. This expectation is extremely difficult to achieve with the current GP shortages where Australians often have to wait up to three to four weeks to see their GP.

PRA arrangements in other jurisdictions have also allowed more hospital pharmacists to be employed and provide clinical pharmacy activities to patients, as well as allow investment into specialised pharmacy services, such as pharmacists specialising in oncology, paediatrics, emergency medicine and geriatric medicine. These services are necessary to safeguard and maximise the federal government's investment into new PBS medicines that treat complex conditions.

Equitable access to healthcare regardless of location, is one of the principals of the National Medicines Policy (NMP).[2] Truly equitable healthcare cannot be achieved without established PRA arrangements in all states and territories in Australia. SHPA therefore, strongly recommends that the Commonwealth should make the PRAs a uniform policy in Australia and enter into PRAs with NSW and ACT, ensuring a consistent standard of care for vulnerable patients, and alleviating pressure on the primary care sector in the immediate post-discharge period.

Cost of investment: Anticipated to be relatively cost neutral as number of PBS medicine dispensing episodes does not increase as a result of this change

b. Enable public hospital pharmacies to supply PBS-subsidised medicines for public hospital inpatients to achieve equity and enhance quality use of medicines and medicines safety.

The PBS aims to provide timely, reliable and affordable access to necessary medicines for Australians in line with the central pillars and the principle of equity in the NMP. However, the current limitations in PBS funding for medications in hospital settings, particularly for public hospital inpatients, present a significant challenge to achieving timely and equitable access to necessary medicines. Despite over 20 years of discussions and evolving healthcare models, including Hospital in the Home programs and telehealth services, that blur the lines between hospital and community, the scope of PBS subsidy remains restricted, creating inequities in access.

Public hospitals are sometimes unable to fund treatment for expensive medicines for inpatients without PBS support. This is often problematic for drugs that require hospitalisation as part of the treatment, such as blinatumomab, iron infusions, depot injections for schizophrenia, and oral chemotherapy, highlighting a tension emblematic of historical federal-state funding conflicts.[27]

This issue is further exacerbated by the evolving definition of hospital inpatients and the shifting landscape of healthcare delivery, with public hospitals facing challenges in funding high-cost medicines for inpatients. Public hospitals treating patients taking high-cost medicines in the community that are listed under Section 100 Highly Specialised Drugs (HSD) or are high-cost Section 85 medicines, are often forced to open PBS packs of very high-cost medicines, such as those used to treat cystic fibrosis, or oral chemotherapy, to ensure continuation of therapy in hospital.

The lack of access to PBS subsidised medicines for public hospital inpatients also creates cost-shifting incentives at the expense of efficient, quality and safe healthcare delivery and impacting patient healthcare outcomes. Without PBS subsidy for public hospital inpatients, there are perverse incentives to delay initiation of certain higher cost treatments until the point of discharge to access PBS subsidy, such as antipsychotic depot injections, iron infusions, Hepatitis C medications, infusions for osteoporosis, and cancer therapy. In some cases, patients are provided outpatient prescriptions for high-cost medicines to be dispensed under the PBS in the community, and bring it to the hospital for administration as an inpatient.

The lack of uniform access to PBS subsidised medicines not only hampers patient outcomes but also introduces inefficiencies, cost implications, and ethical dilemmas for clinicians. SHPA strongly advocates for the extension of the PBS to cover all hospital medications which has been identified by the National Centre for Social and Economic Modelling as a key measure that would increase equity of access, remove incentives for cost shifting, and better meet the needs of patients.[28]

RECOMMENDATION 7

Improve First Nations equity of access to medicines and clinical pharmacy services, and support medication adherence.

For many years, Indigenous Australians have experienced significantly poorer outcomes in areas of health compared to other Australians. The burden of disease for Aboriginal and Torres Strait Islander peoples is currently 2.3 times that of other Australians.[29] This disparity has persisted despite various policy efforts aimed at addressing them.

a. Enabling hospital pharmacists to supply all medicines to Indigenous Australians under the Closing the Gap (CTG) PBS Co-Payment Program

The current exclusion of public hospital pharmacies from the CTG PBS Co-payment Program creates substantial barriers for Indigenous patients, leading to ongoing inequities in accessing vital medicines. This exclusion results in Indigenous patients being charged regular co-payments at discharge or outpatient appointments at public hospitals.

Attempts by public hospital pharmacists to facilitate access through community pharmacies are hindered by the inability to register eligible Aboriginal and Torres Strait Islander people for the CTG PBS Co-payment Program via HPOS. Public hospital pharmacists do not have a commercial incentive and should be able to register eligible patients to facilitate continuity of care and vital medicines access.

These issues have resulted in ongoing inequity in the provision of medicines to Indigenous people in public hospitals, reducing their medication adherence and impacting their ability to meet treatment goals and improve their overall health. In many instances the current policy design does not place Indigenous patients at the centre of its care, often impacting their access to medicines.

Research shows that Indigenous people have lower medication adherence compared to other population groups[30], and that over a quarter of patients fail to make it to a local pharmacy until days later to have their discharge prescription dispensed.[31] Poor access to medications can potentially compromise a patient's health and cause preventable hospital readmissions. This also prevents the provision of expert advice related to the new medication regimen by the pharmacist who has counselled them during their inpatient stay. Hospitals also have better access to Aboriginal Health Workers who can support the medication counselling process at discharge providing culturally appropriate and safe care.

Some states and territories are using their hospital budget to absorb the co-payment costs to attempt to correct the inequity caused by the Federal Government's exclusion of public hospital pharmacies from participating in the CTG PBS Co-payment Program. Hospital pharmacists are involved in various workarounds across Australian healthcare settings to facilitate access to the CTG PBS Co-payment Program, often leading to high variability and inconsistency in the quality of care being provided as evident is Table 2 below. These inconsistencies result in further access inequities and confusion amongst Indigenous people receiving or not receiving variable subsidies based on where they happen to receive care.

SHPA has been relentless in its advocacy on this issue which the Senate supported in its amendment of the National Health Amendment (effect of Prosecution-Approved Pharmacist Corporations) Bill 2023 in March last year. SHPA continues to advocate for this significant and low-cost measure that will improve access to medicines in public hospitals for Indigenous Australian. Given that hospitals account for approximately 1.5% of the overall $67M CTG PBS expenditure per annum, SHPA estimates enabling hospital pharmacists to supply all medicines to Indigenous Australians under the CTG PBS Co-Payment Measure to approximately cost the government a modest $1M.

Cost of investment: ~$1 million to enable hospital pharmacists to supply all medicines to Indigenous Australians under the CTG PBS Co-Payment Program

Table 2: CTG PBS Co-payment Program State-by-State Variations

	ACT	NSW	Vic	Qld	SA	NT	WA	Tas
PBS quantities of medications are supplied to Indigenous patients on discharge from public hospitals	✓	✗	✓	✓	✓	✗	✗	✓
Subsidies are available for PBS quantities of medications supplied to Indigenous patients on discharge from public hospitals	✓	✗	✓	✓	✓	✓	✓	✓
	Whilst many public hospitals use their budget to absorb the co-payment costs not funded by the Commonwealth through the CTG PBS Co-payment Program, this places pressure on already overstretched hospital services and does NOT contribute to patient's safety net.							
The **Federal Government subsidises the PBS co-payment** for Indigenous patients needing medications upon discharge from public hospitals	✗	✗	✗	✗	✗	✗	✗	✗
All Indigenous patients discharging from any hospital in the State/Territory have the **same access to discharge medications**	✓	✗	✗	✗	✓	✗	✗	✓

b. Expanding the CTG PBS Co-payment Program to include all medicines listed under Section 100 programs

The CTG PBS Co-payment Program currently only enables reduced co-payments for Section 85 General Schedule PBS medicines, and not medicines listed under Section 100 programs. These programs, including the Highly Specialised Drugs Program, Efficient Funding of Chemotherapy, and Opiate Dependence Treatment Program, encompass crucial treatments for various medical conditions, particularly those with complex and specialised healthcare needs. Unfortunately, the current program's exclusions result in Indigenous patients facing regular co-payments for these vital medicines, hindering their ability to adhere to prescribed treatment regimens.

The National Medicines Policy states that cost should not be a substantial barrier for Australians to access the medicines they require. Yet, results from the 2018–19 National Aboriginal and Torres Strait Islander Health Survey[32] showed that cost was the most common barrier (36%) preventing Indigenous Australians from having their prescriptions filled in the past 12 months.

Expanding the CTG PBS Co-payment Program to encompass all medicines listed under Section 100 programs is not only a matter of equity but is crucial for addressing the unique healthcare requirements of Indigenous patients. Many medications falling under Section 100 programs are for conditions with a higher prevalence or severity among Indigenous populations. For example, Indigenous Australians have a higher rate of cancer diagnosis, and are approximately 40% more likely to die from cancer compared to non-Indigenous Australians.[33]

A compelling argument for this expansion lies in the commitment to providing equitable healthcare access and eliminating disparities in medication affordability. By including all medicines listed under Section 100 programs in the CTG PBS Co-payment Program, we ensure that Indigenous patients can access these essential medications without facing financial barriers. This not only promotes adherence to prescribed treatments but also supports better health outcomes, reducing the risk of preventable complications and hospital readmissions.

Furthermore, aligning the CTG PBS Co-payment Program with Section 100 programs acknowledges the diverse and complex healthcare needs of Indigenous populations. It emphasizes a patient-centric approach that recognizes the importance of specialized

medications in managing various health conditions prevalent among Indigenous communities. This expansion represents a tangible step toward healthcare equity, aligning with broader national efforts to address health disparities and improve the overall well-being of Indigenous Australians.

c. Enabling Section 94 public and private hospital pharmacies to be Approved Service Providers and participate in the IDAA Program

The Section 100 RAAHS program rules prevent Indigenous patients from collecting their DAAs from their local DAA packing pharmacies and receiving appropriate counselling by a pharmacist. The Section 100 RAAHS Program rules stipulate that PBS items must be supplied directly by the approved pharmacist or the approved hospital authority, to the participating Aboriginal Health Services (AHS), to be supplied to the patient by a nurse or Aboriginal Health Worker, and not directly to the patient by the supplying pharmacy.

This means that Indigenous patients travelling into rural, regional or urban areas away from where their DAA packing pharmacy is located, are unable to access their DAAs when and where they need them, and receive appropriate counselling by a pharmacist, and must instead travel back to their remote location to collect the DAA from their Section 100 RAAHS. Patients who are accessing healthcare from hospitals in urban, regional, or rural locations may be travelling for several days or weeks before returning to their remote communities. This process is inefficient, not patient-centred and contributes to reduced medicines adherence, and medicines wastage.

Similarly, Indigenous patients requiring DAAs upon discharge from hospital, or after receiving care as day admitted patients, or in an out-patient clinic, are also unable to access DAAs when and where they need them, since Section 94 public and private hospital pharmacy departments are currently unable to participate in the Indigenous DAAs (IDAA) Program. Only Section 90 Pharmacies are eligible to become an Approved Service Provider and participate in the current IDAA Program.

d. Integrating pharmacists within Aboriginal Community Controlled Health Services to improve chronic disease management

Pharmacists employed by ACCHOs would facilitate safe and quality use of medicines, improve compliance and support safe transitions of care for Indigenous communities. Integrating pharmacists within Aboriginal Community Controlled Health Services, as recently supported by the Medical Services Advisory Committee's (MSAC) positive assessment of the *Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management (IPAC) project*[34], would improve chronic disease management. Embedding pharmacists into ACCHOs would ensure that First Nations patients discharging from hospital can receive comprehensive medication management support, preventing avoidable hospital readmissions.

Research indicates that ACCHOs that provide integrated pharmacist access during usual care showed improvements in cardiovascular disease risk factors in Aboriginal and Torres Strait Islander adults with chronic disease, with preliminary reports showing a 34% reduction in the number of hospital admissions, 37% reduction in potentially preventable hospitalisations; 32% reduction in emergency department presentations; and 25% in unplanned admission length of stay.[35]

The policies discussed above, clearly contravene government aims to provide care to Indigenous patients that is place-based and person-centred, creating further complexities and barriers to continuity of care and preventative healthcare measures. SHPA recommends partnering with a health sector specific leadership group to drive jurisdiction-wide changes relating to health for Indigenous people. These leadership group should involve diverse groups of people with multidisciplinary health backgrounds to enhance culturally appropriate healthcare delivery.

REFERENCES

1. Dooley, M. J., Allen, K. M., Doecke, C. J., Galbraith, K. J., Taylor, G. R., Bright, J., Carey, D. L. (2004). A prospective multicentre study of pharmacist-initiated changes to drug therapy and patient management in acute care government funded hospitals. British Journal of Clinical Pharmacology, 57(4), 513-521. doi:10.1046/j.1365- 2125.2003.02029.
2. Snoswell C.L., (2020). A meta-analysis of pharmacists and pharmacy technicians' accuracy checking proficiency, Research in Social and Administrative Pharmacy, Volume 16, Issue 6, 760-765, ISSN 1551-7411,
3. NHS England. (2018). Blog:Pharmacy technicians are playing key new roles. Available at: https://www.england.nhs.uk/blog/pharmacy-technicians-are-playing-key-new-roles/
4. National Association of Pharmacy Regulatory Authorities (NAPRA). (2022). Pharmacy Technicians' Scope of Practice in Canadian Jurisdictions. Available at: https://www.napra.ca/wp-content/uploads/2021/12/NAPRA-Pharmacy-Technicians-Scope-of-Practice-in-Canada-Chart-2022-11-EN.pdf
5. Pharmaceutical Society of New Zealand Incorporated.(2023). Technicians. Pharmacy Accuracy Checking Technicians. Available at: https://www.psnz.org.nz/technicians/pact
6. The Society of Hospital Pharmacists of Australia. (2019). Standard of Practice for Pharmacy Technicians to support Clinical Pharmacy Services. Journal of Pharmacy Practice and Research.
7. Penno J., Cameron S., Dyer M., Murray L. (2022). Perioperative clinical support technician: A surgical time-saver. Peter MacCallum Cancer Centre, Melbourne, Victoria.
8. Lim R, Ellett LMK, Semple S, Roughead EE. (2022). The extent of medication-related hospital admissions in Australia: a review from 1988 to 2021. Drug Safety, 45:249-57.
9. Jordan M, Young-Whitford M, Mullan J, Stewart A, Chen TF. (2022). Influence of a general practice pharmacist on medication management for patients at risk of medicine-related harm: A qualitative evaluation. Aust J Gen Pract, 51(7):521-528.
10. Tan EC, Stewart K, Elliott RA, George J. (2013). Stakeholder experiences with general practice pharmacist services: a qualitative study. BMJ Open, 3(9):e003214.DOI:10.1136/bmjopen-2013-003214
11. Buzancic I, Kummer I, Drzaic M, Hadziabdic MO. (2021). Community-based pharmacists' role in deprescribing: a systematic review. Br J Clin Pharmacol, 88:452-63.
12. Shaw C, Couzos S. (2021). Integration of non dispensing pharmacists into primary healthcare services. Aust J Gen Pract, 50:403-8.
13. Sudeshika T, Deeks LS, Naunton M, Peterson GM, Kosari S. (2023). Int. J. Clin. Pharm, 45:980-8.
14. Australian Commission on Safety and Quality in Health Care. (2017) Safety Issues at Transitions of Care: Consultation report on perceived pain points relating to clinical information systems. Sydney: ACSQHC.
15. Lussier ME, Evans JH, Wright EA, Gionfriddo MR. (2019). The impact of community pharmacist involvement on transitions of care: a systematic review and meta-analysis. JAPhA, 1-10. DOI:10.1016/j.japh.2019.07.002
16. Royal Commission into Aged Care Quality and Safety. (2021). Final Report: Care, Dignity and Respect. Volume 1 Summary and recommendations. Australian Government.
17. McDerby, N., Kosari, S., Bail, K., Shield, A., Peterson, G., & Naunton, M. (2019). The effect of a residential care pharmacist on medication administration practices in aged care: A controlled trial. Journal of Clinical Pharmacy and Therapeutics, 1-8. https://doi.org/10.1111/jcpt.12822
18. Ailabouni N, Mangin D, Nishtala PS. (2019). DEFEAT-polypharmacy: deprescribing anticholinergic and sedative medicines feasibility trial in residential aged care facilities. Int J Clin Pharm. 41: 167–78.
19. Westbury, J., Gee, P., Ling, T., Brown, D., Franks, K., & Bindoff, I. et al. (2018). RedUSe: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities. Medical Journal Of Australia, 208(9), 398- 403. doi: 10.5694/mja17.00857
20. SHPA Committee of Specialty Practice in Clinical Pharmacy. (2013). SHPA Standards of Practice for Clinical Pharmacy Services. J Pharm Pract Res 43 (2 suppl): S2-S69.
21. Roessler P. (2022). Standards driving quality. JPPR, 52(3). 159-60. DOI: 10.1002/jppr.1815
22. Dooley MJ. (2022). Improving the care for patients undergoing surgery: must haves and nice-to-haves. JPPR, 52(2), 81-2. DOI: 10.1002/jppr.1806
23. Dooley, M. J., Allen, K. M., Doecke, C. J., Galbraith, K. J., Taylor, G. R., Bright, J., & Carey, D. L. (2004). A prospective multicentre study of pharmacist-initiated changes to drug therapy and patient management in acute care government funded hospitals. British Journal of Clinical Pharmacology, 57(4), 513-521. doi:10.1046/j.1365- 2125.2003.02029.
24. Australian Government, Department of Health and Aged Care. (2022) Future focused primary health care: Australia's Primary Ehalth Care 10 Year Plan 2022-2023. Available at: https://www.health.gov.au/sites/default/files/documents/2022/03/australia-s-primary-health-care-10-year-plan-2022-2032-future-focused-primary-health-care-australia-s-primary-health-care-10-year-plan-2022-2032.pdf
25. Huxtable R. (2023). Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025. Available at: https://www.health.gov.au/resources/publications/nhra-mid-term-review-final-report-october-2023
26. Australian Government, Department of Health and Aged Care. (2022) Guiding Principles to Achieve Continuty in Medication Management. Available at: https://www.health.gov.au/sites/default/files/2022-11/guiding-principles-to-achieve-continuity-in-medication-management.pdf

27. Misko J., Jenkins B., Rawlins M. (2022). Navigating the Pharmaceutical Benefits Scheme: federal versus state government funding for high-cost medicines – a problem for public hospitals. Australian Health Review 46, 316-318.https://doi.org/10.1071/AH22002
28. Brown L., Payne A., Nepal B., Gong C., Cooper G. National Centre for Social and Economic Modelling. (2010). Modelling Options for the Public Funding of Hospital Medicines in Australia. Accessed at: https://www.researchgate.net/publication/325710081_Modelling_Options_for_the_Public_Funding_of_Hospital_Medicines_in_Australia_The_Current_System_And_Proposals_For_Reform_Report_Summary_Prepared_By_Modelling_Options_for_the_Public_Funding_of_Hospital_
29. Australian Institute of Health and Welfare (2020) *Indigenous health and wellbeing*, AIHW, Australian Government
30. Cass A, Lowell A, Christie M, Snelling PL, Flack M, Marrnganyin B et al. (2002) Sharing the true stories: improving communication between Aboriginal patients and health care workers. Med J Aust, 176(10):466- 470. 2 Fallis BA, Dhalla IA, Klemensberg J, Bell CM (2013) Primary Medication Non-Adherence after Discharge from a General Internal Medicine Service. PLoS ONE 8(5): e61735.
31. Fallis BA, Dhalla IA, Klemensberg J, Bell CM (2013) Primary Medication Non-Adherence after Discharge from a General Internal Medicine Service. PLoS ONE 8(5): e61735.
32. Australian Bureau of Statistics. (2018-19). *National Aboriginal and Torres Strait Islander Health Survey*. ABS. Accessed at: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release.
33. Australian Institute of Health and Welfare. (2018). Cancer in Aboriginal & Torres Strait Islander people of Australia. AIHW.
34. Department of Health and Aged Care. (2022). 1678 – Integrating Pharmacists within Aboriginal Community Controlled Health Services to Improve Chronic Disease Management (IPAC Project) Available at: http://www.msac.gov.au/internet/msac/publishing.nsf/Content/1678-public
35. Couzos S, Smith D, Biros E. (2020) Integrated pharmacists in ACCHSs- Analysis of the assessment of clinical endpoints in Aboriginal and Torres Strait Islander patients with chronic disease (IPAC study). Draft Report to the PSA.