The Pharmacy Guild of Australia
TAS Branch

Submission to the House of Assembly appointed Select Committee Inquiry on Transfer of Care Delays (Ambulance Ramping)

Contact: Monique Mackrill, Branch Director

Pharmacy Guild of Australia, Tasmanian Branch

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The Pharmacy Guild of Australia, Tasmanian Branch (the Guild) welcomes the opportunity to provide this submission to the House of Assembly appointed Select Committee Inquiry on Transfer of Care Delays (Ambulance Ramping).

The Guild is a national employers' organisation with over 90 years of experience in representing and promoting the value of the role of community pharmacy in the Australian and Tasmanian health care systems. Community pharmacies are a vital part of the Tasmanian health system with the potential to make an even bigger contribution to the health of all Tasmanians.

In Tasmania there are approximately 160 pharmacies located across the state, serving major regional centres as well as rural and remote communities. In Australia, pharmacies must be owned by registered practicing pharmacists, who invest in staff, services, infrastructure, and medications to help people manage health conditions.

By virtue of Commonwealth Government policy to ensure timely subsidised medication supply under the Pharmaceutical Benefits Scheme (PBS) community pharmacies, as approved agents of the PBS, ensure that there is equitable access to this cornerstone of Government Public Health Policy.

The Guild and its members across Tasmania recognise the increasing demand on Tasmania's health system including access to hospital care by use of an ambulance when required. We believe the recommendations from the recently released independent report commissioned by the Government "*Tasmanian Review into Pharmacist Scope of Practice*"[1] for pharmacists to be able to prescribe for minor ailments and work with GPs in partnered prescribing arrangements will certainly assist with meeting increased health care demands and help to reduce the number of people using emergency departments for non-acute conditions.

Our submission will address the following Terms of Reference:

f: further actions that can be taken by the State Government in the short, medium, and long term to address the causes and effects of transfer of care delays, and-

g: any other matter incidental thereto.

[1] pharmacist_scope_of_practice_review_-_final_report.pdf (health.tas.gov.au)

Availability of Primary Care Services - Impacting on Increased Visits to Emergency Departments

Patients are increasingly unable to access timely primary healthcare for common, everyday conditions.

This places an increasing burden on healthcare systems, especially emergency departments and general practice, and negatively affects broader patient outcomes.

Nationally this burden is demonstrated by:

- Non-urgent emergency department (ED) presentations, which accounted for 10% of all ED presentations in 2020-21[2] and have increased from 8.3% in 2018-19.[3]
- Potentially preventable hospitalisations: there were an average of 23.6 potentially preventable hospitalisations per 1,000 people in 2020-21.[4]
- Increasing waiting times for GP appointments and an industry-declared GP crisis: the average number of days that a patient is waiting for a GP appointment has increased in every State and Territory between 2019 and 2022.[5]

The Guild acknowledges the widely reported issues impacting Tasmania's health system regarding transfer of care, whereby people are not able to be admitted to hospital for care and are left in ambulances until hospital care becomes available. Hospitals at capacity and staff shortages to manage incoming patients are cited as the main causes to ambulance ramping. [6],[7] Presentations to emergency departments(Eds) in Tasmania have grown around six percent in the last five years, with 173,267 people attending Tasmania's EDs in 2021/22.[8]

The Guild is also acutely aware of the difficulty many people have in gaining timely access to general practitioners(GPs), particularly in areas under served by GPs. Efficient, affordable access to primary care would assist with the increasing numbers presenting directly to hospital due to an inability to access a GP. Tasmania currently has 60 full time equivalent (FTE) GP positions available, based on current work trends the actual number of GPs required to fill the 60 FTE positions is probably closer to 90.[9]

A recent report by Deloitte predicts that by 2032, Australia's GP shortfall will be in the vicinity of 11,400. Alarmingly only around 14% of medical graduates are choosing to specialise as GPs, with the majority choosing other specialities, with higher remuneration.[10]

Demand for GPs in major cities is projected to increase by 35.4% by 2032, while demand in regional and remote areas is projected to increase by 25.9% in the same period. This will impact Tasmania due to its regional nature and higher levels of chronic disease burden in rural and regional areas.

It is well documented that people living in rural and remote locations experience poorer access to healthcare, greater burden of disease and poorer health outcomes.[11]

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[2] Australian Institute of Health and Welfare. Australia's hospitals at a glance 2020-21.
[3] Australian Institute of Health and Welfare. Australia's hospitals at a glance 2018-19.
[4] Australian Institute of Health and Welfare. Admitted patient care 2020-21, Safety and quality of the health systems. Table 8.1: Selected potentially preventable hospitalisations per 1,000 population, by PPH category, all hospitals, 2016-17 to 2020-21.
[5] GP wait times increase as Australia faces 'perfect storm' of flu, COVID and doctor shortage - ABC News
[6] https://www.abc.net.au/listen/programs/pm/ambulance-tasmania-paramedics-speak-out/102899546
[7] "Totally Unacceptable": Woman Dies After Ramped For Nine-Hours In Tasmanian Emergency Department | Triple M
[8] Emergency department care - Australian Institute of Health and Welfare (aihw.gov.au)Table 4.1: Emergency department presentations by type of visit, states and territories, 2021–22
[9] Tasmania doesn't have enough GPs to meet the growing demand — and experts warn it will get worse - ABC News
[10] General Practitioner Workforce in Australia | Deloitte Australia | Economics
[11] Rural and remote health - Australian Institute of Health and Welfare (aihw.gov.au)

This is due to the distance-decay relationship where people who live further from healthcare services have lower rates of usage and where longer travel time leads to worse patient outcomes'[12]

People who reside in lower socio-economic areas in Tasmania are increasingly represented in emergency department presentations across the State.

The Australian Institute of Health and Welfare (AIHW) report on health workforce found that *'the number of employed FTE clinicians working in their registered professions decreased with increasing remoteness'*.[13] However, it was noted that the opposite was true for nurses and midwives, who had a greater number of registered and working clinical FTE nurses and midwives in remote and very remote areas compared to major cities. Due to disparities in the distribution of the health workforce and the impact that has on patients living in rural and remote locations, enabling available health professionals in these areas to work to their full scope would be of great benefit to patients.

Community Pharmacy and Pharmacist Scope of Practice

In recent years and post COVID-19 there has been a growing appreciation of the increased capacity of pharmacists in community pharmacy to provide more healthcare services outside of medication supply, including vaccinations as well as wider diagnostic and treatment options, including protocol prescribing. Announcements across States and Territories supporting increased pharmacist scope have recognised the unique role pharmacy has in communities across Australia, positioned to improve access to healthcare. (Appendix 1)

Community pharmacy is Australia's most frequently accessed and most accessible health destination, with over 459 million individual patient visits annually and 2,127 pharmacies open after-hours, including weekends and public holidays.[14] The equitable distribution of community pharmacies across metropolitan, regional, rural and remote locations means that for the majority of Australians, community pharmacy is an accessible and convenient provider of healthcare. In Tasmania there are more than 50 pharmacies that open after hours including weekends; larger regions in the State including Hobart, Launceston, Devonport, and Burnie all have pharmacies which operate 9am – 9pm seven days per week.

There are 333 suburbs and localities across Australia which have no GP but at least one community pharmacy.

Of concern locally is the slated closure of a large GP practice in Bridgewater later this year which will leave some 7000 people residing in this low socio economic area without GP services. Undoubtedly this one closure alone will substantially increase the current pressures on Hobart's emergency departments and exacerbate the current ramping issues.

Bridgewater has one community pharmacy owned by Pharmacy Guild of Australia Tasmanian member Mr Geoff Hope. Mr Hope has raised the concerns of people in the community who will be without GP services.

The accessibility of community pharmacy, particularly the ability to walk-in and seek advice from a pharmacist, without an appointment in most cases, is of huge benefit to patients unable to access a GP appointment, especially in medically underserviced areas.

[12] Rural and remote health - Australian Institute of Health and Welfare (aihw.gov.au)
[13] Health workforce - Australian Institute of Health and Welfare (aihw.gov.au)
[14] Pearson, D., De lure, R. (2021) *NAB Pharmacy Survey 2021.* NAB. https://business.nab.com.au/nab-australian-pharmacy-survey-2021-48091/

It allows pharmacists to identify and triage patients who require urgent review and work collaboratively with other health professionals to ensure these patients are prioritised.

Patient benefits from health professionals working to their full scope of practice and improved access to healthcare may include:

- empowerment to exercise patient-directed care, whereby patients make decisions regarding where and how they address their health care needs and are not disadvantaged in any way based on that choice.
- greater focus on prevention of disease and early intervention leading to better long-term outcomes.
- a more holistic, patient-centred approach to healthcare where the patient is an active participant in determining the management and treatment of their ailments and/or health prevention strategies to optimise their health and wellbeing.

Frustratingly there are existing health services such as health screening and condition management programs currently only available through GPs, which are well within a pharmacist scope of practice and would help to better manage chronic disease and identify health concerns if they were more accessible

For example Asthma Action Plans require a GP to initiate and are provided to people who have already been diagnosed with asthma. The National Asthma Council Australia recommends people with asthma should have their own individual written action plan that includes instructions on what to do when asthma symptoms worsen.[15] Currently only one in four people nationally aged 18 years and over have an Asthma Action Plan[16].

Asthma affects 66,000 people in Tasmania, or more than one in eight people,[17] resulting in Tasmania having the second highest prevalence of asthma in any state or territory in Australia. Tasmania's Brighton municipality has the highest rates of asthma, while Launceston has the highest total number of people with asthma.[18] Corresponding hospital data for Tasmania shows the incidence of people presenting to ED with respiratory conditions, which would include asthmatic exacerbations usually due to environmental triggers or poor management.

With access to GPs becoming more problematic, preventative health, chronic disease management and screening programs are less accessible. This again results in people using hospitals for primary care, placing strain on the emergency services, including ambulances and hospital EDs. Data shows that of the 173,267 people who presented to emergency departments in 2021/22 mainly by ambulance in Tasmania, only 28% were admitted to the hospital for further treatment.[19]

The Tasmanian Government's release of the independent Review of Tasmanian Pharmacists' Scope of Practice has provided a path forward for Tasmanian pharmacists to be able to do more to ease the healthcare access in the State. The Guild provided as part of the submissions to the review our commissioned Ernst and Young report, detailing economic benefits to Tasmania's health system including Primary Care, Emergency and Hospital visits. Outlined are specific conditions suitable for pharmacist treatment under increased scope of practice, many of which directly contribute to non-urgent visits to emergency departments in the State. (Appendix 2)

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[15] National Asthma Council Australia, 'How is asthma treated?', https://www.nationalasthma.org.au/understanding-asthma/how-is-asthma-managed; accessed 09/02/2022.
[16] Asthma, 2020-21 financial year | Australian Bureau of Statistics (abs.gov.au)
[17] PHIDU 2019. Asthma Atlas of Australia. Adelaide: PHIDU.
[18] 3 Public Health Information Development Unit (PHIDU) 2020. Social Health Atlas of Australia. Adelaide: PHIDU
[19] Emergency department care - Australian Institute of Health and Welfare (aihw.gov.au)Table 4.14: Proportion (%) of Emergency presentations with an episode end status of Admitted to this hospital(a), by triage category, states and territories, 2021–22

Importantly we hope that the Government ensures that the Health Department is supportive in working with stakeholders to deliver on horizons identified in the report (Appendix 3) and proactively seeks opportunities to utilize pharmacists working at full scope.

Partnered prescribing with GPs to provide care for people in residential aged care facilities including medication continuance will help to alleviate residents routinely accessing hospital care via ambulance.

Community pharmacists working to their full scope will deliver increased patient benefits, relieve pressure on the broader health system, and take pressure off overcrowded and overworked general practices.

This will increase the capacity of hospitals and general practice to manage the more complex acute and chronic health conditions that are outside of the scope of other providers. It could also encourage more patients to maintain routine care, reducing the prevalence and impact of preventable disease.

Pharmacists could be working to full scope of practice in the following domains of competency:

1. **Medication supply and dispensing**
    a. Medication Continuance which involves supplying medicine without a prescription to ensure continuity of treatment (e.g., emergency supply, Continued Dispensing, and prescription renewal).
    b. Therapeutic substitution which involves issuing a patient with an equivalent prescribed medicine at the same dosage to ensure continuity of treatment (e.g., during a medicine shortage) without the need for a new prescription.
    c. Therapeutic adaptation which involves adapting a prescribed medicine to manage health conditions according to a patient's need (e.g., titrate medicine doses or manage a Quality Use of Medicines (QUM) issue such as with swallowing).
    d. **Prescribing**
        a. Supervised prescribing which is limited authorisation to prescribe medicines under supervision or in collaboration with another authorised health professional (e.g., "pharmacist partnered charting" in hospitals and residential care facilities).
        b. Structured prescribing which is limited authorisation for pharmacists to prescribe medicines within a recognised protocol (e.g., prescribing antibiotics for urinary tract infections). A good example of this is the North Queensland Community Pharmacy Scope of Practice Pilot.
        c. Deprescribing (and re-prescribing) which involves a pharmacist monitoring treatment outcomes and using clinical knowledge and professional judgement to cease treatments where appropriate with follow-up monitoring of the patient (e.g., ceasing a benzodiazepine for insomnia).
    e. **Medication review** involves a pharmacist reviewing a patient's medicines to optimise quality use of medicines (QUM), ensure safe and appropriate use, and identify and address any medicine-related problems.
    f. **Population health** includes:
        a. Patient screening and risk assessment involves pharmacists conducting evidence-based screening programs for eligible population groups (e.g., for cardiovascular disease, Type 2 diabetes, obstructive pulmonary diseases, and Sleep Apnoea). This may include conducting a blood pressure check, weight check and glucose level check in the community pharmacy.

b. Preventive health programs and health promotion involves pharmacists providing health and wellbeing services with preventive health and lifestyle support (e.g., pharmacists consulting, assessing, and monitoring patients for travel health, weight management and smoking cessation programs).

c. Harm minimisation involves pharmacists consulting, assessing, monitoring and supporting patients, including as part of formalised programs (e.g. opioid dependence treatment or Naloxone Take-home programs). Pharmacists will adapt, extend, and prescribe treatments. Complex cases may be referred to a GP or relevant Alcohol and Drugs Services.

g. **Health condition management** involves pharmacist assessment, treatment, monitoring, review, and referral of patients with acute and chronic health conditions. Examples include:

a. In-pharmacy diagnostic testing which involves conducting an in-pharmacy test (including on a walk-in basis) to help manage acute health conditions, including prescribing treatments (e.g., influenza, COVID-19, Streptococcus throat infection and chlamydia).

b. In-pharmacy monitoring which involves conducting in-pharmacy tests to support management of chronic health conditions, including renewing, adapting, prescribing and deprescribing treatments (e.g., spirometry for asthma/COPD, HbA1c for Type 2 diabetes, cholesterol/lipid tests for dyslipidaemia).

c. Device Use Review which involves a pharmacist reviewing and assessing a patient's use of a medical device to identify and address any issues and improve the patient's knowledge and use of the device. This helps patients self-manage their conditions and minimise wastage of consumables like blood glucose meters, home blood pressure meters to empower patients , and health APPs for use on smart devices.

d. Self-management of everyday health conditions (also known as Common or Minor Ailments) involves pharmacists providing pharmacological and non-pharmacological support to patients to self-manage common, non-complex acute-care conditions (e.g., pain, nausea and vomiting, hay fever, common colds, vaginal thrush, and tinea). Pharmacists will prescribe treatments when appropriate.

e. Self-management of chronic health conditions involves pharmacists helping patients to self-manage chronic health conditions (e.g., asthma, Type 2 diabetes, dyslipidaemia, and hypertension). This includes working with medical practitioners to initiate, monitor and adapt treatments for newly diagnosed conditions without the need for a prescription, monitoring a patient's condition and response to treatment, and renewing, adapting, prescribing or deprescribing medicines to continue treatment.

h. **Medicines administration** involves pharmacist administration of injectable and non-injectable medicines for the purpose of immunisation, management of chronic conditions, and treatment of acute episodes (e.g., vaccines, injectable medicines).

i. **Ordering and interpreting laboratory tests** where appropriate to diagnose and/or manage acute or chronic health conditions (e.g., tests for therapeutic drug monitoring or to assist with diagnosis of specific conditions).

As shown in Appendix Two, pleasingly the Tasmanian independent report, mirrors the Guild's recognised domains of competency. The scope of practice of individual pharmacists will differ depending on their skills, knowledge, attributes, experience, and accountability. Individual scope of practice for a pharmacist may be influenced by the services offered in the pharmacy where they work, reflective of the needs of the local community.

When undertaking activities involving PBS-listed medicines (e.g., prescription renewal, prescribing treatment), pharmacists should be able to prescribe, dispense and/or supply these as pharmaceutical benefits for eligible patients.

Building a New Eco-System for Healthcare Delivery - Considerations

There are many benefits to health practitioners including pharmacists being enabled to work to their full scope, including increased job satisfaction through opportunity for greater responsibility and more rewarding practice; potential for increased remuneration commensurate to level of practice and responsibility; and opportunity for interprofessional education and practice that provides a greater understanding of the role and capability of other healthcare professionals. From a future workforce position, the appeal of working to full scope, where health practitioners are using the full extent of their skills and training may lead to an increase in people entering and staying in the workforce.

Health practitioners working to their full scope of practice may enable sharing of workloads with other health practitioners where scope overlaps, leading to reduced burden and stress levels that are experienced with overwork and isolation.

The 2022 Skills Priority List reports that most regulated health professions are experiencing workforce shortages.[20] For employers, this means difficultly filling job vacancies and maintaining sufficient staffing levels to broaden the range of health services beyond core functions. It also means increased labour costs due to disparities in supply and demand.

Benefits to employers from health professionals working to full scope of practice are primarily associated with increased workforce due to greater appeal to enter health professions and reduced workforce attrition due to greater job satisfaction including:

- Retention of employees and reduction in staff shortages.
- Implementation of innovative models of practice to meet the needs of the community.
- Delivery of a broader range of services to patients.
- A workforce that is motivated to upskill and practice at a higher level

The 2015 Productivity Commission Research Paper into Efficiency in Health identified role expansions and associated amended scopes of practice as health workforce reform actions that could provide greater workforce flexibility, potentially lower labour costs, better patient access and higher workforce satisfaction.[21]

Governments can benefit from health professionals working to full scope by viewing it as an opportunity to utilise the health workforce to achieve the aims of health strategies and address health priorities of government such as universal health coverage and health security. Utilising health practitioners to their full scope enables the government to deliver health care services to more Australians, whilst reducing the burden on the hospital system.

[20] 2022 Skills Priority List almost doubles occupations with skills shortages | Ministers' Media Centre (dewr.gov.au)
[21] Research paper - Efficiency in Health (pc.gov.au)

Productivity gains and economic benefit from reduced absenteeism from work due to illness can be realised, because of timely access to health services and treatment, and the ability to deliver more preventative health services.

Pharmacists working at their full scope must be supported by training, education, regulatory and policy change along with remuneration. Consumer education is required to promote new services available at their local community pharmacy.

Funding of health services is a shared responsibility between the Commonwealth, State and Territory governments, private health insurers, and consumers.

Health professionals working to full scope, particularly in community settings, would be of benefit to the Commonwealth, States and Territories by reducing reliance on hospitals to provide non-urgent care where primary care services are not available.

Utilising the available health workforce to the full extent of their training to provide screening and risk assessments services, preventive health services such as vaccination, and management of everyday health conditions would keep people out of hospitals enabling hospitals to focus on critical care services. It also presents an opportunity to develop innovative funding models.

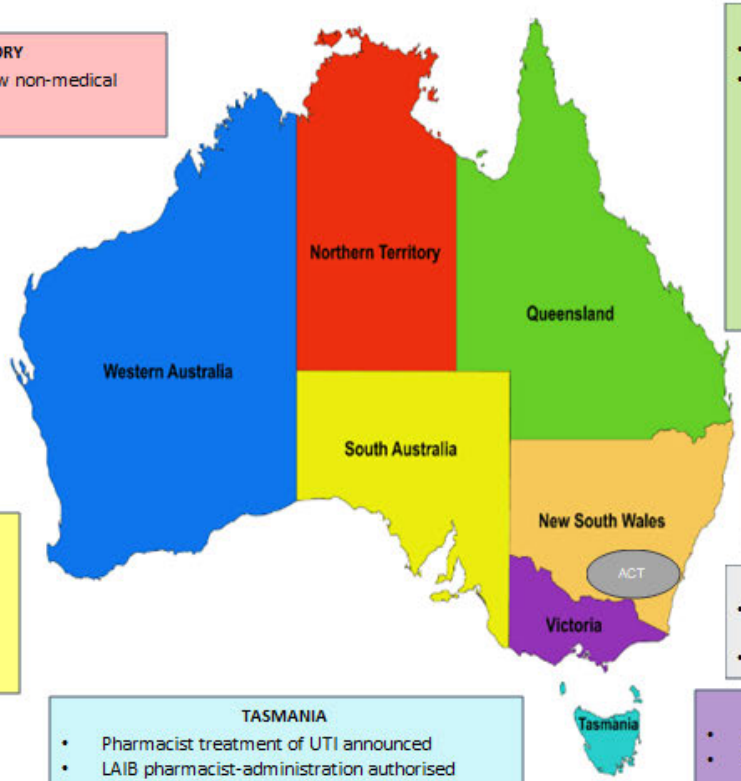
Additional benefits to funders of health professionals working to full scope is that funding costs for some health services may be reduced where patients who are willing, and can afford, to pay private service fees. This has been the experience in Queensland where patients accessing treatment of uncomplicated urinary tract infections through community pharmacy pay both a consultation fee and cost of the medication, with neither being subsidised by the government. This should be considered the exception not the norm for funding of health services, especially for patients that are eligible for subsidised healthcare and medicines. Funding mechanism should be leveraged to support equitable patient access by ensuring appropriate remuneration for all healthcare professionals.

More efficient access to healthcare services can be enabled through subsidisation of community pharmacy services for vulnerable or target populations, allowing pharmacies to offer a wider range of services, improving access to services for the community as a whole and helping to stem the flow of people seeking hospital care. Appropriate funding mechanisms equivalent to other healthcare providers for the delivery of preventive health care would support increased and affordable access to these services and overall better health outcomes for the community.

In addition to appropriate funding and remuneration for delivery of health services, incentive programs should be available to all health professionals to encourage practice in regional, rural, and remote areas to address the issue of maldistribution of workforce.

Health care access in all Australian jurisdictions, including Tasmania is in crisis and community pharmacy and their pharmacists have the capacity, the skills and the willingness to play a bigger role; we need the support and will of the Government to support community pharmacy through system reforms across policy, regulation and funding mechanisms.

This map shows the current inconsistencies in pharmacist scope of practice across Australia.



NORTHERN TERRITORY

- Legislation amended to allow non-medical prescribing

QUEENSLAND

- Pharmacist treatment of UTI permanent practice
- Scope of Practice Pilot (NQ) commenced – medication management (vaccines, injectable medicines, therapeutic adaption & substitution, Continued Dispensing), Pharmacist Prescribing (reflux, nausea/vomiting, rhinitis, impetigo, shingles, atopic dermatitis, psoriasis, acne, wound management, ear infections, musculoskeletal pain & inflammation, smoking cessation, hormonal contraception, travel health, weight management, oral health: NQ Pilothealth.qld.gov.au)

WESTERN AUSTRALIA

- Pharmacist treatment of UTI permanent practice
- LAIB pharmacist-administration authorised

NEW SOUTH WALES

- Pharmacist prescribing trial – Statewide UTI treatment, resupply of oral contraceptives (OCP), NSW Pharmacy Trial
- Full scope pilot aligned to QLD pilot announced
- Long-acting injectable buprenorphine (LAIB) administration pilot

SOUTH AUSTRALIA

- Select Committee on Access to Urinary Tract Infections
- Select Committee on Health Services recommendations for permanent UTI treatment service and pharmacy prescribing pilot

AUSTRALIAN CAPITAL TERRITORY

- Pharmacist prescribing trial - UTI treatment and OCP resupply commenced
- LAIB pharmacist-administration authorised

TASMANIA

- Pharmacist treatment of UTI announced
- LAIB pharmacist-administration authorised

VICTORIA

- LAIB pharmacist-administration authorised
- Pharmacist prescribing trial commenced – UTI, resupply of oral contraceptives, skin infections, Vic Pilot Info Pack

Appendix 2

State Summary Report:
Tasmania

Tasmania

Scope of Practice in Tasmania

Tasmanian pharmacists have the authority to work within the full scope of pharmacy practice in accordance with their individual training, experience and expertise, as defined by the National Competency Standards Framework for Pharmacists in Australia[1] and authorised by relevant Tasmanian legislation and regulations.

Tasmanian Poisons Regulation

In Tasmania pharmacists are authorised to administer influenza vaccinations and diphtheria-tetanus-acellular pertussis (dTpa) and measles-mumps-rubella vaccinations to persons aged 10 years or over and 16 years or over, respectively. Before pharmacists can begin administrating these vaccines, they need to complete an approved training program, and administer five vaccinations under supervision.[2]

Current barriers which limit a pharmacists ability to work to their full scope in vaccinations are regulations relating to patient age and the range of vaccines that can be administered, as well as full access to the NIP for all eligible patients, and for all vaccines on the Schedule.

An expansion of practices into all conditions will generate a total dollar benefit of:

$108m per annum

An expansion of practices into all conditions will generate a total time-saving benefit of:

- 130,000 consultations in primary care
- 1,000 hours in emergency services
- 6,500 days in hospital care services

Annual healthcare cost-reduction benefit of:

$9.8m for the Australian Government

$5.5m for the State Government

Annual quality of life benefit of:

$66.0m

Total productivity dollar benefit arising from reduced absenteeism and presenteeism of:

$26.5m

Regional areas represent **92%** of total dollar benefits

Remote and very remote areas represent **8%** of total dollar benefits

1 Pharmaceutical Society of Australia (2016). National Competency Standards. Retrieved from here accessed on 7th Feb, 2022
2 Department of Health, Tasmanian Government (n.d.) Forms and guidelines for pharmacists. Retrieved from here, accessed on 12th May, 2022.
* Based on the ASGS geographical indication, there are no major cities in the state of Tasmania and all area is classified as either regional or remote and very remote.

TAS Economic Analysis: Expected Financial Benefits

	Annual Benefit*** ($m)				Ten Year Total Benefit*** ($m)				Total* ($m)
	Reduced Healthcare Costs		Productivity Gains	Quality of Life***	Reduced Healthcare Costs		Productivity Gains	Quality of Life***	
	For the Australian Government	For the State and Territory Governments			For the Australian Government	For the State and Territory Governments			
Uncomplicated urinary tract infections	0.6	0.8	0.5	0.1	6.3	8.1	4.3	1.0	17.8
Ear, nose and throat (ENT) infections	1.3	0.5	0.1	0.0	12.0	5.0	0.6	0.2	17.8
Influenza	2.0	0.6	0.2	0.5	11.8	7.7	1.4	6.6	27.5
Acute cellulitis	0.9	0.8	0.3	0.0	8.7	8.2	2.3	0.1	19.3
Respiratory: asthma	0.8	0.7	6.7	11.5	8.3	8.8	59.3	101.4	119.6
Respiratory: COPD	1.1	1.2	0.5	6.5	11.2	13.2	5.2	57.2	86.8
Dyslipidaemia	0.6	0.3	0.1	19.7	4.5	2.4	0.4	173.3	180.6
Hypertension	0.7	0.1	5.9	4.9	4.2	1.3	51.9	43.6	100.9
Mental health: depression	0.5	0.0	5.6	6.8	4.6	0.0	49.2	60.1	113.8
Mental health: anxiety	0.3	0.0	6.5	15.8	2.9	0.0	56.8	139.5	199.2
NIP and non-NIP vaccination	0.9	0.5	0.3	0.1	8.4	6.3	3.3	0.9	18.9
Non-vaccine injectables	0.0	0.0	N/A	N/A	0.1	0.0	N/A	N/A	0.1
Travel medicine "Safe Travel"	0.1	0.0	N/A	N/A	1.1	0.0	N/A	N/A	1.1

*Due to rounding errors, estimated benefits by each condition may not sum to total.
**N/A indicate cases when the benefit cannot be accrued, i.e., because a patient require non-vaccine injectables may not present any productivity gains or improvements in quality of life as a result of pharmacist-led intervention.
*** For quantification of Quality of Life benefit for chronic conditions such as dyslipidaemia, mental health and respiratory conditions, it is assumed that the affected proportion of population received a pharmacist-led intervention in the first analysis year and returned to their pre-condition health utility state and then remained in that state for the duration of the projection period. It is assumed in the base case that the condition would not have been resolved during the 10 year projection period and, consequently, benefits are accrued each year for 10 analysis year. The prevalence of each condition in the Australian population is assumed to remain constant over the projection period, with population growth resulting in an increase in the number of people affected by the condition.

TAS Economic Analysis: Expected Time Saving Benefits

	Annual Benefit		
	Hospital Services (number of days)	Emergency services (number of hours)	Primary Care Services (number of consultations)
Uncomplicated urinary tract infections	851	15	368
Ear, nose and throat (ENT) infections	216	60	23,686
Influenza	1,195	41	374,44
Acute cellulitis	829	322	4,737
Respiratory: asthma	335	58	4,737
Respiratory: COPD	1,780	122	2,369
Dyslipidaemia	172	0	8,069
Hypertension	96	6	14,211
Mental health: depression	N/A	45	12,540
Mental health: anxiety	N/A	127	6,763
NIP and non-NIP vaccination	1,005	234	11,007
Non-vaccine injectables	N/A	N/A	570
Travel medicine "Safe Travel"	N/A	N/A	3,302

**N/A indicate cases when the benefit cannot be accrued, i.e., if the admission to a hospital because of a mental health condition is not considered as potentially preventable hospitalisation as per AIHW definition.*

Appendix 3

Figure 14: Indicative approach to Implementation