Pillar 4: Delivering quality care more efficiently, Productivity Commission

June 2025

Response to survey questions

Section 1: About you

1. **Name:** Jerry Yik, Head of Advocacy and Policy, Advanced Pharmacy Australia
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5. **May we contact you about your response?**

Yes

If yes:

6. **How would you prefer we contact you?**

Email

7. **Whose views does your response represent? (Please include the full names of applicable individuals, groups or organisations).**

Advanced Pharmacy Australia (AdPha)

8. **Do any of the attributed parties identify as Aboriginal or Torres Strait Islander/are any identified organisations an Aboriginal and/or Torres Strait Islander organisation?**

No

Do the attributed parties consent to the PC publishing your response on our website and referring to it in our reports?

Yes, with attribution

9. Guidelines and policies agreement

I have read and agree to the above guidelines and policies.

10. Will you be providing any documents to support your response?

Yes *(Pharmacist prescribers increasing efficiencies in hospital workflow diagram)*

11. For the purposes of this consultation, which of the following best describes you:

I am an industry or advocacy organisation, professional association or peak body

12. Which of the following care sectors will your feedback relate to? Please select all that apply.

- Aged care
- Health

13. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

National, hospital and health organisations

14. Which policy reform areas would you like to respond to?

- Reform of quality and safety regulation to support a more cohesive care economy
- Embed collaborative commissioning to increase the integration of care services

Section 2. Reform of quality and safety regulation to support a more cohesive care economy

15. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

To a great extent

16. What are the reasons for your answer?

The current regulatory fragmentation across the care economy, particularly in relation to regulatory frameworks for pharmacist prescribing, creates significant inefficiencies and cost burdens across hospitals, general practice, and aged care, ultimately impacting patient care. This is especially apparent in the case of collaborative pharmacist prescribing.

The **collaborative pharmacist prescribing** model in Australia was first implemented in hospital settings, and are referred to as Partnered Pharmacist Medication Charting (PPMC) and as Partnered Pharmacist Medication Prescribing (PPMP). It is a proven cost-effective pharmacist-led model of care that enhances medication safety, streamlines care, and supports timely patient discharge (*please refer to uploaded attachment: Pharmacist prescribers increasing efficiencies in hospital workflow diagram*). However, the lack of national regulatory alignment, including pharmacists not recognised as being able

to prescribe on the PBS and jurisdictional variation in implementing collaborative pharmacist prescribing models, is preventing the full realisation of these benefits.

AdPha has been a longstanding advocate for collaborative prescribing, with over twelve years of experience in the field, and remains the sole provider of a nationally recognised credential in collaborative prescribing. AdPha supports the Pharmacy Board of Australia's (PBA) *Pharmacist Prescribing Position Statement* that outlines three prescribing models applicable to all pharmacist prescribers: prescribing via a structured prescribing arrangement, prescribing under supervision and autonomous prescribing.

Collaborative pharmacist prescribing, as seen in numerous hospital-based PPMC/P pilots, fits squarely within the "prescribing under supervision" model. Like junior medical staff who prescribe under the direction of registrars or consultants, pharmacists can operate within their scope of practice, under an agreed medication management plan with appropriate governance and shared responsibility. This is a safe, scalable approach already embedded in practice but held back by fragmented regulation.

Expanding this hospital model across the care continuum, including to aged care, outpatient clinics, and primary care, would enhance continuity, reduce duplication, and generate significant cost efficiencies. For example:

- Tasmania is the first jurisdiction to announce **collaborative pharmacist prescribing in aged care** through the pilot of a pharmacist co-prescribing model in residential aged care facilities. While this is an important step, broader adoption is needed nationally. Pharmacists are well-placed to manage medicines for older people, especially those with complex polypharmacy needs, reducing the time GPs spend on routine prescribing. To realise the full benefits of this model for patients, pharmacists must also be enabled to prescribe under the Pharmaceutical Benefits Scheme (PBS).
- In **outpatient** and specialist settings, pharmacists already work closely with medical specialists, managing treatment plans and medicines optimisation. Empowering them to prescribe collaboratively in these settings would reduce unnecessary referrals and allow specialist doctors to focus on complex cases.
- In **general practice**, embedding pharmacist prescribers could relieve pressure on GPs, particularly in under-served or high-demand areas, as well as support efficiency and timeliness of care.. This also aligns with findings from the *Unleashing the Potential of our Health Workforce – Scope of Practice Review*, which highlights opportunities to reduce reliance on costly specialist care through better use of pharmacists' clinical skills.

Critically, enabling PBS prescribing for pharmacists operating under collaborative or supervised models is essential. The inability to do so delays discharges, fragments healthcare provision, and reduces workforce capacity.

Regulatory reform to support a nationally consistent framework for collaborative

pharmacist prescribing, consistent with the PBA prescribing models and drawing on the demonstrated success of the PPMP, would reduce costs, improve access, and support a more integrated, efficient, and resilient care economy. These changes would also improve workforce flexibility and ensure that high-quality care is delivered by the right professional, in the right setting, at the right time.

17. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

To a great extent

18. What are the reasons for your answer?

Currently, regulatory fragmentation across health, aged care, and disability sectors can compromise safety, delay care, and increase costs, particularly where professionals and providers work across multiple settings.

For example, the Pharmacy Board of Australia's *Pharmacist Prescribing Position Statement* states there are already no regulatory barriers to structured prescribing and supervised prescribing arrangements, however there is still inconsistent jurisdictional implementation of expanded pharmacists scope which includes collaborative pharmacist prescribing. In hospitals, collaborative pharmacist prescribing n has demonstrated benefits for patient safety and discharge efficiency. However, this model cannot be extended to aged care or community settings due to regulatory and funding misalignment—despite pharmacists being well-placed to support safe, timely care in these environments.

Similarly, restrictions that prevent public hospitals from delivering Commonwealth-funded services, such as aged care pharmacy programs, limit access to safe and appropriate care, particularly in provider-scarce regions. These artificial barriers undermine integration and reduce the system's ability to deliver consistent, quality care across the continuum.

Aligning core safety and quality regulations—particularly around prescribing authority, provider eligibility, and workforce credentialing—would enable greater continuity, better use of specialist skills, and more responsive care models. Reform should focus on removing outdated regulatory silos and ensuring safety frameworks support, rather than obstruct, efficient, patient-centred care.

Section 3. Embed collaborative commissioning to increase the integration of care services

19. What is your experience with collaborative commissioning?

AdPha has observed and supported several collaborative commissioning models involving pharmacists that highlight both the potential and limitations of the current system.

One example is the integration of pharmacist-led services into aged care and primary

care through models such as the **Aged Care On-site Pharmacist (ACOP)** program and **hospital-based outreach and in-reach services,** such as Hospital in the Home (HITH). These initiatives reflect elements of collaborative commissioning, involving Local Hospital Networks (LHNs), Primary Health Networks (PHNs), and aged care providers with the shared goal of improving medicines management and reducing avoidable harm.

In these models:

- Participants have included public hospital pharmacy departments, aged care providers, PHNs, and in some cases, general practices.
- Funding and management varied: ACOP is funded through Commonwealth programs, while outreach services are often LHN-funded, but coordination and eligibility are limited by jurisdictional silos and program rules.
- Outcomes included better medication safety, reduced hospital admissions, and improved engagement between aged care and acute care sectors.
- Success factors included clinical leadership, shared governance, pharmacist expertise in complex medication management, and local relationships.

However, these initiatives have not always been sustained or scaled due to structural barriers. For example, **hospitals are ineligible for many Commonwealth-funded pharmacy programs,** even when they may require it to deliver safe and appropriate care, or be the best-positioned or only feasible service provider – especially in rural or under-served areas. This rigid separation between health sectors undermines care integration and service continuity.

20. What are the benefits of pursuing greater collaborative commissioning?

Greater collaborative commissioning between PHNs, LHNs, Aboriginal Community Controlled Health Organisations (ACCHOs), and other care providers – including pharmacists – offers substantial benefits:

- **Service Gaps and Duplication:** Collaborative commissioning enables more effective deployment of limited healthcare resources, especially in areas where jurisdictional funding divides prevent seamless service delivery. For example, in aged care settings, both hospitals and PHNs may fund medicine-related services, but without coordination this can lead to overlap in some areas and gaps in others (e.g., no pharmacist support on weekends, unclear responsibility for follow-up after discharge).
- **Efficiency and Outcomes:** Embedding pharmacists through collaborative models has been shown to improve patient safety, medication adherence, and hospital discharge efficiency. It also reduces pressure on GPs and specialists, especially in complex polypharmacy cases.
- **Costs and Barriers:** Arbitrary program rules that exclude certain providers based on setting (e.g. hospitals being ineligible to provide Commonwealth-funded care in community settings) create inefficiencies and discourage collaboration. These

barriers increase administrative burden, reduce workforce flexibility, and result in sub-optimal care models. True collaborative commissioning should **prioritise capability and local need** over funding source or provider classification.

To be successful, collaborative commissioning must be supported by:

- Flexible, **pooled or blended funding models** that reflect local priorities.
- Clear **governance and accountability frameworks**.
- Recognition that **public hospital pharmacy services can and should be commissioned** where they are best placed to deliver care.
- A shift away from siloed, program-based approaches that prevent innovative, patient-centred service models.

In summary, embedding collaborative commissioning, particularly models that integrate pharmacist expertise across care sectors, would deliver more efficient, equitable and effective care. The current separation between state and Commonwealth funding streams should not be a structural barrier to collaborative, locally designed solutions that improve outcomes and reduce duplication.

21. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

BARRIERS

Barriers to collaborative commissioning are deeply rooted in governance, funding structures, and legacy program design. Despite shared goals between PHNs, LHNs, and ACCHOs, structural misalignments continue to limit integrated planning, delivery, and evaluation of care. Key barriers include:

1. Fragmented Funding Models

Healthcare is funded and delivered across federal and jurisdictional levels, both of which already have varied and complex funding systems. This fragmentation can lead to duplication, service gaps, and an inability to co-commission or pool funds for shared priorities.

2. Rigid Program Eligibility Rules

Current commissioning frameworks often disallow specific provider types (e.g. public hospitals, LHNs) from participating in Commonwealth-funded programs, regardless of local capacity or need. This prevents commissioning decisions from being based on service quality, outcomes, or community fit.

3. Siloed Governance and Accountability

There is no single point of shared accountability between PHNs, LHNs, and ACCHOs,

resulting in fragmented service planning and competing or duplicative initiatives. Lack of transparency in decision-making and inconsistent engagement processes further weakens coordination.

SOLUTIONS

AdPha recommends reforming funding, eligibility, and governance settings to enable true collaborative commissioning—allowing LHNs, PHNs, and ACCHOs to jointly plan, fund, and deliver care based on local capability and need. Removing rigid program rules and enabling flexible, pharmacist-led models will support more efficient, integrated, and patient-centred care across the system.

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