Consumers Health Forum OF Australia

SUBMISSION

RESPONSE TO THE PHARMACEUTICAL SOCIETY: *PHARMACISTS IN 2023 DISCUSSION PAPER*

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Introduction

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers and those with regard for healthcare consumer affairs. It works in the public interest to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF is an advocate of co-design and consultation processes, so we would like to thank the Pharmaceutical Society of Australia (PSA) for the opportunity to respond to the *Pharmacists in 2023: Discussion Paper* (the discussion paper) and for opening these questions to other organisations and individuals.

CHF applauds the PSA's renewed commitment to quality, safety, and meeting evolving community needs. We support the PSA's intention to expand pharmacist roles but feel that this discussion paper has focused too much on community pharmacists and has overlooked the possibilities for hospital and consultant pharmacists, particularly at the point of clinical handover when communication between GPs and community pharmacies is crucial. With the title 'Pharmacists in 2023', CHF does wonder where PSA sees hospital pharmacists and consultant pharmacists fitting in and whether organisations like the Society for Hospital Pharmacists of Australia (SHPA) have been consulted in this vision.

The current community pharmacy system works well for many. Australian consumers value pharmacists as accessible and approachable health professionals[i], but with rapidly moving technologies, changing community needs and expectations, workforce changes and moves to a more integrated primary health system there are pressures to reimagine how people receive their care and medicines.

Many consumers[1] do not currently use (or intend to use) pharmacist services[ii]. For some this accessing care in a new setting would mean using another service from another provider in a system that is already fragmented and difficult to navigate[iii]. Our consultations showed that consumers rely on pharmacists to be their medication experts within a broader health care team and they are appreciated as some of the most accessible and approachable health professionals in the system so have potential to help with collaboration of services, rather than being another provider.

Pharmacists are in a strong position to promote safer prescribing habits[iv], improve medication management, build health literacy and help consumers to understand and navigate a complex system. These services should not necessarily be provided in community pharmacies but should be delivered when and where patients need them and could involve their health provider if appropriate.

Crucial to success will be the involvement of consumers in the design, implementation and evaluation of changes to ensure they are taken up. This needs to involve continued, authentic engagement and seek a high level of consumer input at the individual level and in pharmacist and pharmacy organisations involved in discussions.

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[1] Our responses to this discussion paper are based on surveys and consultations conducted by CHF and others. This includes the PSA and CHF consultation conducted in November 2017 for the '10 Year Action Plan' for the pharmacy profession and the Pharmacy Guild's research for their 'CP2025 the Future of Community Pharmacy'[1] strategy. CHF also undertook the 'Pharmacists and Primary Health Care Consumer Survey'[1] in 2015 to ensure that consumers' opinions were considered and reflected during a major shift in how Australians receive such care following the finalisation of the 6CPA, the launch of a Pharmacy Trial Program, and the establishment of Primary Health Networks.

Discussion

Question 1: Should any of these objectives be considered more important for patient care than others?

Question 6: What could be incorporated into the design of the program to ensure accountability and an appropriate level of quality?

In CHF's 2015 survey, consumers raised two key concerns with changing current service delivery and settings: keeping their GP informed, and the quality and safety of service provided. CHF feels that all health professionals delivering the same level and type of service should be bound by the same Standards of Practice, training and reporting requirements. These reporting requirements should involve updating an individual's MyHealth Record (MHR) where possible to ensure GPs and other health professionals can see which services have been provided in pharmacies, in addition to medications dispensed.

Consumers involved in the November 2017 consultation felt that pharmacists were well placed to be a key point of liaison in the health system. Integrating pharmacists and pharmacies within health care teams and settings such as GP practices should be a priority as this could alleviate concerns around delivery and setting.

Question 2: What immediate gaps need to be filled to realise these objectives?

Question 34: What needs to be considered in preparing the pharmacist workforce for new roles?

As mentioned in the introduction, consumers identified pharmacists as being well positioned as a point of contact for the broader health system. In many cases, they are not seeking another service provider but are looking for someone who can provide clarity or guidance about whether they need to seek medical attention. Pharmacists often take on the role of medicines expert, health promoter, or as a health issue translator. This work should be more explicitly taken on and recognised within the health system, remunerated appropriately and, importantly, given careful consideration as to how such roles would link in with future directions in primary health care service delivery and attempts to improve integrated and coordinated community-based care in this setting.

Question 3: What processes, tools or mechanisms would support the delivery and outcomes of medication management programs by pharmacists to integrate with others in a person's healthcare team?

CHF understands that the following processes, tools and mechanisms would improve patient outcomes and experiences of medication management programs and enable better integration of and communication between health professionals.

Tools - CHF supported the King Review recommendation (2018) that there should be one electronic personal medications record system that covers all Australians and can be accessed appropriately to link community pharmacy, hospitals and all doctors. This system would keep a record of primary health

care services delivered in pharmacies e.g. vaccines to ensure services are not duplicated across health care providers. CHF hopes that the MyHealth Record (MHR) system will support such integration by making communication and collaboration between health care providers easier.

Processes - CHF supports the trial and use of technology such as telehealth to provide consumers with real time access to trained pharmacists in situations or locations where they may otherwise not have access e.g. in the home or locations not serviced by a community pharmacy.

Pharmacists should also be actively seeking consumer feedback to improve outcomes using the information and recommendations of the Australian Commission on Safety and Quality in Health Care (ACSQHC)[v].

Mechanisms - CHF also supports the potential for non-dispensing pharmacists in multidisciplinary teams, as outlined in the discussion paper this would involve things such as sharing expertise through education, training, clinical governance and spending more face-to-face time with consumers in health settings such as general practice and in ACCHOs to improve quality use of medicines rather than on transactional items in the pharmacy. Pharmacists' roles in assisting with lifestyle risk factor management and patient self-management should also be explored such as delivering brief interventions for smoking cessation.

Question 4: How can remuneration mechanisms better reflect the range and complexity of care required for some medication management services?

Question 10: How would pharmacists be remunerated for the time spent with patients based on the complexity of the issues identified and outcomes achieved?

Question 11: What are the barriers to implementation and how can these be overcome?

Currently, pharmacists receive a fixed Administration, Handling and Infrastructure (AHI) fee for dispensing medicines regardless of whether they add value for the consumer. CHF agrees that pharmacists should receive funding that reflects the time and expertise required to deliver best practice care, however this should be linked with measurements of quality e.g. explaining the Consumer Medicines Information (CMI)[vi], collecting patient reported outcomes through questionnaires[vii], or updating a patient's MHR. A more appropriate funding model such as a scale of fees based on complexity would support pharmacists to deliver care that is driven by quality and safety, is valuable and convenient for consumers, and contributes to integration of the wider health system.

Pharmacist professional services currently funded through the 6CPA model and not the MBS is a barrier to pharmacist's expanding and innovating their roles in other settings and away from dispensing – funding through the MBS and other potential avenues such as practice incentive payments via block grants and funds held and administered by PHNs would benefit patients looking to receive care where it is needed and would be more likely to be leveraged for service innovation and development that integrates well locally.

Question 5: If medication management services were outcomes-focussed in their funding, what must be considered in designing an appropriate funding mechanism?

In the past, CHF has argued that the current fee for service funding model tends to promote episodic, time-based care and does not lend itself to continuity of care or a focus on patient outcomes. The Productivity Commission[viii] and the Australian Healthcare & Hospitals Association[ix] have found that a combination of fee for service and bundled payments would be more appropriate to address the wide range of care (both episodic and longer term). For example, hospitals receiving funding for the number and mix of patients that they treat so busier hospitals and complex cases are acknowledged[x]. The option of bundled payments would be particularly beneficial for consumers with chronic or complex conditions as it promotes efficiency, greater continuity of care, and a multi-disciplinary team approach (AHHA, 2015).

Bundled payments also tend to promote more of an outcomes-focussed approach as the payment is made for the patient's outcome, not the individual services, which incentivises efficiency between service providers. Research has found that this helps clinicians to focus on the outcomes that the patient values.

Currently, pharmacists sit separately to the other health care professionals who are involved with the Health Care Homes (HCH) model that is being trialled in Australia. If funding is to reflect better patient outcomes, then pharmacists should be included as part of the healthcare team. This funding should be administered by the MBS, not the CPA.

The use of some patient recorded experience measures (PREMs) would give information on how consumers rate their experience when dealing with their pharmacists. These would be particularly useful for people who have complex and chronic conditions who use pharmacists on a regular basis. All the professional services should have a PREM built in and the outcomes of those measures should from part of the evaluation of any future Community Pharmacy Agreement.

As we move generally to a more outcome focussed health system then we should also explore the use of Patient Reported Outcome Measures (PROMs) which would give us a better understanding of the impact of pharmacists and pharmacy services on people's health.

These measures should be used in both community pharmacy and hospital-based pharmacy services.

Question 7: How can pharmacists be more involved in Collaborative Care teams?

As previously mentioned, consumers indicated that pharmacists could be a key point of liaison in the health care system. Some believe that, because of their accessibility, pharmacists would be able to offer continuity of care in a way that GPs cannot. Directly involving pharmacists in the HCH model; and any future development of that model of care would be a good place to start. In addition, examining how pharmacists are utilised – or could be utilised - in state-funded community health centres should also be considered for wider uptake in other states. We understand that co-health in Victoria is one model and that the Victorian Government have funded a number of community-based hubs involving 24-hour access to pharmacists through their Supercare Pharmacy initiative[xi].

CHF was pleased to see that from 1 July 2019, a new Workforce Incentive Program will streamline existing GP, nursing and allied health incentive programs, replacing the General Practice Rural Incentive Program and the Practice Nurse Incentive Program (PNIP)[xii]. For the first time general practices will be able to access incentive payments to employ non-dispensing pharmacists. The

inclusion of pharmacists within general practice brings benefits for consumers in terms of better medicines management, to the system through better use of medicines and reduced adverse events, and to health professionals who may not be aware of their prescribing habits and the importance of deprescribing. To speed up the inclusion of pharmacists within practices, the Australian Government should remove a component of the pharmacy trial program under the Sixth Community Pharmacy Agreement (6CPA) and reallocate to fund general practices (through the Workforce Incentive Program or through PHNs) as an incentive to employ non-dispensing pharmacists.

Question 8: How can services and models of care be delivered in locations that best suit the needs of the consumer? E.g. Home-based care, Aboriginal and Torres Strait Islander health and rural and remote settings?

Question 9: What are the barriers to implementation and how can these be overcome?

As mentioned in the PSA's discussion paper, current evidence demonstrates that significant gaps exist in the quality use of medicines in Australia. Medication safety is a significant problem with an estimated 230,000 medication-related hospital admissions happening in Australia each year.[xiii] Funding for Medicines programs such as MedsChecks, Home Medicines Reviews (HMRs) and Residential Medicine Management Reviews (RMMRs), somewhat addresses this need but current program guidelines restrict the pharmacist's ability to deliver services where the consumer feels comfortable or via telehealth.

HMRs are a good example of how consumers may miss out on because of the current program guidelines, state that the review must be delivered "face-to-face at the patient's home except in the following circumstances: For patient cultural reasons; or Because of pharmacist safety concerns relating to being inside the patient's home. If either circumstance applies, Prior Approval to conduct the HMR interview in an alternative location must be obtained."[xiv]

While there are specific benefits to conducting the medicines review in the home, the current program guidelines mean that consumers not comfortable with this arrangement miss out and so this option to receive the service in an agnostic setting such as a general practice should be available to all. Consumers also miss out if the pharmacist has reached their service 'cap' for the month or if there is no consultant pharmacist who will travel to their home.

Where and when most appropriate as defined by consumers. If they want to receive a service in the pharmacy, Aboriginal Controlled Community Health Organisation (ACCHO), Community centre or telehealth this should be an option. The Australian Government should abolish 'caps' on HMRs and fund the program through the MBS. The Australian Government should set the MBS referral criteria to ensure these services are appropriately targeted and represent value for money. Having caps on services increases the likelihood that consumers will be made to wait until the next month when the pharmacist can claim reimbursement for their time, travel and expertise.

Question 12: How can pharmacists be more involved in vaccination services?

Pharmacists are accessible health professionals and consumers should be able to receive vaccination services if they meet the health requirements and would like to access this service in a pharmacy. Given that convenience and access are key reasons for expanding pharmacist services, vaccinations appear to be a clear option for pharmacists to deliver. As mentioned above – there is a need to ensure safety and quality by incorporating training, recording, and collaborating requirements, and to conduct further

consumer consultation into whether this is a service that people would use. This example highlights the importance of ensuring there are systems in place (such as the MHR) to ensure GPs can see updated records and that protocols to guide "step-up" referrals to a GP or emergency department are in place and adhered to in the event of complications. This is particularly important in cases where vaccinations are linked with government funding and would need to ensure the GP is aware that the service has taken place e.g. childhood vaccinations.

Question 13: How can we increase recognition of pharmacist-provided care?

Consumers clearly see value in pharmacists and the potential of pharmacy services. Further consultation with consumers is required to determine precisely what changes would increase recognition of pharmacist services as health services. Some important factors in any setting include the environment (does it feel like a health care setting?) and how confident consumers feel that they are receiving advice from a trained health professional and can distinguish them from the assistant.

Given the retail setting, it will be important for consumers to feel that pharmacist services are not being advertised to them unnecessarily. Advertising of pharmacist programs should be regulated according to the *Guidelines for advertising regulated health services*:

> "The following principles underpin these guidelines:
>
> - advertising can be a useful way to communicate the services health practitioners offer to the public so that consumers can make informed choices
> - advertising that contains false and misleading information may compromise health care choices and is not in the public interest
> - the unnecessary and indiscriminate use of regulated health services is not in the public interest and may lead to the public purchasing or undergoing a regulated health service that they do not need or require." [xv]

It is also important that there are no incentives to up-sell services and that they should only be promoted where the consumer has indicated they may benefit.

Potential expansion of services in pharmacies is something that CHF would particularly like to see explored in rural and remote communities where the pharmacy is the only local health care setting. Different requirements for pharmacies in these areas could mean that more essential services are provided to a community in need.

CHF would also like to further discuss the PSA's Health Destination Pharmacy project and any evaluation arising from that and its implications for future integrated models of care. It strikes us that it's conception appeared to be based on significant consultation and evidence, that the learnings should be shared, discussed and built upon, particularly in order to contribute to how future patient and family centred health care homes could work in the patient's interests.

Question 14: How should health promotion and screening programs be designed to eliminate concerns about fragmentation, and ensure that the care that a pharmacist provides can be captured and recognised by others providing care to an individual?

As mentioned in answer to question 3, use of one electronic personal medications record system would ensure pharmacist-provided care is captured and recognised by other health care providers.

Incorporating these services in the MBS would also align pharmacist-provided services, funding, and reporting with other areas of the health system and would help to dispel the sense of fragmentation.

Having a non-dispensing pharmacist delivering health promotion programs in the settings where the patient normally receives their care may also help to eliminate these concerns.

Question 15: What kinds of programs or remuneration mechanisms could recognise this valued role of the pharmacist and address the perception of "incentive to sell"?

As previously mentioned, bundled and outcome-based payments are generally effective in promoting health care providers to work together and focus more on patient outcomes. Having pharmacists as part of the multi-disciplinary teams in general practice and ACCHOs as part of patient and family-centred healthcare models would distance them from the retail setting and address this perception.

In our consultation, consumers expressed concern about the amount of influence that the pharmaceutical industry may have on pharmacists and pharmacies, which could be addressed through more transparent remuneration mechanisms e.g. the $1 discount and price disclosure.

Consumers should also be confident that their interests are represented in the forthcoming 7CPA discussions by a consumer organisation such as CHF. Discussions for previous agreements have happened behind closed doors and it does not appear that consumers or the broader health profession are consulted in how significant amounts of funding are allocated to community pharmacies.

Question 16: How can pharmacist activities and provision of care be captured in an electronic shared care record? What value would this provide the consumer, wider health care team, and the health system?

The benefits of shared pharmacist electronic records are well known. Most importantly they benefit the consumer by tracking their progress towards the safety net, maintaining a comprehensive record of medications, vaccinations, allergens, and previous reactions, makes the outcomes of reviews visible to all their health professionals (not just the doctor who requested a review), and can be a useful record of regular checks by a pharmacist such as blood pressure. Use of such a system will also reassure consumers that their health professionals will be kept up to date and will not be 'out of the loop'.

At the system level, more information about consumers can help service providers to meet their needs, understand what they want from a pharmacy, and monitor outcomes as determined by the consumer.

As we have seen recently with the MHR, consumers want to know why and what data is being collected from them, who will have access to this, and their right to see their data, refuse to have it collected, and have it removed if they wish. These concerns will need to be considered and addressed with any electronic record containing personal information.

Question 17: Separate to the existing process for advanced practice credentialing, would formal recognition of pharmacist specialisation in defined areas of clinical practice (to a defined standard) be beneficial for future practice? (For example, mental health, oncology, cardiology, paediatrics etc and/or pharmacist-practice specialties such as medicines information, pharmaceutical compounding)

Question 18: Assuming a robust process for defining standards of clinical practice for such specialisation, what benefits would formal pharmacist specialisation provide?

Question 19: Should some roles, services or activities be restricted to defined levels of practice or specialisation?

CHF would like to know how the PSA sees the role of consultant pharmacists who are accredited separate from the supply of medicines? The Australian Association of Consultant Pharmacy states that,

> "Accredited pharmacists think innovatively and become experts at clinical problem solving. Their knowledge can be enhanced with further study and experience to gain qualifications as Diabetes Educators. Specialisation in areas such as asthma, mental health and pain management enable accredited pharmacists to develop their areas of expertise further."

This indicates that much of what is described in questions 17-19 is already happening but could be formalised or expanded in the future. CHF supports providing specialisation information to patients so that they can select an appropriate expert, however we are not sure where a new credentialing program would fit within the existing system.

Question 20: Do you believe that pharmacists have the current skills to be able to prescribe in a collaborative role. How could this be developed in the future?

Question 21: Should independent prescribing be a key focus for the pharmacist profession?

Question 22: Should the decision to initiate a prescription medicine always be separated from the supply of that medicine? How can this be implemented in practice?

Question 23: What are the barriers to implementation and how can these be overcome?

While consumers clearly have confidence in the profession, prescribing and the blurring of pharmacist/GP roles was raised as a concern in the 2015 survey and later consultation. Further research should be completed before this becomes a key focus of the profession. There are also current examples where prescribing and supply are not separate (emergency supply), however these are only in exceptional circumstances.

Convenience is probably one of the main reasons for consumers to support pharmacist prescribers, however there are a few safety issues that CHF would like to highlight.

A new prescription is sometimes the only time a consumer will visit their GP and, if used effectively, is an important opportunity for a health check. This opportunity may be missed for these consumers, however there are many who see a GP regularly and may benefit from proposed changes.

Consumers have told us that keeping their GP informed is very important to them so any changes to prescribing practices would need to involve collaboration between health care providers. If GPs are not on board then many patients may feel nervous using these services and this may negatively impact their relationship with their pharmacist.

It is known that some consumers 'doctor shop' for prescriptions and generally need to overcome a few barriers such as making and paying for an appointment and answering the GP's questions before they receive a prescription. As some of the most accessible healthcare providers, pharmacists might become targets of 'doctor shopping' behaviour. CHF therefore recommend ensuring there are safe guards such as real-time prescription monitoring in place prior to changes to prevent inappropriate prescribing.

While they are medicines experts, pharmacists do not have the same training in diagnosis and taking case histories that GPs have. This may not be clear to consumers and pharmacists may start to be relied on as de facto GPs.

Examples where access is the issue e.g. regional or remote geographical locations where a pharmacy is the only health service available and extended practice would provide significant benefit to the population should receive special review.

Question 24: Are there other areas of pharmacist involvement that may improve medicines management and patient care that have not been identified?

Question 25: Should any of these areas be considered higher priority for implementation than others?

Two key areas that consumers felt should be high priority for expansion were education and the scope of hospital pharmacists.

Hospital pharmacists currently have a limited scope of practice but could be doing far more to close the gap between hospital and community pharmacies. There is a lack of communication between the two settings such as record of prescriptions that would help to reduce the level of medication misadventure experienced by patients after discharge from hospital. Hospital pharmacies are an essential and important service that could be better used to improve patient outcomes.

Pharmacist education of other health professionals in deprescribing of medicines and awareness of prescribing habits is an important role that should be strengthened. Consumers consider pharmacists to be up-to-date with medical advances and think they could play an important part in educating the wider body of health professionals. Pharmacists could play a much larger role in the deprescribing process and effectively reduce medication burden or harm while improving the consumer's quality of life.

Question 26: What system changes or incentives can encourage innovation in pharmacist care?

Question 27: Can a funding model be proposed that shifts the retail/medication supply focus to a clinical decision making and chronic disease management?

We called for the 6CPA to be more transparent and for it to ensure consumers and tax payers are getting value for money. CHF welcomed the decision to include the provision for an independent review of the whole 6CPA as we see it as a critical step towards greater transparency in any future arrangements and reform to ensure community pharmacy continues to meet the changing needs of the Australian community.

A funding model for professional services that is not tied to community pharmacies would allow pharmacists to tailor services to their local population. We have previously outlined the benefits of moving the funding to the MBS and/or other forms of direct to practice incentive payments where referrals to pharmacists could be included in items for chronic disease management plans and other forms of chronic disease management shared care.

We have also already discussed the innovation and efficiency that can be driven by bundled payments through formal inclusion of pharmacists in the HCH model. The HCH model is targeted to improve outcomes for consumers with chronic and complex conditions so a higher level of involvement would mean pharmacists are more involved with shared clinical decision making and chronic disease management as well as self-management.

As raised in questions 17-19, how do accredited consultant pharmacists fit into proposed changes?

Question 28: What value do funders and policy makers place on services as opposed to the medicines provision function? Can a funding model remunerate pharmacists for time spent and health outcomes as a result of intervention?

Question 29: Should the Community Pharmacy Agreement (CPA) transform to a framework that supports future models of pharmacist care? How?

Question 30: Outside the CPA, what other remuneration options exist and how could they be adopted?

To remove current distortions, achieve better integration, and allow people to choose to access the same primary health care service in a range of settings, the MBS reimbursement should be equal for the same service regardless of provider. Consumers would benefit from increased choice and access.

For this reason, CHF will continue to support the removal of professional pharmacy services from the Community Pharmacy Agreement to be administered in alternative ways in order to optimise value and stimulate innovation. As recommended in the King Review, the Agreement should be limited to discussions of the remuneration and associated regulations for community pharmacy dispensing of medicines under PBS subsidy and related services, including the pricing to consumers for such dispensing.

Question 31: What are the major system enablers to ensure pharmacists can deliver the services and activities that contribute to safe and effective use of medicines?

CHF's consultations with consumers found a noticeable difference between pharmacies that influenced whether they would feel comfortable receiving a service in that environment. The key factor seemed to be how they felt speaking to the pharmacist and whether they were able to distinguish who the pharmacist is, whether they seemed accessible/approachable, and whether the environment itself felt conducive to private conversations or felt more like a busy shop.

Many pharmacies have started to address these concerns with things like uniforms, pharmacists spending more time in front of the counter, having private consultation rooms, and further separating or removing retail from the dispensing area all contributing to give the sense that the community pharmacy setting is as much, if not more so, a health care rather than retail setting.

PSA has an ongoing leadership role in positioning the profession as primary health care providers and the settings they work in – including community pharmacy – as health care destinations. Our previous comments about the implications and future of the Health Destination Pharmacy project refers.

Question 32: How do we ensure and measure quality and standards of practice of pharmacist delivered services, and 'raise the bar' in delivery of care?

Training in collaboration with consumers should be included as part of continuing professional development for all health professionals to remind providers about their role in health literacy, effective communication, and helping patients to achieve better outcomes.

The use of PROMS and PREMS and the publication of those would improve transparency and give measure of the quality of the services from a consumer perspective.

In other areas of the health system we are moving to greater transparency of accreditation outcomes as a way of reassuring consumers that the services they are accessing are safe and high quality. As pharmacists move to providing a broader group of professional services and becoming more part of the primary health care community there needs to be consistency of accreditation. There is not national primary health care accreditation system with the RACGP having its own Standards for General practice and other parts of the primary health system having their own. The Australian Commission of Safety and Quality in Health Care (ACSQHC) is currently embarking on work to develop a national set of primary health care standards that are intended to provide guidance to a range of professions and settings. Consultations are underway on some options for this work. Pharmacists and particularly community pharmacy need to be included in this.

The outcomes of any such accreditation need to be publicly available so that consumers know how their pharmacy and pharmacists measure up. There are a range of models which could be examined for this process and those could be developed as part of the accreditation standards. What consumers want is a commitment from pharmacist and community pharmacy to be part of such a system.

Conclusion

CHF believes that pharmacists are a valuable part of the health care team and should be encouraged to work up to the limits of their scope of practice and their role should be promoted. In terms of providing professional services they sit in the primary health care team and consumers want to see them working as part of their team with strong communication between all parts of the team with the consumer firmly in the centre. Pharmacists' medicine management expertise goes beyond primary health care and they need to build close links with specialists and hospital services with a good flow of information and mutual respect that again puts the interests of the consumer at the centre.

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