KPMG

Department of Health and Ageing

Evaluation of the Rural Pharmacy Programs

Final Report

November 2010
This report contains 110 pages
Appendices comprise 16 pages
Final RPWP Evaluation Report 11 Nov 2010

AUDIT ▪ TAX ▪ ADVISORY

Executive Summary

Scope and purpose of the evaluation

This document reports on the findings of the evaluation of rural pharmacy workforce programs funded under the Fourth Community Pharmacy Agreement, namely the:

- Rural Pharmacy Workforce Program (RPWP);
- Pre-registration Incentive Allowance; and
- Rural Pharmacy Maintenance, Rural Pharmacy Start-Up and Rural Pharmacy Succession Allowances.

The general purpose of the evaluation was to assess the effectiveness and efficiency of the collective group of programs that are referred to in the report as the Rural Pharmacy Workforce Initiative and to consider future directions for the Initiative. The evaluation was to consider a number of specific questions within the constraints of available data and within a reduced timeframe.

The evaluation was undertaken within specified parameters that impact on the scope and depth of the evaluation. Most notably, the evaluation:

- Was undertaken within a specific timeframe that limited the scope of consultation activities;
- Was limited to the use of secondary data; and
- Focused on the Initiative as a whole and did not consider the effectiveness of individual programs.

Summary findings

Appropriateness of the Initiative: The Initiative addresses an important and on-going need namely, workforce shortage in some rural and remote areas and challenges in retaining the workforce in these areas. Further, the range of strategies funded to address this need is consistent with what was the priority need and the strategies focused on the factors critical to address that need. Most notably, the Initiative included strategies that:

- Address professional isolation and provide emergency relief (factors that the literature recognises as being critical to both recruiting and retaining health care workers in rural and remote areas);

- Encourage both students and post graduates to gain exposure to and experience in working in rural and remote areas (the literature suggests that this is an important factor in influencing the decisions of individuals to take up a career in a rural and remote area);

- Target rural people to take up a career in pharmacy (there is evidence in the literature that people with a rural connection are likely to return to rural areas to work);

- Support innovation through funding of small projects; and

- Assist pharmacy owners to ensure that their business remains viable.

These and other aspects of the Initiative were an appropriate mix of strategies that are consistent with both the evidence in the literature regarding effective workforce strategies and consistent with widely held views amongst those working in workforce strategy about what is required to address the rural and remote workforce need. KPMG notes that the landscape is changing however, that may require a change in the strategy mix.

Effectiveness of the Initiative: the evaluation found that the Initiative was successful in achieving its operational targets, it is well supported by stakeholders and recipients of grant payments, and that the range of strategies adopted by the Initiative is consistent with the 'evidence' regarding strategies that are likely to be effective. The available data were not sufficient however, to determine whether the Initiative has directly impacted on workforce outcomes. KPMG notes that this was also a limitation that constrained the previous evaluation and notes that the previous evaluators recommended the establishment of a workforce database to redress this important issue. There is some anecdotal evidence that suggests that the Initiative has made a contribution to workforce outcomes - feedback from recipients suggests that, in some cases, various programs were an important factor in their decision to work in rural and remote areas of Australia.

Efficiency of the Initiative: the evaluation did not identify factors that may have impacted on the efficiency of the Initiative. Grant recipients rarely commented on issues such as burden of reporting or grant application being an issue. KPMG notes that the proportion of all funding that is expended on administration of the various programs is in the order of ten percent and also notes that there are no firm benchmarks for grant funding administration. However, KPMG notes that there are opportunities to simplify the programs' structure that should improve operational efficiency.

Opportunities and future directions

There are changes both within community pharmacy and in the broader health policy and service delivery environment that require reassessment of whether the current mix of strategies is optimum to address future workforce requirements and challenges. Further, KPMG has noted a number of structural issues that suggest that there are opportunities to optimise the impact of the programs regardless of the changing landscape within which the programs are operating.

Changing landscape: The most important changes that impact on community pharmacy and on workforce strategies are:

- It appears that within the last ten years, Australia has moved from experiencing a net shortage in workforce to now entering a period of potentially an excess of pharmacists or at least a vastly diminished problem – the challenge in the future is more likely to be to ensure that the workforce is distributed so that there is greater equity in access to community pharmacy services (refer also to note on need for policy clarity).

- Community pharmacy is moving more towards a corporate model with business partnerships being the dominant model and 'managed' pharmacies appearing to become more evident including in rural areas - this should strengthen the economic viability of community pharmacy suggesting that the Australian Government's investment mix should focus more on solutions for areas where the traditional community pharmacy model is less viable.

- Broader workforce policy decisions and strategies that have resulted in the creation of Health Workforce Australia and Health Training Networks should now be considered in terms of their role in some aspects of the current Initiative – particularly with respect to clinical placements.

- The Australian Government's primary health care policy that will result in the funding of regionally based primary health care organisations that will have a workforce development role (yet to be precisely defined) may have an impact on both pharmacy workforce program delivery and on pharmacy workforce strategy.

Structural improvements and policy clarity: throughout the evaluation, KPMG noted and some stakeholders commented on the need for some improvements in structural arrangements and clarity of policy as follows:

- There is no apparent overarching mechanism that ensures that these programs and other strategies outside of these programs that also share the broad aim of improving access that people living in rural and remote areas have to community pharmacy services are integrated and adequately linked. Further, there does not appear to be a mechanism that identifies areas of workforce shortage and ensures a policy response to these priority areas.

- Linkages between program areas need to be strengthened – such as between the academics in UDRHs and the Pharmacy Schools.

- Informal processes that are relied on to share innovation, program learnings and experiences should be strengthened by implementation of more formal mechanisms – such as processes that take the outcomes of innovative projects that are under funded under this Initiative and promulgated proactively across the industry.

- The stated objective of the Initiative is to increase the proportion of community pharmacists working in rural and remote areas (equity of access), whereas the programs are more focused on net increase in access and less focused on workforce distribution issues within rural and remote areas.

- There are clear synergies between some programs within the Initiative and between programs outside this Initiative that suggest that some programs should be restructured to capitalise on those synergies.

Accordingly, KPMG identified the following findings:

Finding 1: that there is some confusion in the interpretation of the policy intent of the initiative. The clarification of the policy intent of the Initiative as part of implementation of the Fifth Agreement coupled with ensuring that all statements of objectives are consistent with the policy intent and aligning all funding programs to these objectives and the development of an explicit program logic may address this.

Finding 2: that there is limited evidence of a strategic focus overarching the Initiative. A more strategic approach could strengthen the Initiative by including:

1) a process that systematically assesses workforce shortages and need;
2) funding allocations that address priority need; and
3) explicit policy priorities and overarching strategy to achieve the specific objectives.

Finding 3: there is no process that explicitly assesses the investment mix against workforce priorities. The implementation of such a process would improve the strategic response to identified priorities.

Finding 4: there is no requirement for organisations in receipt of funding, to set up formal mechanisms to collaborate and exchange information with other relevant organisations. Such arrangements could strengthen the Initiative.

Finding 5: established processes to share could strengthen rural pharmacy practice and be used to actively promote rural pharmacy.

Finding 6: the response to increasing access to community pharmacy services could be strengthened by the funding of innovative workforce options that would address the needs of communities where the traditional community pharmacy model is not viable. This could be a priority for the small projects funding program.

Finding 7: assessment of how current strategies that promote the Initiative could be improved to ensure that potential recipients are aware of the programs for which they are eligible to receive assistance and support could streamline promotion activities and enhance stakeholder awareness of programs.

Finding 8: there is no process or structure that allows the collation of workforce data required to assess workforce shortages and to monitor the impacts of program funding this limits the Initiatives ability to identify strategic priorities and respond to need.

Finding 9: there may be opportunities to merge related programs to improve administrative efficiency and potentially improve program effectiveness.

Contents

Inherent Limitations

This report has been prepared as outlined in the Scope Section. The services provided in connection with this engagement comprise an advisory engagement which is not subject to Australian Auditing Standards or Australian Standards on Review or Assurance Engagements, and consequently no opinions or conclusions intended to convey assurance have been expressed.

The findings in this report are based on a number of sources of information that KPMG cannot guarantee the reliability of. The survey of program participants reflects the views of only those who responded to the survey. Any projection to the wider population of participants is subject to the level of bias in the method of sample selection.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by various stakeholders consulted during the evaluation.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

Third Party Reliance

This report has been prepared at the request of the Department of Health and Ageing in accordance with the terms of KPMG's contract. Other than our responsibility to the Department of Health and Ageing, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

1 Introduction

KPMG was engaged by the Department of Health and Ageing (DoHA) to undertake an evaluation of rural pharmacy workforce programs funded under the Fourth Community Pharmacy Agreement, namely the:

- Rural Pharmacy Workforce Program (RPWP);
- Pre-registration Incentive Allowance; and
- Rural Pharmacy Maintenance, Rural Pharmacy Start-Up and Rural Pharmacy Succession Allowances.

This collection of programs is referred to in the report as the *Rural Pharmacy Workforce Initiative*.

The original terms of reference of the evaluation were to:

- Analyse the existing need for assistance and support to pharmacies to ensure pharmacies provide community pharmacy services in rural and remote areas, in order to allow the population to have equitable access;
- Identify the extent to which the existing rural pharmacy programs meet the level of need identified, and assess the programs' effectiveness;
- Assess the efficiency of administration and delivery of existing rural pharmacy programs in the context of other rural health access programs, for government, pharmacy and other stakeholders; and
- Analyse the impact of the implementation of the ASGC remoteness classification to the current pool of rural and remote pharmacies in Australia, currently classified under the PhARIA rural and remoteness classification system.

The extent to which the evaluation was able to address these terms of reference was subject to the availability of data from secondary sources and constrained by the reduced timeframe for the evaluation. Consequently, the evaluation focussed on agreed priority areas.

1.1 Purpose and scope of the evaluation

At a high level, the evaluation was to understand the appropriateness, effectiveness and efficiency of the programs as a collective response to rural and remote pharmacy workforce issues in Australia to inform future program directions. In doing this, the evaluation posed the evaluation questions and sub questions outlined in Table 1 below.

Table 1 Evaluation questions and sub questions

Evaluation questions and sub questions
Is the Program effective?
To what extent have individual programs contributed to the overarching objective(s) of the Rural Pharmacy Workforce Program?
Is access to community pharmacy services being maintained (or increased)?
Does the Program meet current workforce requirements or does it need to be modified/enhanced and if so how?
Are programs sufficiently accessible to target populations?
Are target groups aware of programs?
Are those students engaged in the programs being progressed to and being retained in rural and remote employment?
Has the rate of return to rural and remote areas changed (increased) since the beginning of the Program?
Can the administration of the Program be improved and if so how?
How well are the individual programs coordinated across the Rural Pharmacy Workforce Program?
Are Program arrangements sufficiently flexible and responsive to adapt to current and emerging needs?
Are the individual programs part of a cohesive strategy?
What is the future direction of the Program?
Are Program supports sufficient or need to be enhanced?
Can programs be streamlined?
What are the impacts and implications of the new classification system?
How can the programs be better targeted?
What are the requirements for on-going monitoring?

1.2 Program objectives

The primary objective of rural pharmacy workforce programs under the Fourth Community Pharmacy Agreement is to "…maintain and improve access to quality community pharmacy services for the community in rural and remote areas of Australia, and to increase the proportion of the total pharmacy workforce starting practice in rural and remote Australia and staying in rural and remote practice for at least five years."[1]

The program does this through a series of workforce related strategies targeted at recruiting and retaining pharmacists in and to rural and remote areas. Section 3 of this report outlines the various programs in detail (Figure 1 provides a diagrammatic overview of the set of programs).

[1] Fourth Community Pharmacy Agreement between the Commonwealth of Australia and the Pharmacy Guild of Australia 2005, p.19.

2 Evaluation approach

The evaluation of rural pharmacy programs applied four key methods. These were:

- Program mapping and review;
- Stakeholder consultation;
- An online survey of rural pharmacy program recipients; and
- ASGC impact analysis (data analysis of current and future classification systems).

Analysis of rural pharmacy workforce data was a fifth evaluation method plan for the evaluation. However, exploration with DoHA and the Guild identified that pharmacy workforce data is not available. As such this method was not applied in the Evaluation.

Each of these methods is discussed in more detail below.

2.1 Program mapping and review

The purpose of the program mapping and review was establishing a common understanding of each of the 14 programs within the scope of the evaluation and to make a preliminary assessment of:

- The extent to which the Program is congruent with policy and the broad aims and objectives of the Agreement.
- Whether the elements of the program form a cohesive strategy.
- Whether there are any overlaps in administration and/or activity that produce inefficiency or confusion.

KPMG was provided with the following documentation by both DoHA and the Pharmacy Guild of Australia (the Guild) to undertake the program mapping exercise:

- Funding agreements for the Pre Registration Incentive Allowance and Rural Pharmacy Workforce Program;
- Business rules for each of the programs administered by Medicare Australia (the Rural Pharmacy Maintenance Allowance, the Start Up Allowance and the Succession Allowance);
- Public program guidelines for each of the programs administered by the Guild;

- A sample of program reports required under the Rural Pharmacy Workforce Program and Pre Registration Incentive allowance; and
- A sample of pre registrant and host pharmacy reports provided to the Guild.

These documents were reviewed using a common template that detailed, for each program the:

- Program objective;
- Target group and eligibility criteria;
- Core program activities;
- Total program funding;
- Funding recipients; and
- Key performance indicators / critical success factors.

The templates relating to programs administered by the Guild were discussed with the Guild to ensure that the appropriate interpretations had been made about the programs.

This approach enabled the programs to be reviewed in their entirety to identify the:

- Alignment with the program objective;
- Presence or absence of a cohesive strategy; and
- Any overlap between programs.

2.2 Stakeholder consultation

A series of interviews were undertaken with key stakeholders identified by DoHA and the Guild. Stakeholders consulted included representatives of peak bodies, DoHA, universities and the Guild.

The purpose of the stakeholder interviews was to:

- Understand the experiences of DoHA and the Guild in administering the RPWP and relevant Rural Pharmacy Programs;
- Gain insight into the views of other key stakeholders (see Appendix A for list of stakeholders); and

- Obtain corroborating information from stakeholders where views are not personal opinions but statements of fact.

Interviews were conducted over the telephone and applied a semi structured format that considered:

- The current and future workforce issues for rural and remote pharmacies;
- The role of the programs in responding to the current and future workforce issues;
- Strengths of the programs;
- Key program issues; and
- Potential strategies for the future.

Given the broad range of stakeholders consulted, these themes were tailored according to the interviewees' familiarity with the range of programs being evaluated.

2.3 Online survey

An online survey was undertaken to gauge the views of program recipients in rural and remote areas regarding the extent to which rural pharmacy programs had met their needs.

The survey focused only on programs that directly targeted rural pharmacists or pharmacy students / graduates, namely the:

- Rural Pharmacy Maintenance;
- Rural Pharmacy Start Up Allowance;
- Rural Pharmacy Succession Allowance;
- Continuing Professional Education (CPE) Allowance;
- Emergency Locum Service;
- Pre Registration Incentive Allowance; and
- Rural Pharmacy Scholarship Scheme.

The survey was distributed to pharmacists and pharmacy students based on available email contact details for recipients of the CPE allowance, the Pre Registration Incentive Allowance and the Rural Pharmacy Scholarship Scheme. Email contact details were not available for other programs. Analysis of the CPE Allowance recipient data based on postcode suggested

that at least half of the rural and remote pharmacies were represented (either by owner or employee) in the contact details available and that this constituted a suitable sample for the survey.

The survey asked respondents to identify how satisfied they were with the programs they received and asked them to identify the ways that the program had helped them in their rural practice. The complete list of survey questions is provided in Appendix B.

2.4 Evaluation limitations

There were several limitations to this evaluation, namely:

- The absence of relevant rural pharmacy workforce data;
- The application of a consolidated evaluation approach; and
- Access to appropriate stakeholders.

Each of these limitations is discussed in more detail below.

Absence of relevant rural pharmacy workforce data

The absence of relevant rural pharmacy workforce data meant that the evaluation was not able to make any assessment of or correlation to, the impact of rural pharmacy programs on the rural pharmacy workforce. This was a significant impairment to the depth in which the evaluation could comment on the effectiveness of the programs. KPMG notes that the same issue constrained the previous evaluation and that the evaluators recommended an action to rectify this matter. KPMG also notes that the lack of data is likely also to constrain the effectiveness of the overall Initiative (this is discussed further in section 7.3 of this report).

Application of a consolidated evaluation approach

There was a delay in the commencement of the evaluation which meant that the reduced timeframe constrained the evaluation. This meant that the evaluation had a reduced pool of information from which it could draw findings. Further, it was not viable for this evaluation to undertake individual evaluations of the 14 programs. Rather the approach of the evaluation has been to focus on the appropriateness, effectiveness and efficiency of the programs as a collective approach to rural pharmacy workforce issues. This has meant that the evaluation has limited ability to comment of the appropriateness, effectiveness and efficiency of the individual programs in any significant detail.

Access to appropriate stakeholders

The evaluation was constrained in its ability to access stakeholders to be interviewed. There were limitations to the approach through which stakeholders were identified for interviews. Namely, DoHA identified a list of priority stakeholder groups outside the Department to be consulted in the evaluation. As DoHA did not have individual contacts with these stakeholders, the Evaluation sought suitable contacts from the Guild. Interviewees were limited to the contact lists provided. In some instances, there may have been additional or more appropriate stakeholders to inform the evaluation. The method of identifying stakeholders meant that these stakeholders were not included in the evaluation.

3 Scope of programs evaluated

Rural pharmacy programs under the Fourth Community Pharmacy agreement, collectively termed the Rural Pharmacy Allowance and Support Initiative (the Initiative), incorporates three broad program streams with a total 14 sub-programs within these. The three streams and their respective sub-programs are:

- ***Pharmacy allowance schemes*** which are administered by Medicare Australia and encompass the:
  - Rural Pharmacy Maintenance Allowance;
  - Rural Pharmacy Start Up Allowance; and
  - Rural Pharmacy Succession Allowance.
- ***The Rural Pharmacy Workforce Program*** which is administered by the Guild and encompasses the:
  - CPE Allowance;
  - Emergency Locum Service;
  - Rural Placement Allowance;
  - Administrative Support to Pharmacy Schools;
  - Rural Pharmacy Scholarship Scheme;
  - Pharmacy Academics at University Departments of Rural Health;
  - Rural Pharmacy Promotion Campaign;
  - Rural Pharmacy Newsletter;
  - Small Project Funding; and
  - Rural Commissioned Projects Research Scheme.
- The ***Pre Registration Incentive Allowance*** which is administered by the Guild.

Each of these programs provides different incentives to recruit or retain the rural and remote pharmacy workforce in Australia. This section provides an overview of the Initiative in terms of its program structure.

3.1 Objectives of the Initiative

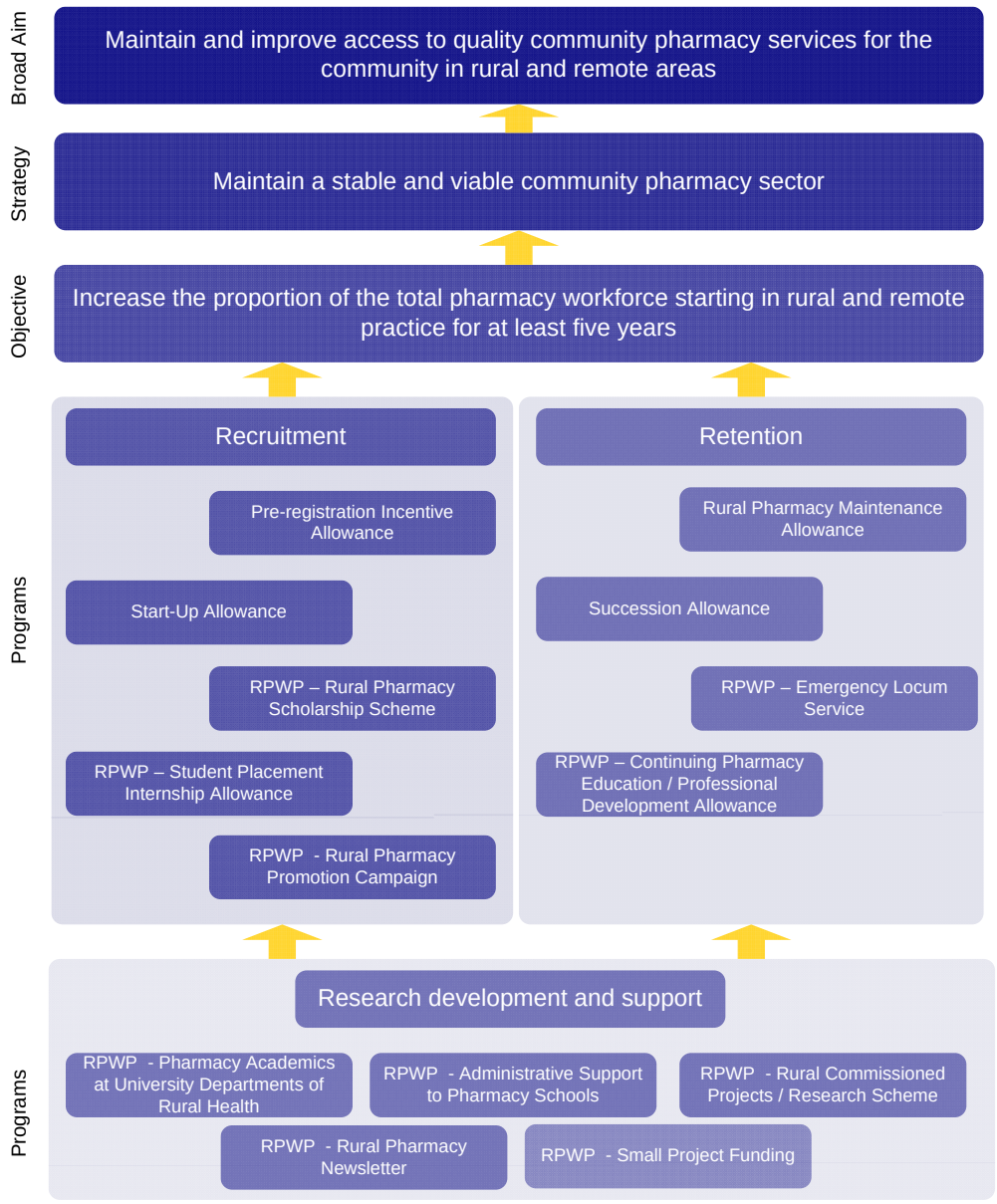
As mentioned in section 1.2, the central objective of the Initiative is to "…maintain and improve access to quality community pharmacy services for the community in rural and remote areas of Australia, and to increase the proportion of the total pharmacy workforce starting practice in rural and remote Australia and staying in rural and remote practice for at least five years."[2] In order to achieve this aim, the Initiative comprises a range of strategies and funded activities that have one of three broad purposes as follows:

- ***Recruitment*** of pharmacists to the rural and remote pharmacy workforce pool;
- ***Retention*** of pharmacists working in rural and remote areas to reduce the rate of attrition, thereby contributing to an increased workforce pool in rural and remote areas; and
- ***Research development and support*** activities that aim to both enhance recruitment and retention strategies and to directly support pharmacists working in rural and remote areas.

Figure 1 below represents the conceptualisation of the way the 14 sub-programs of the Initiative relate to its broad aim, strategy and objective. An overview of each of the 14 programs is provided in section 4.2.

[2] Fourth Community Pharmacy Agreement between the Commonwealth of Australia and the Pharmacy Guild of Australia 2005, p.19.

Figure 1 Program conceptualisation of the Initiative



Source: Developed by KPMG
Not to scale

3.2 Objectives of the individual programs

The table below provides detail about the objectives of each of the programs encompassed within the Initiative and provides the target group that each program is directed towards, the purpose area (recruitment, retention or research and support) and the eligible PhARIAs. More detail regarding each of the programs under the Initiative is provided in Appendix C.

Table 2 Overview of individual program objectives for programs incorporated in the Initiative

Program	Objective	Target	Eligible localities	Funding recipient	Strategy area
Pharmacy allowance schemes Overarching objective: *maintain and improve access to quality community pharmacy services for the community in rural and remote areas of Australia, and to increase the proportion of the total pharmacy workforce starting practice in rural and remote Australia and staying in rural and remote practice for at least five years*					
Rural Pharmacy Maintenance Allowance	Retain rural and remote pharmacies through income support recognising the additional financial and personal costs of operating a pharmacy in a rural / remote area.	Pharmacy owners	PhARIAs 2-6	Pharmacy owner	Retention
Rural Pharmacy Start Up Allowance	Encourage the establishment of new pharmacies in remote areas where there is evidence that a pharmacy can be viable and would be supported by the community.	Pharmacy owners	PhARIAs 5-6	New Pharmacy owner	Recruitment
Rural Pharmacy Succession Allowance	Prevent the loss of pharmacies in rural and remote locations by providing incentives for the purchase of pharmacies where the existing owner is having difficulty selling the business.	Pharmacy owners	PhARIAs 4-6	New Pharmacy Owner	Retention
Rural Pharmacy Workforce Program Overarching objectives: 1 *to increase the number of pharmacists in rural and remote practice through offering appropriate incentives and enhancing the attractions of rural practice;* 2 *to increase the length of stay of pharmacists in rural and remote practice by removing or reducing disincentives to practice in rural areas; and* 3 *to develop innovative solutions to overcome the barriers to the delivery of pharmacy services in rural and remote communities.*					
CPE Allowance	Reduce the additional costs incurred by pharmacists practicing in rural and remote communities in continuing to undertake	Pharmacists working in	PhARIAs 1-6[3]	Pharmacists	Retention

[3] PhARIA 1 eligibility excludes capital cities, suburbs and major regional centres as prescribed in the program guidelines eligibility criteria

Program	Objective	Target	Eligible localities	Funding recipient	Strategy area
	professional development, training and using professional education and thereby encourage and enable them to undertake training and development opportunities.	rural and remote locations			
Emergency Locum Service	Support pharmacists in rural and remote areas through direct access to pharmacist locums in emergency situations.	Pharmacy owners	PhARIAs 2-6	Community pharmacies	Retention
Rural Pharmacy Scholarship Scheme	Provide financial support to encourage and enable students from rural areas of Australia to undertake undergraduate or graduate entry studies in pharmacy that lead to a registrable qualification as a Pharmacist.	Existing and potential pharmacy students	PhARIAs 1-6[4]	Student	Recruitment
Rural Placement Allowance	Provide positive placement experiences for pharmacy students in rural and remote communities, encouraging students to return to rural or remote practice on graduation.	Pharmacy students	PhARIAs 1-6[5]	Students	Recruitment
Administrative support to pharmacy schools	Assist universities in the administration of the Rural and Remote Pharmacy Scholarship Scheme, the Rural Placement Allowance Scheme and the Aboriginal and Torres Strait Islander Pharmacy Scholarships.	Pharmacy schools	N/A	Pharmacy Schools	Research and support
Pharmacy Academics at University Departments of Rural Health	• Raise the profile of rural pharmacy within Pharmacy Schools and UDRH. • Increase rural content in rural curricula so that pharmacy graduates will be equipped with the necessary skills to	Pharmacy students. graduates and owners	N/A	Universities	Research and support

[4] PhARIA 1 eligibility excludes capital cities, suburbs and major regional centres as prescribed in the program guidelines eligibility criteria
[5] PhARIA 1 eligibility excludes capital cities, suburbs and major regional centres as prescribed in the program guidelines eligibility criteria

Program	Objective	Target	Eligible localities	Funding recipient	Strategy area
(UDRH)	practice effectively in rural areas and encourage them to enter rural practice. • Provide advisory, mentoring and developmental support to pharmacists practising in UDRH areas and to increase the number of trained preceptors to supervise students in the area and provide academic support and mentoring to students on internship placements in UDRH areas.				
Rural Pharmacy Promotion Campaign	• Raise the profile of pharmacy in rural and remote areas. • Encourage metropolitan pharmacists to practice and undertake locum placement in rural areas. • Promote pharmacy as a career to year 9-12 students. • Increase the awareness of the Fourth Pharmacy Agreement and the RPWP. • Undertake research to underpin an ongoing rural pharmacy promotion campaign to improve recruitment and retention to rural pharmacies.	Pharmacy owners, pharmacists, pharmacy students, high school students	N/A	The Guild	Recruitment
Rural Pharmacy Newsletter	Publicise rural initiatives under the Rural Pharmacy Workforce Program and create networking and distribution opportunities with other organisations.	Pharmacists, pharmacy students, allied health professional	N/A	The Guild	Research and support

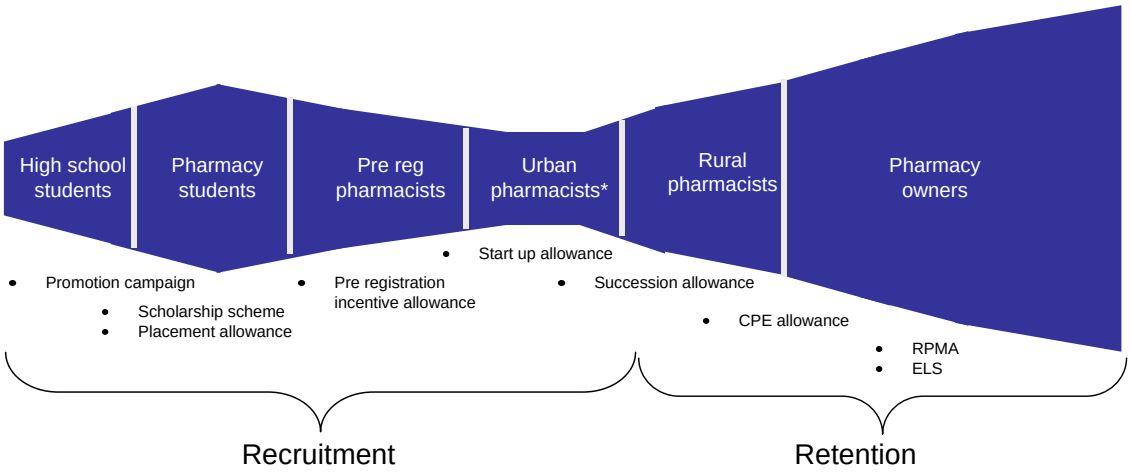
Program	Objective	Target	Eligible localities	Funding recipient	Strategy area
Small Project Funding	Promote the delivery of quality pharmacy services to rural and remote communities through projects which develop innovative local strategies and ideas for rural pharmacy services.	Pharmacists and researchers	N/A	Researcher	Research and support
Rural Commissioned Projects	Promote the delivery of quality pharmacy services to rural and remote communities through projects and research which address areas of need identified by the PP-SAC Rural and Indigenous Steering Committee and PP-SAC.	Researchers	N/A	Successful tenderer	Research and support
Pre-registration incentive allowance scheme Overarching objective: *To provide incentives to rural pharmacies and some hospital authorities to employ a pharmacy pre registrant to increase the rural pharmacy workforce.*					
Pre-registration incentive allowance scheme	Provide incentives to rural pharmacies and some hospital authorities to employ a pharmacy pre registrant to increase the rural pharmacy workforce.	Pharmacy owners	PhARIA 1-6[6]	Pharmacy owner	Recruitment

[6] PhARIA 1 eligibility excludes capital cities, suburbs and major regional centres as prescribed in the program guidelines eligibility criteria

3.3 Program response to rural and remote workforce issues

Recruitment and retention of pharmacists to rural and remote areas forms the central focus of the Initiative. The distribution of funding of programs across the Initiative according to recruitment and retention target groups is shown in Figure 2 below. The size of each component reflects the relative proportion of total funding that is directed to each group.

Figure 2 Recruitment and retention strategies under the Initiative



* Note that the 'urban pharmacists' element refers to the incentives available for urban pharmacists to start up new pharmacies in priority rural areas.

Research into rural and remote health workforce issues has identified a number of factors that influence the recruitment and retention of staff in rural and remote areas.[7] Three key areas of note particularly relevant to the Initiative relate to:

- Maintaining professional connections and networks in an often professionally isolated environment;
- The importance of a positive rural experience during university (or childhood) in influencing people to locate in rural and remote locations; and
- The influence of additional financial costs on people's decision to locate in rural and remote locations.

[7] Refer to the previous evaluation report where the Evaluators were commissioned to undertake a literature review. Human Capital Alliance (2004). Evaluation of the rural pharmacy initiatives program. Report to the Department of Health and Ageing, Canberra.

The table below provides an overview of where the programs providing direct support to recipients address these influencing factors.

Table 3 Program response to influencing factors in rural and remote workforce recruitment and retention

Program area	Professional connections	Positive rural experience	Off setting financial costs
Rural Pharmacy Maintenance Allowance			✓
Rural Pharmacy Start Up Allowance			✓
Rural Pharmacy Succession Allowance			✓
CPE Allowance	✓		✓
Emergency Locum Service			✓
Rural Pharmacy Scholarship Scheme		✓	✓
Rural Placement Allowance	✓	✓	
Pre registration incentive allowance	✓	✓	

3.3.1 Nature of Support

Most programs under the Initiative that provide direct support to pharmacies, pharmacists, pre registrants and students are based on financial payments which can be categorised as either:

- Payments to assist with accommodation and travel costs; or
- Payments that are financial incentives or general financial support.

In addition, one program focuses on providing support for service provision, namely the Emergency Locum Service, which provides 24 hour access to emergency locum placement services.

The table below summarises the nature of assistance provided by the program under the Initiative according to the three streams of support described above.

Table 4 Categorisation of program support

Program area	Assistance with accommodation and travel costs	Financial incentive /support	Service support
Rural Pharmacy Maintenance Allowance		✓	
Rural Pharmacy Start Up Allowance		✓	
Rural Pharmacy Succession Allowance		✓	
CPE Allowance	✓		
Emergency Locum Service	✓		✓
Rural Pharmacy Scholarship Scheme		✓	
Rural Placement Allowance	✓		
Pre registration incentive allowance		✓	

4 Summary of Initiative funding and activities

4.1 Funding overview

Under the Fourth Community Pharmacy Agreement, a total of $111m[8] was committed to the Initiative to address the following rural pharmacy priorities:

- Rural pharmacy maintenance allowance;
- New pharmacy start-up and support allowance;
- Succession planning and incentives;

} Pharmacy allowance schemes

- Rural pharmacist pre-registration incentive; and
- Rural pharmacy workforce program.

Funding allocations for each program stream are outlined in the table below.

Table 5 Funding under Fourth Community Pharmacy Agreement for rural pharmacy priorities

Program stream	Funding
Pharmacy Allowance Schemes[9]	$75m
Rural Pharmacy Workforce Programs[10]	$25.3m
Pre Registration Incentive Allowance[11]	$10.4m ($6.6m under current Funding Agreement 2007-2010)

4.1.1 Funding distribution

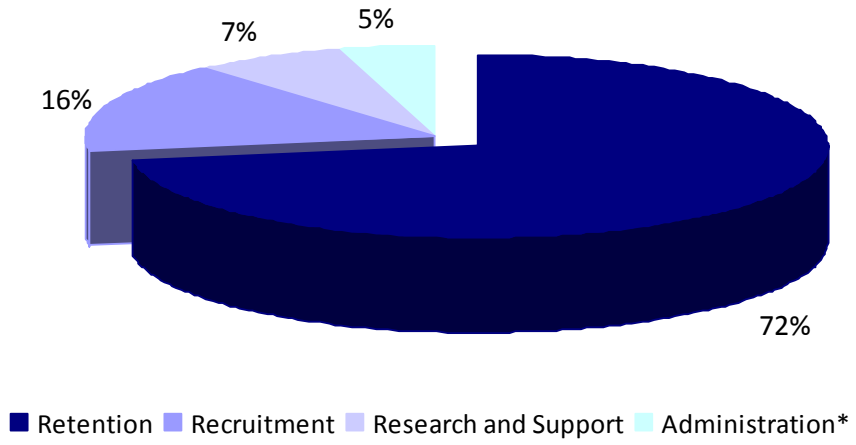
Purpose area

The allocation of funding under the Initiative is heavily weighted to the retention of existing rural pharmacists. Under the Agreement[7], 72 percent of the funding is provided for this strategy area followed by 16 percent directed towards recruitment initiatives. Figure 3 below

[8] Fourth Community Pharmacy Agreement between the Commonwealth of Australia and the Pharmacy Guild of Australia 2005, p 22.
[9] DoHA, n.d. *Rural Pharmacy Maintenance Allowance Overview and Start Up and Succession Allowance Overview*, documentation provided by DoHA.
[10] Australian Government, 2006 *Rural Pharmacy Workforce Program Funding Agreement between the Commonwealth of Australia and The Pharmacy Guild*
[11] Australian Government 2007 *Pre Registration Incentive Allowance Funding Agreement between the Commonwealth Government of Australia and the Pharmacy Guild of Australia*

provides an overview of the distribution of funding between the three key elements of the Initiative: recruitment, retention and research and support. It also provides the proportion of Initiative administration costs.

Figure 3 Funding under the Fourth Community Pharmacy Agreement according to strategy area.

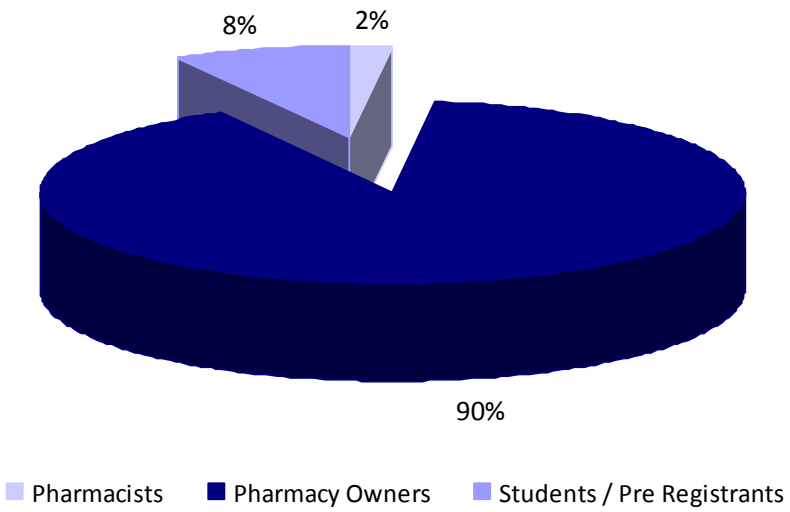


Administration excludes any funding paid to Medicare Australia for the administration of the Pharmacy Allowance Schemes

Recipients

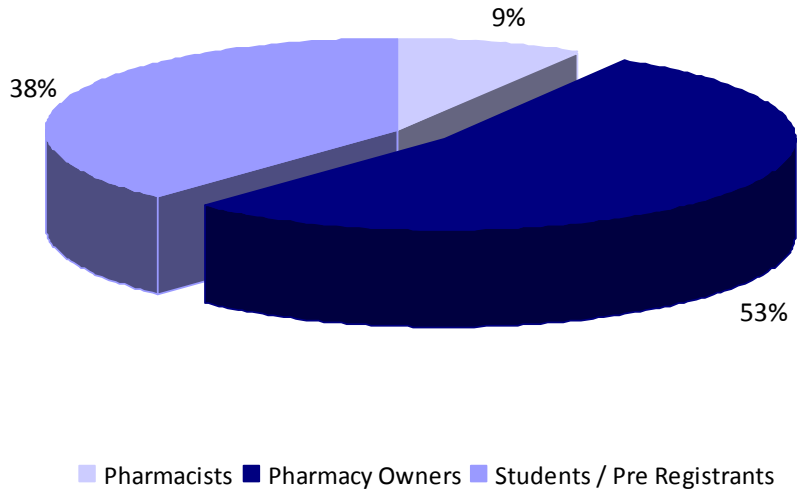
In line with the above, the majority (90 percent) of funding available under the program is targeted towards existing rural and remote pharmacy owners. Only two percent of funding is targeted towards existing rural and remote pharmacists. The funding distribution by target recipient is provided in Figure 4 below.

Figure 4 Funding distribution by recipient type



When only the smaller programs under the Initiative are considered, excluding the Rural Pharmacy Maintenance Allowance, the distribution of funding across the three target recipient areas - pharmacy owners, pharmacists and students and pre registrants - funding priorities are somewhat more balanced, as shown in Figure 5 below.

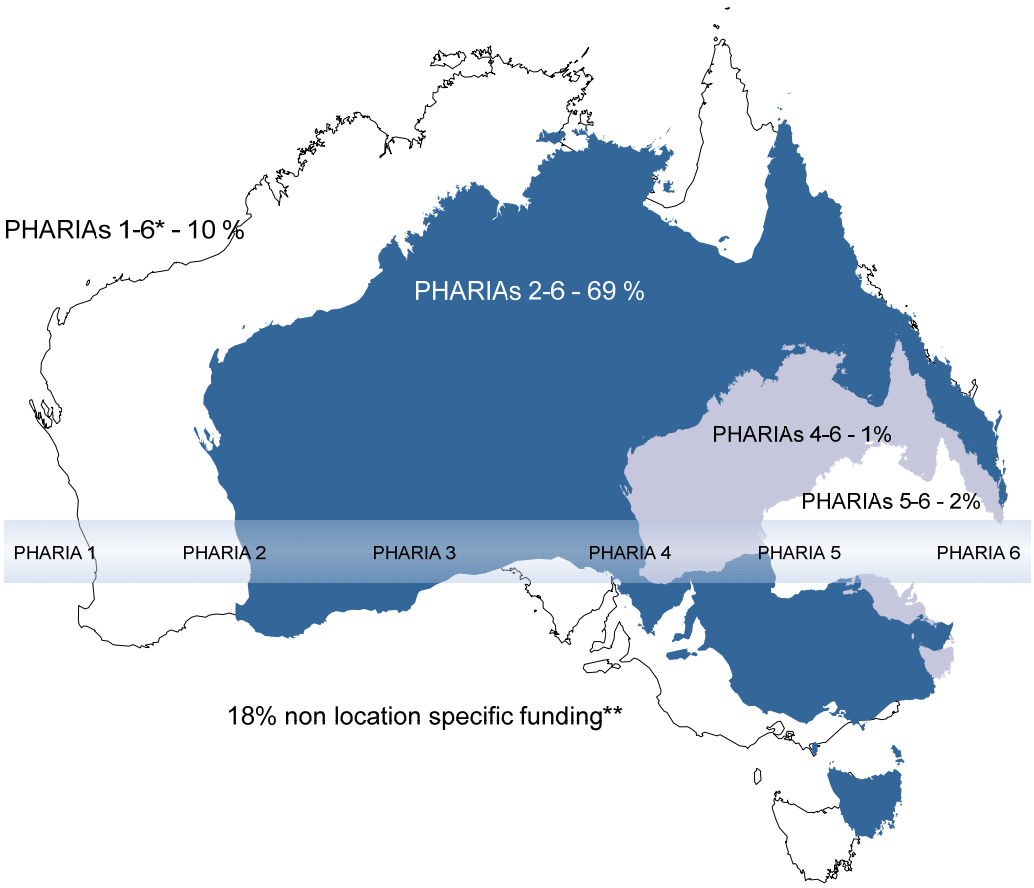
Figure 5 Funding distribution by recipient excluding maintenance allowance



Geography

Data was not available to enable analysis of the total funding provided according to each PhARIA category. Analysis of the program eligibility criteria for each program and the funding allocations for those programs was undertaken however. This analysis has shown that the majority of funding (69 percent) is targeted towards pharmacists/pharmacies in PhARIA categories two to six. Funding availability according to program eligibility criteria is shown in Figure 6 below.

Figure 6 Funding available by eligible PhARIA locations



**PhARIA 1 eligibility excludes capital cities and major centres as prescribed by relevant program guidelines eligibility criteria.*
*** Includes administration and grant funding*
Not to scale
Source: Developed by KPMG

4.2 Individual program funding and activity

This section provides individual program funding activity in the three program streams under the Fourth Community Pharmacy Agreement which are:

- Pharmacy Allowance Schemes;
- Rural Pharmacy Workforce Programs; and the
- Pre Registration Incentive Allowance.

4.2.1 Pharmacy allowance schemes

Under the Fourth Community Pharmacy Agreement, $75m funding was committed to the:

- Rural Pharmacy Maintenance Allowance;
- Rural Pharmacy Start Up Allowance; and
- Rural Pharmacy Succession Allowance.

These allowances are administered by Medicare Australia on behalf of DoHA. The table below outlines the total funding committed to each of these allowance schemes, funding expended as at August 2009 and the number of funding recipients for each allowance scheme. As shown in the table, the majority of funding for these schemes rests in the Rural Pharmacy Maintenance Allowance program, with $71.4m funding provided to 780 rural pharmacies.

Table 6 Funding committed to pharmacy allowance schemes under Fourth Community Pharmacy Agreement[12]

Program	Total funding committed	Total funding expended as at August 2009	No. of recipients
Rural Pharmacy Maintenance Allowance	$71.4m	$50m	780
Rural Pharmacy Start Up Allowance	$1.5 m	$1.608m	16
Rural Pharmacy Succession Allowance	$2.1m	$0.41m	4

[12] DoHA n.d. *Overview of RPMA and Overview of Succession and Start Up Allowances*, documentation provided by DoHA.

Rural Pharmacy Maintenance Allowance

As at August 2009, $50m funding under the Maintenance Allowance had been allocated to recipients under the program, however projections to 30 June 2010 suggest that this was on track to meet funding targets.

Of the 870[13] rural pharmacies in Australia, 780 pharmacies received payment under this allowance. This figure equates to almost 90 percent of all rural and remote pharmacies in Australia. DoHA has advised that it is not known why the remaining ten percent have not applied for the Allowance.

The Rural Pharmacy Start Up Allowance

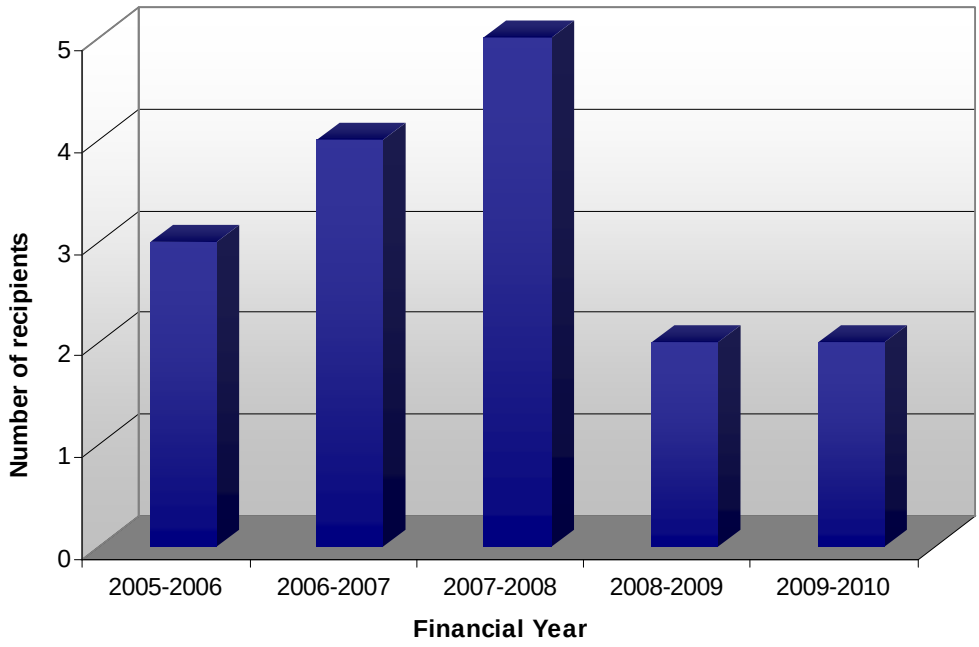
A total of $1.5m notional funding was set aside to the Start Up Allowance program under the Fourth Community Pharmacy Agreement. As at August 2009, the program had exceeded this notional budget by $108,000.

Since the inception of the program under the Third Community Pharmacy Agreement, a total of 29 new pharmacies had started in rural and remote locations across Australia[14]. Under the Fourth Community Pharmacy Agreement, 16 new pharmacies have received funds from the allowance[15].

Allocations of the allowance (at application acceptance) have declined over time with only two recipients in the last two financial years. The figure below shows allowance allocations (at application acceptance) for the Start Up Allowance since 2005-2006.

[13] DoHA n.d. Overview of the Maintenance Allowance, document provided by DoHA
[14] DoHA n.d. *Overview of the Succession and Start Up Allowances*, documentation provided by DoHA.
[15] Ibid

Figure 7 Start Up Allowance Allocations 2005-2006 to 2009-2010



Source: Developed by KPMG based on data provided by DoHA[16]

DoHA have advised that all 16 new pharmacies that received the Start Up Allowance are currently still operating, however it is not known whether these pharmacies are still owned by the same pharmacist.[17]

Of the 16 pharmacies allocated the Start Up Allowance under the Fourth Agreement, no allowances were allocated to pharmacies in the Northern Territory or Victoria. The table below provides an overview of the number of Start Up Allowances provided to new pharmacies by state.

Table 7 Pharmacies allocated the Start Up Allowance by State

State	Number of Pharmacies
New South Wales	4
Queensland	2
South Australia	4
Tasmania	2
Western Australia	4
Total	16

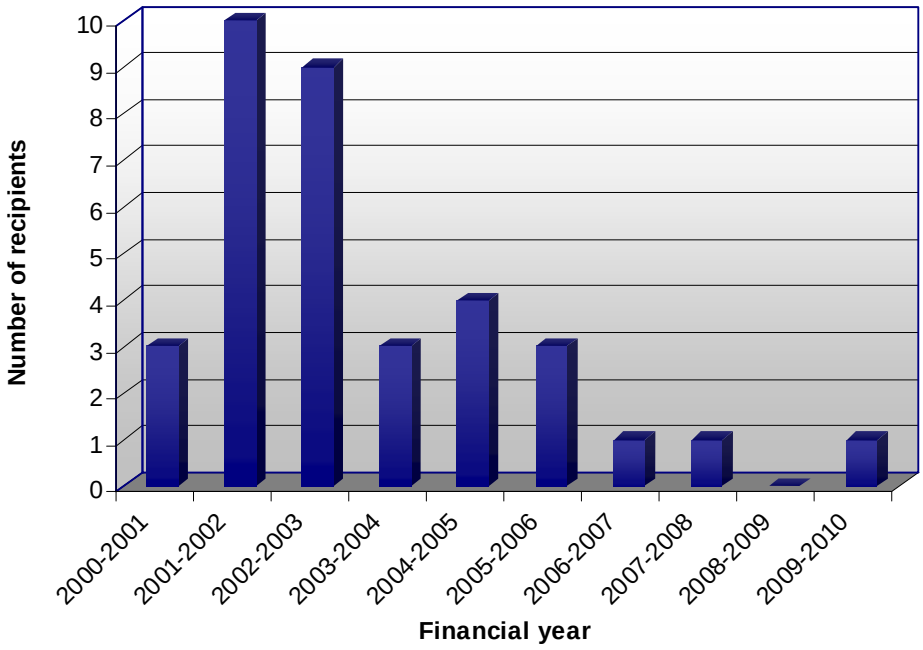
[16] Ibid
[17] Ibid

Rural Pharmacies Succession Allowance

The Rural Pharmacies Succession Allowance was significantly under subscribed during the Fourth Community Pharmacy Agreement. Notional funding of $2.1m was allocated to the program, however less than one quarter of this amount had been allocated at August 2009.

Uptake of the program has declined significantly since the Third Community Pharmacy Agreement. Since 2000-2001, 35 pharmacies[18] have received the allowance. The majority of these allowances were provided under the Third Community Pharmacy Agreement with only five allowances provided since December 2005 under the Fourth Agreement. The number of Succession Allowance allocations since 2000-2001 is provided in Figure 8 below.

Figure 8 Succession Allowance allocations since 2000-2001



It is unclear why demand for the Succession Allowance has declined under the Fourth Agreement. This could be attributed to a number of factors, however there is no conclusive evidence as to why this trend has occurred. Discussions with various stakeholders raised the following possible explanations for this trend:

- A reduction in the number of pharmacies taking more than two years to sell, greater demand for the purchase of rural and remote pharmacies;

[18] Data provided by DoHA

- Existing owners not selling their pharmacies; or
- Existing owners retaining 'ownership' but moving to a managed pharmacy agreement[19].

The table below provides an overview of the number of pharmacies receiving the Succession Allowance by each state in Australia under the Third and Fourth Community Pharmacy Agreements. No succession allowances were provided to pharmacies in the Northern Territory.

Table 8 Pharmacies allocated the Succession Allowance by State under Third and Fourth Community Pharmacy Agreements[20]

State	Third Agreement	Fourth Agreement	Total
New South Wales	4	-	4
Queensland	8	3	11
South Australia	-	2	2
Tasmania	1	-	1
Victoria	7	-	7
Western Australia	10	-	10
Total	**30**	**5**	**35**

4.2.2 Rural Pharmacy Workforce Program

Under the Fourth Community Pharmacy Agreement, $25.3m was committed to the Rural Pharmacy Workforce Program through the Rural Pharmacy Workforce Program Funding Agreement. The program committed $22.1m to direct program funding and $3.2m funding for program administration by the Guild.

The table below details the funding commitments under each program under the agreement and provides an overview of the funding expended to December 2009.

[19] A third party effectively takes over the management of the pharmacy while the existing owner retains legal ownership.
[20] Succession allowance data provided by DoHA

Table 9 Program funding under the Rural Pharmacy Workforce Agreement

Program	Total funding committed under RPWP agreement[21]	Total funding expended To December 2009[22]	No. of funding allocations / recipients To December 2009[23]
CPE Allowance	$2.4m	$2.62[24]	4118[25]
Emergency Locum Service	$0.4m	$0.46m[26]	110
Rural Pharmacy Scholarship Scheme	$4.904m	Not available	102
Rural Placement Allowance	$2.4m	$2.4 m	308,941
Administrative support to pharmacy schools	$1.2m	Not available	16 universities
Pharmacy Academics at University Departments of Rural Health (UDRH)	$3.2m	Not available[27]	11 UDRHs
Rural Pharmacy Promotion Campaign	$1.2m	$1.2	N/A
Rural Pharmacy Newsletter	$0.2m	$0.2m	N/A
Small Project Funding	$0.4m	$0.58	32
Rural Commissioned Projects	$3.84m	$1.065m	2

An overview of program activity for each of the programs under the Rural Pharmacy Workforce Agreement is provided below.

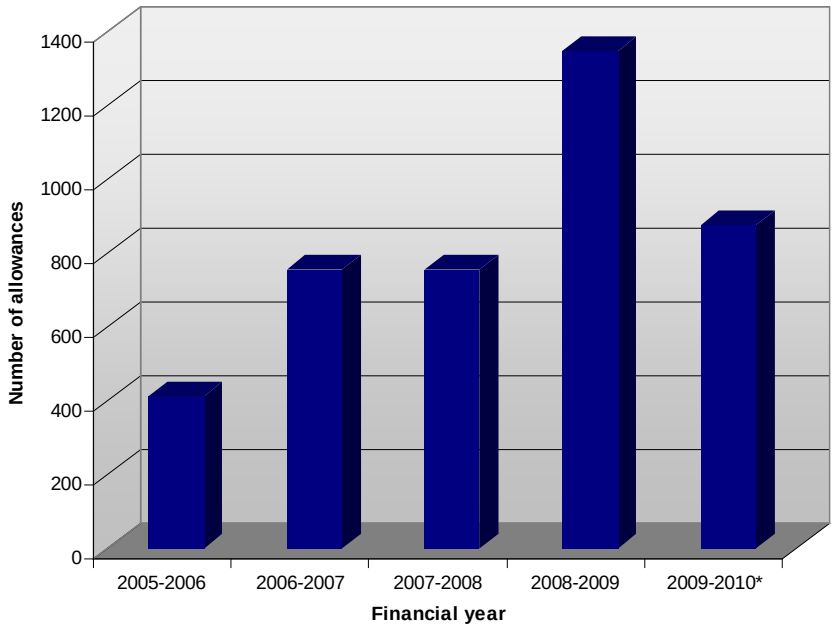
[21] Australian Government, 2006 *Rural Pharmacy Workforce Program Funding Agreement between the Commonwealth of Australia and The Pharmacy Guild* of Australia unless otherwise stated.
[22] Pharmacy Guild of Australia, 2009 *Rural Pharmacy Workforce Program Progress Report 1 July to 31 December 2009* unless otherwise stated.
[23] Ibid
[24] Funding allocation and recipients is to May 2010
[25] Ibid
[26] Movement of an additional $20,000 p/a funding from underspent programs was negotiated between DoHA and the Guild for the period 1 July 2008 to the end of the agreement.
[27] Funding increased by $80,000 per annum from 1 July 2008 however funding distribution has changed over time as some UDRH have had vacant funded positions from time to time.

CPE Allowance

The CPE allowance has been one of the most successful of the programs under the Rural Pharmacy Workforce Agreement. As outlined in Table 9 above, since the commencement of the Agreement to December 2009 4,118 funding allocations had been made to pharmacists and pre registration pharmacists in rural and remote Australia. Funding was substantially increased for the program with Ministerial approval to increase the annual funding for the program to $450,000 per annum using surplus Rural Pharmacy Program funds accrued due to the delay in signing the Fourth Community Pharmacy Agreement and an agreement made between the Department and the Pharmacy Guild to allocate $330,000 unspent funds from the Pharmacy Academics at University Departments of Rural Health (UDRHs).

Figure 9 below provides the number of CPE allowances. It shows that demand for CPE allowances significantly increased from the 2008-2009 financial year. This increase coincides with the movement to an online application system for the program.

Figure 9 CPE allowance allocations 2005-2006 to 2009-2010



**to December 2009*

Source: Developed by KPMG based on data provided by the Guild

The majority of CPE allowance applications receive funding support. Between 1 July 2006 and 31 December 2009, a total of 3867 applications were received with a total of 3,712 (96

percent) approved[28]. The average allowance paid in nominal terms was $652.50 per allowance. The table below provides the average allowance amount for the financial years 2006-2007 to 2009-2010.[29]

Table 10 Average allowance payments 2006-2007 to 2009-2010

Financial year	2006-2007	2007-2008	2008-2009	2009-2010*	Overall Average
Average allowance	$619.16	$659.67	$617.32	$701.30	$652.91

Emergency Locum Service

Over the period of the fourth Community Pharmacy Agreement to 31 December 2009, 110 applications for Emergency Locum Services were made. One hundred percent of these applications were successful. The average response time for emergency locum services was less than one day.[30]

A snap shot of Emergency Locum Services provided for the period 1 July 2009 to 31 December 2010 showed that, of the 24[31] Emergency Locums provided, the majority of these were to pharmacies in New South Wales (13) and Victoria (nine). The remaining three allocations were to pharmacies in Queensland (two) and the Northern Territory (one).[32] For that same period, the distribution of Locums according to PhARIA is provided in the table below.

Table 11 Emergency Locum Service allocated 1 July 2009 to 31 December 2010 by PhARIA[33]

PhARIA	Number of services
PhARIA 2	5
PhARIA 3	3
PhARIA 4	3
PhARIA 5	8
PhARIA 6	5
Total	24

[28] Pharmacy Guild of Australia, 2009 *Rural Pharmacy Workforce Program Progress Report 1 July to 31 December 2009*
[29] The average allowance values are calculated based on original figures provided by the Guild, noting that updated figures have been included in figure 9.
[30] Ibid
[31] Note that there were anomalies in the data reported from the Guild regarding the number of emergency locum services allocated; by state it adds up to 25 services while the reported number was 24.
[32] Pharmacy Guild of Australia, 2009 *Rural Pharmacy Workforce Program Progress Report 1 July to 31 December 2009*
[33] Ibid

On 1 July 2008, funding for this program was increased by $60,000 ($20,000 per annum) using unspent funds from other program areas.

Rural Pharmacy Scholarship Scheme

Since the commencement of the Rural Pharmacy Workforce Program under the Fourth Community Pharmacy Agreement to 31 December 2009, 102 Rural Pharmacy Scholarships have been awarded from a total of 909 applications. All applicants satisfied the criteria which means that the overwhelming majority of applicants were not able to receive any support.

Rural Placement Allowance

Rural placement allowance funding was provided to 16 universities over the course of the Rural Pharmacy Workforce Agreement. Funding was allocated to students according to the individual university guidelines and the Guild's program guidelines. KPMG understands that there is considerable diversity across the universities in terms of marketing, targeting and in rules for the level of funding support.[34] Over the period 1 July 2005 to 31 December 2009, universities reported that 308,941 placement hours had been undertaken[35]. This equates to an average allowance per placement of $11.43[36].

In 2007, the University of Western Australia opted out of the program due to the impact on its existing administration.

Administrative support to pharmacy schools

No additional activity data to report beyond information provided in Table 9.

Pharmacy Academics at University Departments of Rural Health (UDRH)

No additional activity data to report beyond information provided in Table 9.

[34] Based on discussions with the Guild and University representatives interviewed for this evaluation.
[35] Pharmacy Guild of Australia, 2009 *Rural Pharmacy Workforce Program Progress Report 1 July to 31 December 2009*
[36] This may be due to a reporting error

Rural Pharmacy Promotion Campaign

Under the Rural Pharmacy Workforce Agreement, a number of activities were undertaken as part of the Rural Pharmacy Promotion Campaign. These activities included:

- The development and distribution of a promotional DVD in 2009;
- Brochure development;
- Direct mail outs; and
- Production of a 'survival kit' for placement students.

Rural Pharmacy Newsletter

Between 1 July 2006 and 31 December 2009, eight rural pharmacy newsletters were published and distributed to the Rural Pharmacy Newsletter Mailing list. The newsletters contained 46 articles specific to rural pharmacy practice.[37]

Small Project Funding

Between 1 July 2006 and 31 December 2009, there were 75 applications for funding under the Small Project Funding Program. Of these applications, 32 were funded an average funding amount of $18,144.

Projects funded under this program can be classified into two broad streams, namely:

- Workforce related projects that have investigated ways to improve pharmacy workforce outcomes in local communities; and
- Scope of service projects that have explored different service offerings for pharmacies that may enhance the professional satisfaction of the pharmacist and contribute to the viability of the pharmacy.

Under these two streams, nine projects focussed on workforce strategies and were provided with a total of $163,970 combined funding, and the remaining 23 projects focused on the examination of scope of services with combined funding of $416,628.

The range of projects funded under this program is outlined in the table below.

[37] Ibid

Table 12 Projects funded under Small Project Funding

Year	Project Title	Funded amount	Stream	
			Workforce	Scope of Service
2008	*Addressing skills shortages: assistance required to find long term, full time pharmacist for Turnbull's Pharmacy*	$15,400.00	✓	
2008	*Development, implementation and evaluation of a comprehensive training and support package for pharmacy graduates*	$20,000.00	✓	
2008	*Development and evaluation of a rural pharmacy practice and research network to facilitate the provision of pharmacy services*	$20,000.00	✓	
2008	*It's Coolah to Quit*	$14,755.00		✓
2008	*Community pharmacy initiated open ended glaucoma screening and staff training scheme in rural Australia*	$20,000.00		✓
2008	*The development of an adverse drug monitoring intervention tool for use in an Aboriginal Health Service*	$20,000.00		✓
2008	*Quit smoking start living program*	$18,181.80		✓
2008	*To provide regular medications to patients in remote communities fully labelled by pharmacy*	$13,309.08		✓
2008	*Web info/communication enhancement and delivery lasso project. (to encircle the rural community)*	$11,605.65		✓
2008	*Developing a triage service within a pharmacy*	$12,000.00		✓
2008	*Development and implementation of a flexible anticoagulation monitoring service for rural community pharmacies*	$19,125.00		✓
2008	*Furneaux Islands - Enhanced Medication Reviews and QUM Support Program*	$17,710.00		✓
2008	*Scoping the role for an Aboriginal Adherence Worker in primary health care in remote Aboriginal communities*	$9,000.00	✓	
2008	*Wound management for the people of Bendigo*	$19,800.00		✓
2008	*Accessing health information in rural areas using health promotion and internet access through community pharmacy*	$19,820.00		✓
2008	*Development of career pathways for Indigenous people to provide medication support services in remote Aboriginal Health Service (AHS) settings*	$20,000.00	✓	
2008	*Emergency Hormonal Contraception survey from rural community pharmacies in Western Australia*	$19,861.40		✓
2009	*Real-time Primary Care for People Living in the Wimmera*	$18,000.00		✓
2009	*Developing Strategies to Increase HMRs in Aboriginal and Torres Strait Islander Communities*	$20,000.00		✓

Year	Project Title	Funded amount	Stream	
			Workforce	Scope of Service
2009	*Nagel's Amcal Pharmacy Waist Management Program*	$20,000.00		✓
2009	*The Quality Use of Medicines Maximised (QUMAX) for Aboriginal and Torres Strait Islander patients*	$17,682.00		✓
2009	*Generic Medicines are an Equal Choice*	$18,154.00		✓
2009	*Evaluation and enhancement of services provided by Community Pharmacy to Small Rural Health Services*	$15,000.00		✓
2009	*Developing behaviour change capabilities for rural pharmacists: A pilot study of smoking cessation counselling*	$20,000.00		✓
2009	*Pharmacy Remote Accredited Continence Education (PRACE)*	$19,724.00		✓
2009	*Review and improve the HMR process at the Pika Wiya Aboriginal Health Service*	$20,000.00		✓
2009	*Survey the learning needs of new pharmacists to the Northern Territory with a view to developing a number of appropriate CPD opportunities.*	$20,000.00	✓	
2009	*Supporting rural practitioners: Pharmacy-based support mechanisms for drug misuse in rural and remote communities*	$19,735.00	✓	
2009	*Filling the Gap in Professional Services: Medication Use Reviews (MURs) in rural community pharmacies*	$19,935.00		✓
2009	*Strengthening and supporting the rural pharmacy workforce: Developing strategies to reduce violence in pharmacy*	$19,935.00	✓	
2009	*Development of Procedures for Improving Continuity of Care Between Hospital and Community for Residents of Remote Aboriginal Communities*	$20,000.00		✓
2009	*Assessing Training Needs of ATSI Pharmacy Assistants at Aboriginal Community Controlled Health Services in NT*	$19,900.00	✓	

Rural Commissioned Projects

Two commission projects were tendered and funded under the Rural Commissioned Projects program. A total of 13 applications were received for both projects combined.[38]

[38] Ibid

The two projects tendered and awarded under the program were:

- Development of a Model for a Mentoring System for Rural and Remote Newly Qualified Pharmacists; and

- Research to Track the Rural Pharmacy Workforce and Identify the Role that Rural Programs Have on the Retention of the Rural Pharmacy Workforce.

4.2.3 Pre Registration Incentive Allowance

The current Pre Registration Incentive Allowance Funding Agreement was in place from December 2007[39] to 30 June 2010. Under the Agreement, $6.6m direct program funding was provided with an additional $282,569 for program administration. To 31 December 2009, 398 Pre Registration Incentive Allowances had been approved. By 3 March 2010, this figure had increased to 457.

The table below provides an overview of the high level funding and outcomes for the program.

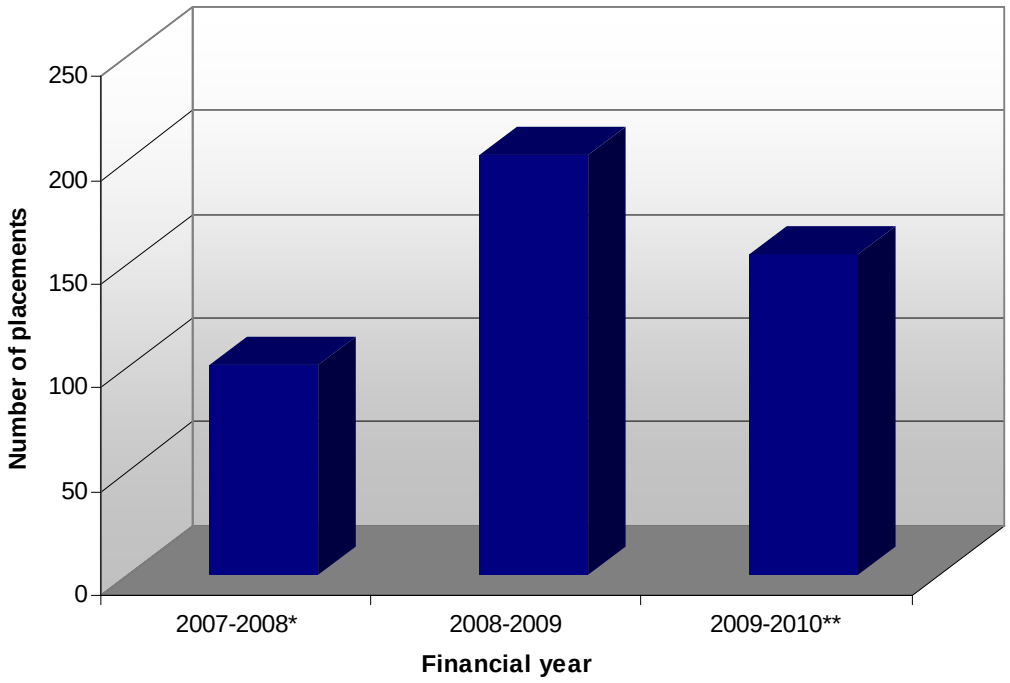
Table 13 Program funding and outcomes under the Pre registration Incentive Allowance Funding Agreement

Program	Total funding committed under relevant agreement	Total funding expended To 31 December 2009[40]	No. of funding recipients To 31 December 2009[41]
Pre-registration Incentive Allowance Scheme	$6.6m[42]	$4.958m	398

Given the agreement was not signed until December 2007 making the 2007-2008 only half a year of program activity, take up of the allowance has been relatively stable at around 100 recipients per six month period. The number of allowances per financial year is shown in the figure below.

[38] Pharmacy Guild of Australia, 2009 *Pre Registration Incentive Allowance Progress Report 1 July to 31 December 2009* .
[40] Ibid
[41] Pharmacy Guild of Australia *Pre Registration Allowance Data Set* provided by the Pharmacy Guild of Australia
[42] Australian Government 2007 *Pre Registration Incentive Allowance Funding Agreement between the Commonwealth Government of Australia and the Pharmacy Guild of Australia*

Figure 10 Pre Registration Incentive Allowance Approvals by financial year[43].



** From December 2007*

*** To March 2010*

Source: developed by KPMG based on data provided by the Pharmacy Guild of Australia

The majority (87 percent) of allowances allocated were for a 12 month placement as shown in the table below.

Table 14 Pre Registration Incentive Allowance Placement length[44]

Placement length	Number of placements	Percentage
12 Months	399	87.3%
6-12 Months	30	6.6%
6 Months	28	6.1%
Total	457	100%

[43] Ibid
[44] Ibid

In line with other state and territory distributions of program funding, overwhelmingly the highest proportions of allowance recipients were pharmacies in New South Wales (34.6 percent), Queensland (22.1 percent) and Victoria (19 percent). The distribution of allowances by state and territory is provided in Table 15 below.

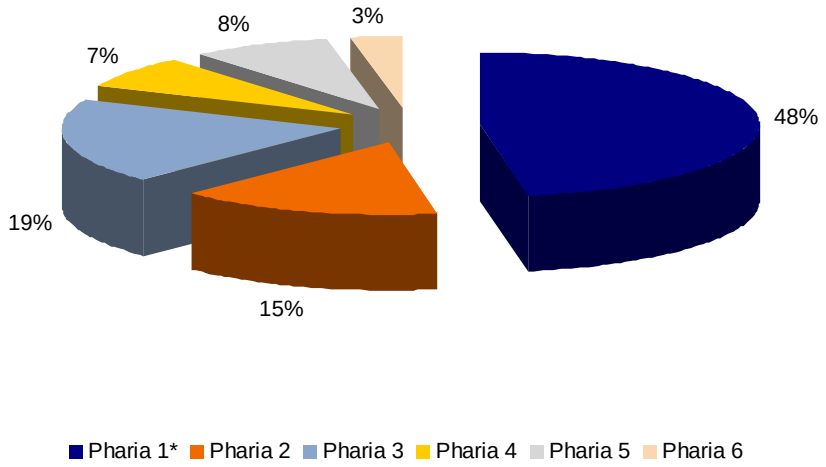
Table 15 Pre Registration Incentive Allowances by state and territory

State	Number of recipients	Percentage
New South Wales	158	34.6%
Northern Territory	24	5.3%
Queensland	101	22.1%
South Australia	31	6.8%
Tasmania	27	5.9%
Victoria	87	19.0%
Western Australia	27	5.9%
Total	**457**	**100%**

Further, considering the allocation of Pre Registration Incentive allowances on a geographic basis, most allowance funding was directed to pharmacies operating in the least remote areas of Australia (see Appendix C3 for a description of Pre Registration Incentive Allowance). Nearly half (48 percent) of the allowances funding went to eligible PhARIA one Pharmacies[45], a further 15 and 19 percent of funding was allocated to pharmacies operating in PhARIAs two and three respectively. Figure 11 below shows the proportion of Pre Registration Incentive Allowance funding for each PhARIA category.

[45] Excludes Pharmacies operating in capital cities and surrounding suburbs and major regional centres as prescribed by the eligibility criteria in the program guidelines.

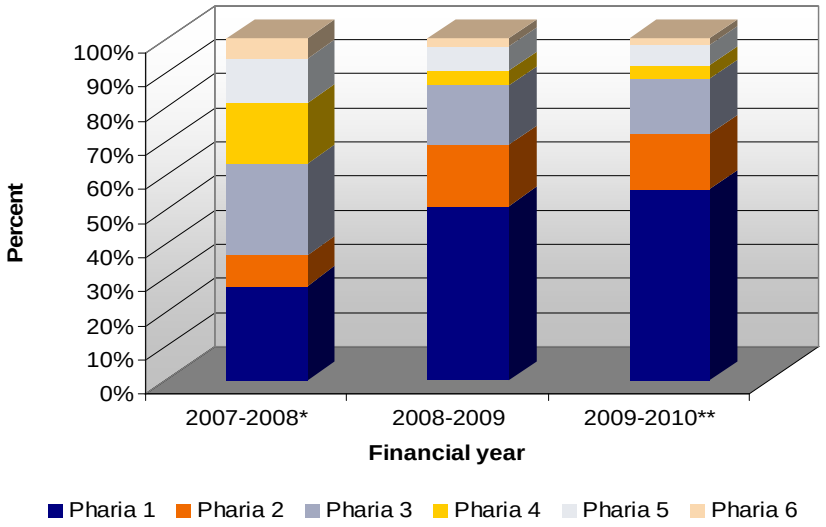
Figure 11 Allocated Pre Registration Incentive Allowance Funding by PhARIA



**PhARIA 1 Excludes capital cities and surrounding suburbs and major regional centres as prescribed by the eligibility criteria in the Pre Registration Incentive Allowance Program Guidelines*

Further to this, the proportion of allowances allocated to PhARIA one Pharmacies has grown substantially since the program's inception under the current agreement in 2007. Note this needs to be viewed in the context that the overwhelming proportion of eligible pharmacies are in PhARIA 1, namely 83% (see Appendix D for further detail). The proportion of allowance allocations by PhARIA for the three financial years since 2007 is shown in Figure 12 below.

Figure 12 Pre Registration Incentive Allowance allocations by PhARIA by financial year



** From December 2007, ** To March 2010*

5 The changing landscape of community pharmacy in Australia, and workforce implications

5.1 Background

The practice of community pharmacy is unlike that of other health professions. It has traditionally been a blend of professional and retail activities, with the financial viability of pharmacies depending on both of these activities. Ownership of community pharmacies is restricted to pharmacists and eligible friendly societies. For many years the number of pharmacies that may be owned by individual pharmacists has been capped, with variations on the actual number varying between jurisdictions. However, through the formation of partnerships, and other, less formal, arrangements, individual pharmacists have been able to exert influence over more than that number. The formation of buying groups has led to a public perception of corporatisation.

The majority of pharmacists in Australia are not involved in pharmacy ownership – they are generally employed by pharmacy owners, hospitals, the pharmaceutical industry and universities. As a consequence of increased pharmacist numbers, and the relatively stable number of pharmacies, the percentage of pharmacists who own a pharmacy has dropped, and may be as low as 20%.[46]

The professional role of the community pharmacist has expanded in recent years, with patient counselling, medication reviews, general health advice and greater involvement with other health professionals adding to the traditional dispensing role. The profession is under pressure from within, and from outside forces, to adapt to contemporary expectations and standards. Opinion leaders within the profession, including academics and regulatory authorities, promote pharmacy as a profession to be utilised more as a source of information and advice, a participant in public health issues, and an integral part of the healthcare team, while still providing the more traditional functions relating to the safe supply of medicines.

In recent years, state and territory parliaments have amended Pharmacy Acts to reflect greater public expectations and accountability, to increase the number of pharmacies a pharmacist may own, and to allow pharmacy owners to access contemporary business structures. The different arms of the profession (Boards, Pharmaceutical Society of Australia (PSA) and Guild) have responded in a collaborative way to introduce more structured, competency based, pre-registration (intern) training with greater Board oversight, and mandatory Continuing Professional Education (CPE). Many pharmacists in the workforce have taken up roles as preceptors for students and interns, putting extra pressure on their time, both in providing education and training, but also in committing themselves to additional (usually after-hours) work liaising with academic colleagues and with the registration body.

The use of pharmacists to undertake medication reviews in patients' homes, aged care facilities and hospitals has seen a further departure from traditional roles, and has created a demand for a trained and accredited pharmacist workforce to participate in these federally

[46] Based on stakeholder discussions.

funded programs. With payments for this work channelled through community pharmacies, another layer of work has fallen to community pharmacy owners who are involved in administration of the payments.

These changes have led to a need for a larger workforce with broader skills – one that needs to move from its more traditional dispensing role to an accessible, effective communicator. Fortunately pharmacist numbers in Australia have increased in recent years, with an increase in the number of graduates including students from overseas, and an increase in workforce numbers from overseas trained pharmacists who are examined by the Australian Pharmacy Examining Council. Reorganisation within pharmacies to allow greater use of trained pharmacy assistants will also free up the pharmacists to take up the new roles.

5.2 Current issues influencing workforce

The traditional determinant for a viable community pharmacy has been profitability. However they find themselves in competition in a number of areas: competition between pharmacies as consumers shop around for best prices[47]; competition for contracts to supply aged care facilities and local hospitals; the advent of mail-order pharmacy; the removal from restrictive schedules of several commonly used medicines and their sale through supermarkets; and the emerging popularity of complementary medicines from alternative practitioners such as herbalists, naturopaths, homeopaths and traditional Chinese medicine practitioners have all had negative effects on the profitability of community pharmacies.

Strategies to maximise the efficiency of distribution of medicines through the Pharmaceutical Benefits Scheme, such as the cap on the number of approved pharmacies and the limitation of approval numbers based on geographical proximity to existing pharmacies may have improved viability of some businesses, but reduced dispensing fees and strategies to eliminate unreasonable profits from the sale of generic medicines may have the opposite effect.

The use of information technology is also having an effect on the workforce. There is a reliance on computers and specialised software for dispensing, checking for drug interactions, side-effects, printing advice sheets, labelling, use of supplementary warning labels, and patient records. While these measures have the potential to improve patient safety, they have led to the need for new skills, technical expertise and backup, and new costs.

The workforce has also been impacted by the relatively recent uptake of specialised extemporaneous dispensing in fit-for-purpose facilities. This has occurred partly because of patient specific dosing (e.g. in oncology) and a trend towards the use of compounded products that are not available commercially. This has led to a demand for pharmacists and technicians with specific skill sets and training.

[47] http://www.choice.com.au/Reviews-and-Tests/Food-and-Health/General-health/Medicines/Discount-medicines/page/All%20about%20PBS.aspx

http://www.choice.com.au/Reviews-and-Tests/Food-and-Health/General-health/Medicines/Discount-medicines/page/Getting-the-best.aspx

Further, since the introduction of Pharmaceutical Benefits Scheme (PBS) dispensing in public hospitals, funding has been provided to hospitals to employ additional pharmacists to provide improved patient counselling at discharge, and to liaise with the patients' community pharmacies to improve the continuum of care as the patient goes back to their general practitioner and community pharmacist. This has led to competition with hospitals for pharmacists, putting more strain on the workforce.

Other changes in the practice of community pharmacy include:

- On-line, just in time ordering with daily deliveries from wholesalers, even in non-metropolitan regions
- Stocking of complementary medicines (to compete with herbalists, homeopaths, naturopaths etc) despite questionable efficacy in many cases
- Co-located services (banking, agencies, lotteries etc)
- Involvement in public health programs such as drug substitution (methadone, buprenorphine) programs, blood pressure monitoring, cholesterol monitoring, anti-smoking support, and widespread involvement in weight-loss programs. The last two are generally associated with product sales, and the weight loss programs in particular have come under the scrutiny of the consumer group CHOICE[48].
- Use of compliance aids such as Webster packs for patients at home, in aged care facilities and in hospitals, which have led to decreases in administration errors, but which have added another step in the dispensing and supply process.
- Trials with smart cards and electronic records which have the potential benefit of providing a complete patient drug history.
- Moves to bring pharmacies on-line to facilitate rapid reimbursement of dispensing costs. This network may be used in the future to minimise drug misuse by increased monitoring of prescribing and supply.

[48] http://www.choice.com.au/Reviews-and-Tests/Food-and-Health/Diet-and-exercise/Weight-loss/Pharmacy-diet-plans/Page/What%20our%20shadow%20shoppers%20found.aspx

http://www.choice.com.au/Reviews-and-Tests/Food-and-Health/Diet-and-exercise/Weight-loss/Pharmacy-diet-plans/Page/What%20the%20experts%20say.aspx

http://www.choice.com.au/Media-and-News/Media-releases/2009%20Media%20Release/Experts%20slam%20chemists%20fast%20track%20diet%20plans.aspx

http://www.choice.com.au/Consumer-Action/Past-campaigns/Health/Drug-advertising/Page/Xenical.aspx

- Increased vigilance of storage conditions for vaccines and other refrigerated products (the cold chain).

- Use of robotic dispensing in very busy dispensaries where accuracy, prescription volumes and timely supply are important. This will also reduce the dispensing load for pharmacists, who may be freed to fill other roles.

- Increased measures to address occupational health and safety issues, and security of products subject to theft during break-ins, robberies, and assaults by drug seekers. These products include drugs of addiction, and compounded products containing pseudoephedrine.

5.3 The future

The introduction in 2010 of a national system of registration for pharmacists is unlikely to have any significant short-term effect on the delivery of pharmaceutical services, but it should be noted that there are other pressures on the current advantages enjoyed by community pharmacy owners. For some years governments have been lobbied by some members of the pharmaceutical industry to consider changes to the scheduling of medicines, with products currently limited to sale in pharmacies proposed to be sold in supermarkets and other unlicensed premises. A review by the TGA (the Galbally Review[49]) recommended (recommendation 5, and endorsed by the Australian Health Ministers' Conference in 2005) that pharmacists be given a five year grace period to improve their management and involvement in the sale of S2 and S3 medicines, or face the prospect of these schedules being removed from the Australian Standard for the Uniform Scheduling of Drugs and Poisons. Mystery shopper programs have exposed shortcomings in pharmacists' performance in this regard putting additional pressure on them to improve their performance.

5.4 Community pharmacies in rural and remote locations

There are additional pressures on the financial viability of pharmacies in rural and remote areas of Australia; dwindling community numbers in some areas of Australia, alternative supply arrangements for customers, such as mail order pharmacies, and competition from pharmacists outside the local area for contracts to supply local hospitals and aged care facilities. While competition has the potential to keep costs to consumers down, the loss of business may be enough to make a local pharmacy non-viable, and the local community loses the resource altogether. A long-standing compromise in some areas has been the establishment of depots in small communities, registered by the Pharmacy Board of that state or territory, serviced by pharmacists in neighbouring towns. The pharmacist may attend the depot for limited periods, and at other times allow customer access to a limited range of non-prescription medicines. Prescriptions can be couriered to depots from nearby pharmacies for

[49]Review of drugs, poisons and controlled substances legislation - The Galbally Review
http://www.tga.gov.au/docs/html/rdpdfr.htm#r5

collection by patients. Arrangements must include secure storage and limited access to medicines by suitably trained and supervised personnel.

In addition, some states and territories license premises in remote areas to sell a limited range of pharmacy-only medicines, for the benefit of local people and travellers, and license local general practitioners to dispense prescription-only medicines where there is a demonstrable community need.

5.5 Broader industry trends impacting on community pharmacy

The recent Australian Government announcements for primary health care reform also have potential implications for community pharmacy. The basis for this reform is the formation of primary health care organisations[50] that will be regionally based and amongst other roles and responsibilities, they may have a primary health care workforce development role[51] and a responsibility to identify primary health care service gaps and identify solutions to address the service gaps. While there appears to be an expectation that these organisations will remain GP focused, the policy intent appears that these organisations take on a broader and more comprehensive primary health care brief. It is early days yet as it will take at least three years for the role of these organisations to evolve. It is important however, that this be considered with respect to the opportunities it may create for community pharmacists as well as the implications it may have for their role.

5.6 Workforce strategy implications

While it is not the role of this evaluation to review current workforce strategies in light of future need and broader health system trends, it is clear that the role of the community pharmacist is broadening and that both the professional and business environment within which pharmacists operate is changing. Consequently, the main implications for future workforce strategies include:

- Whether financial support alone will be sufficient for pharmacists working in rural and remote areas, or whether a diverse range of strategies is required that seeks and develops innovative solutions to workforce needs.

- The need to have differential strategies for communities where the traditional community pharmacy model is not viable or sustainable.

- The need for greater collaboration with other parts of the health care system including regional hospitals and primary health care organisations (medicare locals).

[50] http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01
[51] http://www.agpn.com.au/__data/assets/pdf_file/0013/21451/20091127_pap_Australian-PHCOs-Blueprint-FINAL-Graphic-designed.pdf

6 Analysis of participant survey data

6.1 Purpose and approach to the survey

The survey of program recipients was undertaken to:

- Identify whether the programs met their expectations;
- Assess whether program administrative procedures need to be improved; and
- Assess the factors (including the programs) that influenced the decision of pharmacists to work in a rural or remote area.

The survey was of individuals who received support from one or more programs and thus included pharmacy owners, pharmacists, pre-registrants, students and academics. However as discussed in section 2.3, email contact details were not available for all program recipients. As such, the survey was only sent to recipients of the scholarship scheme, the CPE Allowance and the Pre Registration Incentive Allowance.

6.2 Characteristics of survey respondents

This section of the report provides the data relating to the characteristics of the survey respondents. The characteristics collected by the survey include the respondents' professional status and the state or territory in which they work. The data also identify those respondents who work in a rural pharmacy, how long they have done so, and their reasons for doing so. The tables and discussion below consider each of these characteristics in turn, and the section concludes by considering the implications for analysis of the survey data.

6.2.1 Characteristics of all respondents

Almost three-quarters (72 percent) of survey respondents were registered pharmacists. A very small percentage of respondents (5.2 percent) were pre-registration pharmacists. A surprisingly large percentage (21.5 percent) of survey respondents were students, representing over one-fifth of the survey sample. Two respondents were academics or researchers, and another two respondents did not indicate their professional status.

Table 16 Current professional status of respondents

Current professional status of respondents	Total No	Percentage
A pre-registration pharmacist	15	5.19
A registered pharmacist	208	71.97
A student	62	21.45
Other	2	0.69
(blank)	2	0.69
Grand Total	**289**	**100**

Responses were received from all states and territories. Most respondents worked in New South Wales (37.7 percent) Queensland (18.3 percent) and Victoria (17 percent). Smaller numbers of respondents worked in Western Australia (eight percent), South Australia (6.2 percent) and Tasmania (5.5 percent), and the percentage of respondents from the Northern Territory and the Australian Capital Territory was 3.1 percent and 0.35 percent respectively. A small number of respondents did not indicate the state or territory in which they worked.

Table 17 State of residence of respondents

State of residence of respondents	Total No	Percentage
ACT	1	0.35
NSW	109	37.72
NT	9	3.11
QLD	53	18.34
SA	18	6.23
TAS	16	5.54
VIC	49	16.96
WA	23	7.96
(blank)	11	3.81
Grand Total	**289**	**100**

Respondents were asked to identify whether or not they worked in a rural pharmacy, and the overwhelming majority (79.6 percent) of respondents indicated that they did so. Only one respondent did not disclose this information.

Table 18 Respondents by current work location

Respondents by current work location	Total No	Percentage
Working in a rural pharmacy	230	79.58
Not working in a rural pharmacy	58	20.07
(blank)	1	0.35
Grand Total	**289**	**100**

6.2.2 Characteristics of respondents currently working in a rural pharmacy

In instances where a respondent indicated that they worked in a rural pharmacy, the survey sought additional information in relation to their length of service and their reasons for working in a rural area.

Half (50.2 percent) of the survey respondents who worked in a rural pharmacy had done so for more than five years. Almost one third (31.9 percent) had worked in a rural pharmacy for between one and three years, with much smaller numbers having worked in a rural pharmacy for between three and five years (9.8 percent) and less than one year (8.1 percent).

Table 19 Length of time for which respondents have worked in a rural pharmacy

Length of time for which respondents have worked in a rural pharmacy	Total No	Percentage
Less than one year	19	8.09
1-3 years	75	31.91
3-5 years	23	9.79
More than 5 years	118	50.21
Grand Total	**235**	**100**

Respondents who worked in a rural pharmacy were asked their reasons for doing so, and were able to provide more than one reason. Primarily, respondents worked in rural locations for one of two reasons: 159 (or two thirds) indicated that it was a lifestyle decision and 128 (54.5 percent) respondents indicated that they had an existing connection to the area. For 65 respondents (27.7 percent), the availability of incentives provided a reason to work in a rural pharmacy. Seventy-two (30.6 percent) respondents stated that working in a rural pharmacy as a pharmacy student or as a pre-registrant was a reason for subsequently working as a registered pharmacist in a rural or remote area. Forty-four respondents indicated that other reasons applied.

Table 20 Reasons why respondent was attracted to working in a rural pharmacy

Reasons why respondent was attracted to working in a rural pharmacy	Total No	Percentage
Lifestyle	159	67.7
Existing connection to the area	128	54.5
Availability of incentives	65	27.7
Placement experiences as a Pharmacy student or pre-registration student	72	30.6
Other	44	18.7

For respondents who indicated that they worked in a rural pharmacy, it is possible to align their work location with the Pharmacy Accessibility/Remoteness Index of Australia (PhARIA). PhARIA was designed to provide a comprehensive, standardised measurement of the physical and professional remoteness of pharmacies throughout Australia, for use in the determination of rural and remote pharmacy allowances. The index uses a six category classification system indicated in the table below.

Respondents who indicated that they worked in a rural pharmacy represented all PhARIA categories. Predictably, the number of responses relating to each category broadly followed the PhARIA scale from Highly Accessible to Very Remote. For a small number (12) of respondents, their location by PhARIA category was not provided.

Table 21 PhARIA Category of respondents who indicated that they currently work in a rural pharmacy

PhARIA Category of respondents who indicated that they currently work in a rural pharmacy	Total No	Percentage
Category 1 - Highly Accessible	70	29.79
Category 2 - Accessible (Group A)	32	13.62
Category 3 - Accessible (Group B)	52	22.13
Category 4 - Moderately Accessible	27	11.49
Category 5 – Remote	29	12.34
Category 6 - Very Remote	13	5.53
(blank)	12	5.11
Grand Total	**235**	**100**

6.2.3 Implications for analysis of survey data

The extent to which the survey respondents constituted a representative sample is unknown, but the sample of respondents is not representative of certain population characteristics. Thus, the data generated by this survey should be interpreted with some caution.

The survey was voluntary, and the reasons why respondents chose to participate or not to participate are unknown. Some respondents may have participated for a particular reason or have been very highly motivated to participate. Similarly, there may be many pharmacists who chose not to participate in the survey for reasons of available time, a particular attitude or disinterest.

The data indicate that student pharmacists, representing 21.45 percent of respondents, are over-represented in the survey, but again the motivations for student pharmacists to participate in the survey are not known. One can speculate that their enthusiasm for their intended profession, combined with the possibility of their having more time available to complete the survey, are contributing factors.

When the percentage of pharmacists employed in each state and territory is considered alongside the survey response rate from pharmacists in each state and territory, it can be seen that some states and territories are over-represented in the sample, as others are under-represented. These data are presented in the table below. In particular, the observation can be made that Victoria and the ACT are under-represented, and that Tasmania and the Northern Territory are over-represented.

Table 22 Percentage of Australian retail pharmacists by state compared to percentage of survey respondents by state

State / Territory	Percentage of Australian retail pharmacists by state[52]	Percentage of survey respondents by state
ACT	1.56	0.35
NSW	32.01	37.72
NT	0.58	3.11
QLD	19.99	18.34
SA	7.55	6.23
TAS	2.64	5.54
VIC	25.68	16.96
WA	9.97	7.96

[52] Source - **Table 4.1: Persons employed in health and community services occupations: occupation (6-digit ANZSCO), Australia[(a)] by Remoteness Areas, 2006; http://www.aihw.gov.au/publications/index.cfm/title/10677#detailed_tables accessed 4 June 2010.**

The following table needs to be treated with caution as the population data reflects the distribution of retail pharmacists in 1999 and thus not directly comparable with the sample population. To the extent that the distribution may not have changed in the intervening ten years, it suggests that the sample of respondents (who are currently working in a rural or remote area) is over-representative of pharmacists working in remote areas and under representative of pharmacists working in the more accessible areas (excepting highly accessible areas).

Table 23 Percentage of Australian retail pharmacists by PhARIA category (1999) compared to Percentage of survey respondents (2010) by PhARIA category

State / Territory	Percentage of Australian retail pharmacists by PhARIA category (1999)[53]	Percentage of survey respondents (2010) by PhARIA category
Category 1 - Highly Accessible	24.02	29.79
Category 2 - Accessible (Group A)	21.42	13.62
Category 3 - Accessible (Group B)	19.52	22.13
Category 4 - Moderately Accessible	30.65	11.49
Category 5 - Remote	2.01	12.34
Category 6 - Very Remote	2.41	5.53

6.3 Survey responses by program

Survey respondents were asked to provide feedback about programs they had accessed in the past five years. For each program they had accessed, they were asked a set of questions around their source of awareness of the program, areas in which the program had assisted them and their levels of satisfaction with the program. An analysis of the responses for each of the programs follows.

6.3.1 Rural Pharmacy Maintenance Allowance

Awareness of the program

As outlined in Table 24, the majority of the respondents receiving the Rural Pharmacy Maintenance Allowance (45 respondents) had heard about the program through the Guild. The next most common sources of information about the program were Medicare Australia

[53] Australian Institute of Health and Welfare (AIHW) 2003. Pharmacy labour force to 2001. AIHW cat. No. HWL 25. Canberra: AIHW (National Health Labour Force Series no. 25). Table A.6: Employed pharmacists: age, geographic area, 1999, page 26

and word of mouth, with ten and eight responses respectively. None of the respondents had heard about the program through another pharmacy publication, university publications or communications or a careers counsellor.

Table 24 Responses regarding how the respondent became aware of the program

How the respondent became aware of the program	No.
Rural Pharmacies website	3
Rural Pharmacy newsletter	2
The Pharmacy Guild of Australia	45
Word of mouth	8
Another pharmacy publication	0
Medicare Australia	10
University publication or communications	0
Careers Counsellor	0
Other	7

Note: Respondents were able to select more than one option so total exceeds the total number of respondents receiving rural maintenance allowance

Assistance that the program has provided

The survey responses were generally positive about the level of assistance that the Rural Pharmacy Maintenance Allowance has provided. The most common benefit identified as arising from the program was continuing or commencing practicing as a rural pharmacist, with a total of 44 percent of respondents stating that they felt the Rural Pharmacy Maintenance Allowance had helped a lot in this area, and 39 percent stating that it had helped somewhat. Similarly, a total of 72 percent of respondents felt that the program had either helped a lot or somewhat in accessing education opportunities they would not otherwise have been able to access. Respondents were less positive about the impact of the program on networking with other pharmacists, with the most frequent response being 'Not at all' (31 percent, or 19 respondents). This said, 28 percent of respondents still felt that the program had helped them network with other pharmacists a lot and somewhat respectively.

Table 25: Summary of responses to the question: Please indicate to what degree the Rural Pharmacy Maintenance Allowance has helped in the following areas

Question	A Lot	Some what	Not at all	DNR[54]	Total No.
Continue or commence practicing as a rural pharmacist	44%	39%	8%	8%	61
Network with other pharmacists	28%	28%	31%	13%	61
Access education opportunities I otherwise would not have been able to access	33%	39%	11%	16%	61

Responses to the questions aimed specifically at pharmacy owners indicate that owners were very positive about the impact of the Rural Pharmacy Maintenance Allowance on meeting the ongoing costs of running their pharmacy, with 28 respondents stating that it had helped a lot and 16 stating that it had helped somewhat. Similarly, owners generally felt that the Rural Pharmacy Maintenance Allowance has helped them provide a wider range services to the local community and hire more staff (with a total 39 and 34 respondents respectively stating that the program had helped a lot or somewhat). The 'N/A' responses to this question relate predominately to respondents who are not pharmacy owners.

Responses from owners about the impact of the Rural Pharmacy Allowance in allowing them to open longer hours were more mixed, with nine respondents saying that it has helped a lot, 14 saying somewhat and 13 percent not at all. The question around the impact of the Rural Pharmacy Maintenance Allowance on assisting with the opening of a new pharmacy business was, unsurprisingly, not applicable for the majority of respondents, given the purpose of this program, with seven stating that it had helped them a lot and three saying it had assisted somewhat compared to 11 who said that it had not helped at all.

Table 26: Summary of responses to the question: Please indicate to what degree the Rural Pharmacy Maintenance Allowance has helped in the following areas (Pharmacy Owners Only)

Question	A Lot	Some what	Not at all	N/A	Total No.
Pharmacy Owners Only					
Hire more staff	18	16	13	14	61
Open longer hours	9	14	19	19	61
Provide a wider range of services to the community	19	20	8	14	61
Meet the ongoing cost of running my pharmacy	28	16	5	12	61
Open a new pharmacy business	7	3	11	40	61

[54] DNR= Did not respond

Satisfaction with the program

As outlined in Table 27, levels of satisfaction with the Rural Pharmacy Maintenance Allowance were high in all areas of the service. Timeliness of payments was the area with the highest levels of satisfaction, with 46 percent of respondents stating that they were very satisfied and 46 percent stating that they were satisfied. Similarly, a total of 91 percent of respondents were either satisfied or very satisfied with the timeliness of payments. Respondents were more likely to state that they were satisfied than very satisfied with the ongoing reporting requirements and meeting expectations, but in both cases only a small percentage stated that they were not satisfied.

Table 27: Summary of responses to the question: Please indicate how satisfied you were with the following aspects of the Rural Pharmacy Maintenance Allowance

Question	V. Satisfied	Satisfied	Not Satisfied	DNR	Total No.
Application process	39%	52%	2%	7%	61
Timeliness of payments / service response	46%	46%	2%	7%	61
Ongoing reporting requirements	34%	51%	3%	11%	61
Meeting my expectations	30%	52%	7%	11%	61

6.3.2 Rural Pharmacy Start Up Allowance

Awareness of the program

Only three of the 289 respondents to the survey indicated that they had accessed the Rural Pharmacy Start Up Allowance over the past five years. There were three responses stating that the respondent became aware of the program through the Guild, reflecting the trend from Rural Pharmacy Maintenance allowance recipients of this being the most common source of awareness. One respondent also stated that they were made aware of the program by Medicare Australia, reflecting the opportunity for recipients to select more than one response.

Table 28 Responses regarding how the respondent became aware of the program

How the respondent became aware of the program	No.
Rural Pharmacies website	0
Rural Pharmacy newsletter	0
The Pharmacy Guild of Australia	3
Word of mouth	0
Another pharmacy publication	0
Medicare Australia	1
University publication or communications	0
Careers Counsellor	0
Other	0

Note: Respondents were able to select more than one option so total exceeds the total number of respondents receiving Rural Pharmacy Start Up Allowance

Assistance that the program has provided

The small number of survey respondents who had accessed the Rural Pharmacy Start Up Allowance were generally positive about the assistance that the program has provided- all three felt that it had helped a lot in continuing or commencing practicing as a rural pharmacist, and all felt that it had helped either a lot or somewhat in networking with other pharmacists and accessing education opportunities that could not otherwise be accessed.

Table 29: Summary of responses to the question: Please indicate to what degree the Rural Pharmacy Start Up Allowance has helped in the following areas

Question	A Lot	Some what	Not at all	DNR	Total
Continue or commence practicing as a rural pharmacist	3	-	-	-	3
Network with other pharmacists	2	1	-	-	3
Access education opportunities I otherwise would not have been able to access	2	1	-	-	3
Open a new pharmacy business	2	-	-	1	3

Responses among the pharmacy owners who had accessed the program were also positive, with owners stating that the program had helped them a lot or somewhat in all areas apart from hiring more staff. Here, one respondent stated that it had helped a lot while another said that it had not helped at all. Both of the respondents who answered the question about the impact of the program on opening a new pharmacy business said that it had helped a lot,

suggesting that the program is meeting the objective of helping recipients to start new pharmacies (when it is used).

Table 30: Summary of responses to the question: Please indicate to what degree the Rural Pharmacy Start Up Allowance has helped in the following areas (Pharmacy Owners Only)

Question	A Lot	Some what	Not at all	N/A	Total
Pharmacy Owners Only					
Hire more staff	1	-	1	1	3
Open longer hours	1	1	-	1	3
Provide a wider range of services to the community	2	1	-	-	3
Meet the ongoing cost of running my pharmacy	2	1	-	-	3
Open a new pharmacy business	2	-	-	1	3

Satisfaction with the program

As outlined in Table 31, the small number of respondents who had accessed the Rural Pharmacy Start up Allowance were either satisfied or very satisfied with all aspects of the program. All respondents were very satisfied with the timeliness of payments/service response and two of the three respondents were very satisfied with the program with respect to ongoing reporting requirements and meeting expectations.

Table 31: Summary of responses to the question: Please indicate how satisfied you were with the following aspects of the Rural Pharmacy Start up Allowance

Question	V. Satisfied	Satisfied	Not Satisfied	DNR	Total No.
Application process	1	1	-	1	3
Timeliness of payments / service response	3	-	-	-	3
Ongoing reporting requirements	2	1	-	-	3
Meeting my expectations	2	1	-	-	3

6.3.3 Rural Pharmacy Succession Allowance

None of the survey respondents indicated that they had participated in the rural pharmacy succession allowance, and the survey results do not therefore provide any information about awareness, impact or satisfaction with the program.

6.3.4 Continuing Professional Education Allowance

Awareness of the program

Word of mouth was the most frequent means by which respondents who had accessed the Continuing Professional Education Allowance became aware of the program, with 40 percent of respondents (81 individuals) selecting this as the source of their awareness. In line with the Rural Pharmacy Maintenance Allowance and Rural Pharmacy Start Up Allowance, the Guild was also a major source of information about the program, having been selected by 66 respondents. In addition, the Rural Pharmacies Website was identified as a source of awareness by 23 respondents, with ten percent selecting university publications or communications.

Table 32 Responses regarding how the respondent became aware of the program

How the respondent became aware of the program	No.
Rural Pharmacies website	23
Rural Pharmacy newsletter	11
The Pharmacy Guild of Australia	66
Word of mouth	81
Another pharmacy publication	2
Medicare Australia	0
University publication or communications	10
Careers Counsellor	0
Other	10

Note: Respondents were able to select more than one option so total exceeds the total number of respondents receiving Continuing Professional Education Allowance

Assistance that the program has provided

Respondents were very positive about the impact of the Continuing Professional Education Allowance on their ability to access education opportunities that they would not otherwise have been able to access; 71 percent of respondents stated that the program had helped them a lot in this regard and 23 percent said it had helped somewhat. Respondents were also positive about the impact of the program on their ability to network with other pharmacists and continue or commence practicing as a rural pharmacist, with 86 percent and 85 percent respectively stating that the program had helped either a lot or somewhat.

Table 33: Summary of responses to the question: Please indicate to what degree the Continuing Professional Education Allowance has helped in the following areas

Question	A Lot	Some what	Not at all	DNR	Total
Continue or commence practicing as a rural pharmacist	52%	33%	8%	7%	162
Network with other pharmacists	56%	30%	6%	7%	162
Access education opportunities I otherwise would not have been able to access	71%	23%	1%	4%	162

The majority of respondents receiving the Continuing Professional Education Allowance were not pharmacy owners, and as such the majority of answers to the owner-specific questions were 'N/A'. The pattern of responses from those owners who had accessed the program were mixed; the most positive responses related to the ability of the Continuing Professional Education Allowance to help owners provide a wider range of services to the community, with 15 respondents stating that the program helped a lot and 20 saying it had helped somewhat. Responses about the ability of the program to meet the ongoing costs of running a pharmacy were also largely positive, with 27 saying that the program had helped a lot or somewhat compared to nine who did not feel that it had helped at all. Responses were not so positive with respect to the ability of the program to help with hiring new staff or open longer hours; 14 and 16 respondents respectively felt that the program had not helped at all in this regard.

Table 34: Summary of responses to the question: Please indicate to what degree the Continuing Professional Education Allowance has helped in the following areas (Pharmacy Owners only)

Question	A Lot	Some what	Not at all	N/A	Total
Pharmacy Owners Only					
Hire more staff	8	10	14	130	162
Open longer hours	3	11	16	132	162
Provide a wider range of services to the community	15	20	4	123	162
Meet the ongoing cost of running my pharmacy	12	15	9	126	162
Open a new pharmacy business	2	4	9	147	162

Satisfaction with the program

As outlined in Table 35, satisfaction levels with the Continuing Professional Education Allowance are generally high; over 80 percent of respondents indicated that they were either satisfied or very satisfied with the program across all four aspects considered. The application process was seen as the most satisfactory element of the program, with 50 percent of respondents being very satisfied and 40 percent being satisfied with it. Similarly, 41 percent and 44 percent were very satisfied and satisfied respectively with the timeliness of payments/ service response. Respondents were more likely to be satisfied than very satisfied with ongoing reporting requirements and the ability of the program to meet their expectations, which mirrors the pattern of responses about the Rural Pharmacy Maintenance Allowance. This said, in both instances, 83 percent and 90 percent of respondents respectively were either satisfied or very satisfied with these aspects of the program, with only two percent not satisfied in each case.

Table 35: Summary of responses to the question: Please indicate how satisfied you were with the following aspects of the Continuing Professional Education Allowance

Question	V. Satisfied	Satisfied	Not Satisfied	DNR	Total No.
Application process	50%	40%	6%	4%	162
Timeliness of payments / service response	41%	44%	9%	6%	162
Ongoing reporting requirements	27%	56%	2%	15%	162
Meeting my expectations	40%	50%	2%	8%	162

6.3.5 Emergency Locum Service

Awareness of the program

Only 14 respondents to the survey stated that they had accessed the Emergency Locum Service, and among these the Guild was again the most frequently cited reason for respondents becoming aware of the program with five responses. In addition, four respondents stated that they had become aware of the program through word of mouth and the Rural Pharmacies website respectively.

Table 36 Responses regarding how the respondent became aware of the program

How the respondent became aware of the program	No.
Rural Pharmacies website	4
Rural Pharmacy newsletter	3
The Pharmacy Guild of Australia	5
Word of mouth	4
Another pharmacy publication	0
Medicare Australia	0
University publication or communications	0
Careers Counsellor	0
Other	1

Note: Respondents were able to select more than one option so total exceeds the total number of respondents receiving Emergency Locum Service

Assistance that the program has provided

The survey results indicate that respondents have mixed views on the assistance that has been provided by the Emergency Locum Program. Respondents were most positive about the degree to which it has helped them to continue or commence practicing as a rural pharmacist, with six saying that it had helped them a lot and four saying it had helped them somewhat compared to two who said it had not helped at all.

Table 37: Summary of responses to the question: Please indicate to what degree the Emergency Locum Service has helped in the following areas

Question	A Lot	Some what	Not at all	DNR	Total
Continue or commence practicing as a rural pharmacist	6	4	2	2	14
Network with other pharmacists	2	4	5	3	14
Access education opportunities I otherwise would not have been able to access	3	1	4	6	14

The responses from pharmacy owners only suggest that a maximum of four respondents who had accessed the Emergency Locum Service were pharmacy owners. As outlined in Table 38, it

is not possible to identify specific or marked trends in the answers from these respondents to the owner-specific questions given their low number.

Table 38: Summary of responses to the question: Please indicate to what degree the Emergency Locum Service has helped in the following areas (Pharmacy owners only)

Question	A Lot	Some what	Not at all	N/A	Total
Pharmacy Owners Only					
Hire more staff	2	-	1	11	14
Open longer hours	1	2	1	10	14
Provide a wider range of services to the community	1	1	2	10	14
Meet the ongoing cost of running my pharmacy	1	2	1	10	14
Open a new pharmacy business	1	-	2	11	14

Satisfaction with the program

Satisfaction with the Emergency Locum Service among survey respondents was very high; as outlined in Table 39, respondents were most satisfied with the application process, with ten stating that they were very satisfied and two saying that they were satisfied compared with only one who was not satisfied. Similarly, ten out of the 14 respondents were either very satisfied or satisfied with the timeliness of payments/service response and the ability of the program to meet expectations. Responses around satisfaction with the ongoing reporting requirements were also positive, with none of the respondents stating that they were not satisfied with this aspect of the Emergency Locum Service.

Table 39: Summary of responses to the question: Please indicate how satisfied you were with the following aspects of the Emergency Locum Service

Question	V. Satisfied	Satisfied	Not Satisfied	DNR	Total No.
Application process	10	2	1	1	14
Timeliness of payments / service response	8	2	2	2	14
Ongoing reporting requirements	6	5	-	3	14
Meeting my expectations	7	3	1	3	14

6.3.6 Rural Pharmacy Scholarship Scheme

Awareness of the program

Continuing the trend from the other programs, the Guild and word of mouth were the most commonly cited sources of information for making respondents aware of the Rural Pharmacy Scholarship Scheme with 25 and 21 responses respectively. Other frequently cited sources included Careers Counsellors, University publications/communications and the Rural Pharmacy Newsletter.

Table 40: Responses regarding how the respondent became awareness of the program

How the respondent became aware of the program	No.
Rural Pharmacies website	3
Rural Pharmacy newsletter	10
The Pharmacy Guild of Australia	25
Word of mouth	21
Another pharmacy publication	0
Medicare Australia	0
University publication or communications	13
Careers Counsellor	18
Other	15

Note: Respondents were able to select more than one option so total exceeds the total number of respondents receiving the Rural Pharmacy Scholarship Scheme

Assistance that the program has provided

Respondents were generally positive about the level of assistance that the Rural Pharmacy Scholarship Scheme has provided. As outlined in Table 41, accessing education opportunities that would not otherwise have been accessible was the area in which the program had provided the most assistance, with 54 percent of respondents stating that it had helped a lot and 21 percent saying it had helped somewhat. A substantial percentage of respondents (43 percent) also felt that the program had helped a lot in continuing or commencing practicing as a rural pharmacist, with only one percent saying that it had not helped at all. A total of 69 percent of respondents also stated that the program had helped them network with other pharmacists, although twice as many said that it helped somewhat rather than 'helped a lot'.

Table 41: Summary of responses to the question: Please indicate to what degree the Rural Pharmacy Scholarship Scheme has helped in the following areas

Question	A Lot	Some what	Not at all	DNR	Total No.
Continue or commence practicing as a rural pharmacist	43%	17%	1%	39%	70
Network with other pharmacists	23%	46%	10%	21%	70
Access education opportunities I otherwise would not have been able to access	54%	21%	10%	14%	70

Given the program is directed towards students, it is not surprising that the vast majority of respondents who had accessed the Rural Pharmacy Scholarship Scheme were not pharmacy owners, and therefore by far the highest response to the questions aimed at pharmacy owners was 'N/A'. As outlined in Table 42, the responses appear to indicate that the program has been more useful in helping to hire more staff than opening longer hours or opening new pharmacies. However, it is not possible to draw meaningful trends from the responses to the owner-specific questions given the very small number of responses to each of the owner-specific questions (no more than four owners answered each question).

Table 42: Summary of responses to the question: Please indicate to what degree the Rural Pharmacy Scholarship Scheme has helped in the following areas (Pharmacy Owners only)

Question	A Lot	Some what	Not at all	N/A	Total No.
Pharmacy Owners Only					
Hire more staff	2	2	0	66	70
Open longer hours	1	0	2	67	70
Provide a wider range of services to the community	1	1	0	68	70
Meet the ongoing cost of running my pharmacy	1	1	0	68	70
Open a new pharmacy business	1	0	1	67	70

Satisfaction with the program

In a similar way to the other programs, levels of satisfaction with the Rural Pharmacy Scholarship Scheme were high. Indeed, the proportion of respondents stating that they were very satisfied with the program was among the highest of all the programs; 69 percent of respondents were very satisfied with the timeliness of payments/service response and 68 percent felt that the program was meeting their expectations (with nobody stating that they were not satisfied with this aspect of the program). Similarly, none of the respondents said that they were not happy about the application process, while 94 percent were either very satisfied or satisfied. As with many of the other programs, respondents were more likely to be satisfied than very satisfied with the ongoing reporting requirements, but this may be likely to

be reflective of the nature of this aspect of the scheme (requirements for reporting are by their nature less likely to lend themselves to high levels of satisfaction).

Table 43: Summary of responses to the question: Please indicate how satisfied you were with the following aspects of the Rural Pharmacy Scholarship Scheme

Question	V. Satisfied	Satisfied	Not Satisfied	DNR	Total No.
Application process	53%	41%	0%	6%	70
Timeliness of payments / service response	69%	20%	6%	6%	70
Ongoing reporting requirements	37%	53%	3%	7%	70
Meeting my expectations	68%	26%	0%	6%	70

6.3.7 Rural Placement Allowance

Awareness of the program

The Guild and word of mouth were again the most common means by which respondents had become aware of the Rural Placement Allowance, with 29 respondents selecting the former and 11 the latter. University publications/communications were the next most frequently cited information sources with ten responses.

Table 44 Responses regarding how the respondent became aware of the program

How the respondent became aware of the program	No.
Rural Pharmacies website	5
Rural Pharmacy newsletter	6
The Pharmacy Guild of Australia	29
Word of mouth	11
Another pharmacy publication	0
Medicare Australia	0
University publication or communications	10
Careers Counsellor	1
Other	4

Note: Respondents were able to select more than one option so total exceeds the total number of respondents receiving the Rural Placement Allowance Scheme

Assistance that the program has provided

As with the other programs, respondents were generally positive about the level of assistance provided by the Rural Placement Allowance; 53 percent for example stated that program helped a lot in continuing or commencing practicing as a rural pharmacist. The proportion of respondents who said that the program did not help at all was higher for networking with other pharmacists and accessing education opportunities that would not have otherwise been available (17 percent in each case), but in both cases the majority of respondents still felt that the program helped either somewhat or a lot.

Table 45: Summary of responses to the question: Please indicate to what degree the Rural Placement Allowance has helped in the following areas

Question	A Lot	Some what	Not at all	DNR	Total No.
Continue or commence practicing as a rural pharmacist	53%	25%	6%	17%	53
Network with other pharmacists	25%	34%	17%	25%	53
Access education opportunities I otherwise would not have been able to access	34%	28%	17%	21%	53

Satisfaction with the program

As with the other programs, levels of satisfaction with the Rural Placement Allowance were high. Respondents were particularly satisfied with the application process, with 43 percent stating that they were very satisfied with this aspect of the program and 45 percent saying they were satisfied. Satisfaction levels were also high with the timeliness of payments, ongoing reporting requirements and ability of the program to meet respondents' expectations, with over 80 percent being either satisfied or very satisfied with each aspect of the program.

Table 46: Summary of responses to the question: Please indicate how satisfied you were with the following aspects of the Rural Placement Allowance

Question	V. Satisfied	Satisfied	Not Satisfied	DNR	Total No.
Application process	43%	45%	2%	9%	53
Timeliness of payments / service response	30%	51%	4%	15%	53
Ongoing reporting requirements	23%	58%	2%	17%	53
Meeting my expectations	32%	53%	2%	13%	53

6.3.8 Additional Comments about Rural Pharmacy Programs

An analysis of the text responses to the question in the survey which asked respondents "Do you have any other comments about the Rural Pharmacy Programs?" reinforces the high levels of satisfaction about the programs, with respondents on the whole being positive about the programs and encouraging their continuation. Indeed 82 of the 110 free text responses were either supportive of the program or encouraged it to be continued. Example responses included:

- *"Please keep it up, we rural and remote pharmacists need all the support we can get"*
- *"The program has definitely been successful and I hope it continues"*
- *"The scholarship scheme is fantastic!'*
- *"I would really like to see the Continuing Professional Development allowance continued"*
- *"Keep it going, we need it in the bush so we can keep in touch and offer our customers the best available service"*
- *"Please keep supporting our rural pharmacies. Staffing and staff costs are much higher in the bush pharmacy programs help to support these employees programs"*

- *"Being from a rural town and having to travel to a city to study has been a struggle but the pharmacy guild of Australia has helped me incredibly to achieve my dream. The support has been fantastic."*

The free text responses also contained a number of suggestions for improvements in the programs. By far the most common suggestion was to increase awareness of the programs, as a number of respondents stated that they only became aware of them via word of mouth. This reinforces the results of the survey questions on awareness of the programs, where word of mouth was identified as one of the primary information sources for all of the programs. Survey responses included:

- *"The rural programs need to be more assessable to students. Unless you go looking for them you don't know about them."*

- *"Most of the information to support the rural practice is not available knowingly; I came to know only by word of mouth."*

Suggestions for addressing this issue included emailing all eligible pharmacies so they know about the program and for which programs they are eligible.

6.4 Summary

Overall, the survey respondents were generally positive about the assistance provided by the programs, and levels of satisfaction among recipients were very high. The positive message was also further reinforced by the free text comments provided by respondents at the end of the survey. A summary of the key themes arising from analysis of the survey responses is outlined below:

Awareness of the Programs

The top two sources of awareness for each of the programs were the Guild and word of mouth, each of which typically gained significantly more responses than the other example information sources provided. Analysis of the free text responses indicated that the prevalence of word of mouth as an information source highlighted an issue around the communication of the program; pharmacists feel that information on the programs is not being sufficiently well distributed to them and in many cases they would not have heard about the programs other than through word of mouth.

Citations of other information sources tended to depend more on the type of program; Medicare Australia for example was not regularly cited as an information source for any of the programs apart from the rural pharmacy maintenance allowance, while university publications/communications were only cited for relevant programs such as the Rural Pharmacy Scholarship Scheme, Rural Placement Allowance and Continuing Professional Education Allowance.

Assistance Provided by the Program

Responses about the level of assistance provided by the programs were generally positive for all of the programs, with the clear majority of respondents in each case stating that the program had either helped them either somewhat or a lot. The level of support provided by the programs in each of the categories differed depending on the program; for the majority of programs continuing or commencing practicing as a rural pharmacist was the category that most respondents said the program had helped a lot (this was the case for the Rural Pharmacy Maintenance Allowance, Rural Pharmacy Start Up Allowance, Emergency Locum Service and Rural Placement Allowance). Perhaps unsurprisingly given their nature, respondents accessing programs that provide education allowances were the most likely to state that the program had enabled them to 'Access education opportunities I would otherwise have not been able to access', and therefore this category gleaned the highest number of 'A lot' or 'Somewhat' responses for the Continuing Professional Education Allowance and Rural Pharmacy Scholarship Scheme.

The questions aimed at pharmacy owners only varied considerably in their pattern of responses across the programs. The education focussed programs, which are accessed primarily by students, inevitably elicited a high proportion of 'N/A' responses since few recipients of funding under these programs are pharmacy owners. In addition, the number of responses to the owner-specific questions for a number of programs (such as the Rural Pharmacy Start Up allowance and Emergency Locum Service) was so low that it was not possible to draw out meaningful trends in the pattern of responses.

The program accessed by the highest proportion of pharmacy owners was the Rural Pharmacy Maintenance Allowance. Owners under this program were generally positive about the ability of the programs to help them in meeting the ongoing costs of running their pharmacies, provide a wider range of service to the community and hire more staff. Owners were also sceptical about the ability of the grant to allow them to open longer hours with this category yielding the highest proportion of 'Not at all' responses for this program.

Satisfaction with the Programs

Across every one of the programs surveyed, satisfaction levels among survey respondents were either high or very high. Across all of the programs, the application process and timeliness of payments/service response were typically the areas with the highest proportion of "Very Satisfied" responses. Ongoing reporting requirements was typically the aspect of the scheme that was least likely to elicit a 'Very Satisfied' response, but this is likely to be in part due to the fact that the nature of this aspect of the scheme is less likely to lend itself to high levels of satisfaction among respondents.

Across each of the programs, the proportion of respondents who stated that they were not satisfied with the program was low, and for every aspect of every program (with the exception of one aspect of the Emergency Locum Service, which had a low proportion of respondents) the proportion of respondents stating that they were not satisfied with the program was less

than ten percent. This trend was reinforced by the free text responses from the survey which were largely positive about the programs and strongly supportive about their continuation.

7 Evaluation findings

This section presents the key findings from the evaluation addressing the following matters:

- Appropriateness of the Initiative;
- Effectiveness of the Initiative; and
- Administrative efficiency.

There are a number of findings that relate to more than one of these evaluation areas that are discussed before presenting the findings relating to these three specific matters.

As discussed in the section on scope and limitations of the evaluation (section 2.4), readers of this report must consider the following, specifically in relation to the findings:

- The evaluation focuses on the Initiative overall rather than individual programs within the Initiative.
- Input from stakeholders may not reflect the views of all stakeholders.
- There are potential survey biases because the respondents may not be representative of the 'population' of program participants/grant recipients.

7.1 General findings

This section discusses issues raised during the evaluation by stakeholders and/or KPMG's own observations of policy and structural related matters which influence the appropriateness, effectiveness and/or efficiency of the Initiative. The specific matters discussed are:

- Policy clarity;
- Overarching strategy;
- Balanced strategy mix;
- Linkages within the Initiative and strategies/programs outside of the Initiative;
- Mechanisms to share innovation and learnings; and
- Innovative solutions.

Some of these matters overlap but are discussed as separate issues.

Policy clarity

The policy aim of the Initiative is to "maintain and improve access to quality community pharmacy services for the community in rural and remote areas of Australia and to increase the proportion of the total pharmacy workforce starting practice in rural and remote Australia and staying in rural and remote practice for at least five".[55] KPMG also notes that this Initiative is funded as part of what is referred to in the Budget Portfolio Statement for Health and Ageing as 'outcome 2' which is that "Australians have access to cost-effective medicines".[56]

The programs funded within this Initiative have the following more specific objectives:

1. To increase the number of pharmacists in rural and remote practice through offering appropriate incentives and enhancing the attractions of rural practice.

2. To increase the length of stay of pharmacists in rural and remote practice by removing or reducing disincentives in rural and remote communities.

3. To develop innovative solutions to overcome the barriers to the delivery of pharmacy services in rural and remote communities.

While the broad policy aim and these specific objectives are not incompatible, there is however, an important difference in emphasis between the policy aim and the more specific objectives which may or may not have been intentional. The broad policy aim of improving access and the more specific statement emphasising "the proportion" suggests that the primary policy intent is to improve equity of access. The more specific Program objectives focus on increasing workforce numbers. While the latter can aid in improving equity of access, increasing overall access does not necessarily either improve equity of access between people living in metropolitan and rural areas or improve equity of access for people living in different rural areas. This could be considered to be a minor point of difference. The difference in emphasis was apparent when interviewing stakeholders; some emphasised the importance of supporting existing pharmacies, others on addressing areas of workforce shortage. At least one senior Departmental representative considered that equity of access was the actual policy intent.

If the primary policy intent was to improve equity of access then there are a number of important implications for the type of strategy response and the target of funded programs. These implications include:

- Both strategy and programs need to focus on areas of greatest disadvantage (regarding equity of access).

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55 http://www.health.gov.au/internet/main/publishing.nsf/Content/F7FBDB333D030BFFCA2570C000003A44/$File/4cpacompilation.pdf; p 22 accessed 28 May 2010.

56 Budget Portfolio Statement for Health and Ageing (p6), http://www.health.gov.au/internet/budget/publishing.nsf/Content/FC56ADA5294DA8A4CA2572C90001BFF3/$File/00_PBS.pdf; accessed 28 May 2010.

- Strategies and programs that may be suited for more mainstream rural areas where equity is less of an issue may not be suited to areas of greatest workforce need.

- The investment mix needs to balance the need to prevent any reduction in equity of access with the need to focus on areas that are of priority.

The various programs operating within the Initiative have tended to focus on where the traditional community pharmacy model is already viable (refer section 4.1.1). There has been much less emphasis on pursuing solutions and strategies that focus explicitly on areas of greater need. One stakeholder characterised the overall Initiative as being a "passive" strategy – one that aims to maintain the traditional approach and the status quo. This approach is appropriate if the policy intent is on increasing workforce numbers, whereas the approach may need to be modified if the policy focus is more on equity of access.

Finding 1: that there is some confusion in the interpretation of the policy intent of the initiative. The clarification of the policy intent of the Initiative as part of implementation of the Fifth Agreement coupled with ensuring that all statements of objectives are consistent with the policy intent and aligning all funding programs to these objectives and the development of an explicit program logic would assist this.

Overarching strategy

Related to the above issue is the need for the overarching strategy to be clearly articulated and understood. A strategic approach to addressing the policy aims and objectives would involve:

- Initial and on-going assessment of workforce shortages and need;

- Identification of priority areas of workforce shortage;

- Assessment of options to address workforce shortages and workforce need; and

- Implementation of strategies to address identified priorities.

With the exception of some individual programs within the Initiative, the overall Initiative operates in a passive manner – existing pharmacies received pre-determined allowances, and eligible individuals who qualify for assistance receive assistance. A more strategic and pro-active approach would prioritise allocation of funding to address workforce shortages in priority areas, set priorities to govern allocation of innovation funding, and target student scholarships and clinical placements in priority areas.

Further, there is no clearly articulated strategy within which the individual programs have been developed and refined. The strategy is more defined by the individual components of the Initiative. The importance of having an overarching strategy that is clearly articulated and aligned with the policy aims and its specific objectives, is to ensure it is understood by all stakeholders, that there is a clear line of sight from policy to objectives to strategy to actions

on the ground and thus, to ensure that the actions on the ground are the appropriate actions to achieve the aims.

Finding 2: that there is limited evidence of a strategic focus overarching the Initiative. A more strategic approach could strengthen the Initiative by including:

1) a process that systematically assesses workforce shortages and need;
2) funding allocations that address priority need; and
3) explicit policy priorities and overarching strategy to achieve the specific objectives.

Balanced strategy and investment mix

The Initiative addressed a number of priority areas and it targets different stakeholder groups to meet its objectives. Section 4.1 of this report considers the investment mix from a number of different perspectives from which it appears that:

- Funding is heavily weighted to existing pharmacies;
- Direct investment in recruitment is relatively small; and
- Distribution of funding is not commensurate with equity gaps.

Given that viability of existing pharmacies is a crucial factor in there being employment opportunities, it could be argued that payments to existing pharmacies (which accounts for just over 72 percent of all Initiative funding) also assists with recruitment and thus the investment in recruitment is greater than the funding of those programs that are explicitly recruitment orientated.

One of the important considerations for any initiative that is multi-faceted and multi-targeted, is to ensure that the investment mix is optimum - would the investment mix if adjusted, have a greater impact. Factors that are usually considered in determining the investment mix include:[57][58]

- Policy priority – has government policy articulated specific priorities.
- Relative need – that is, in this context, are there shortages in one area that are greater than in other areas.

[57] The National Health and Hospitals Reform Commission for example, developed a set of guiding principles some of which relate to investment mix .
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/E7F320C6A8E33990CA2577210045AF6C/$File/APPENDIX%20F.pdf

[58] http://www.buseco.monash.edu.au/centres/che/pubs/rr22.pdf

- Capacity to benefit – what programs/strategies are more likely to have an effect from which the community will benefit.

- Cost effectiveness – which strategies achieve the greatest outcome for a given cost.

These factors influence decisions to inform the investment mix that is likely to generate the greatest benefit.

It is clear that business rules have been developed for some programs to optimise benefit. Examples include:

- The payment made to a pharmacy owner under the rural maintenance allowance is determined by the level of remoteness of the pharmacy and its financial viability (number of prescriptions dispensed is used as a proxy). Thus, the more remote the pharmacy and the lower the number of dispensed prescriptions, the greater the value of the allowance paid.

- The student scholarship program targets students who have a demonstrable connection with a rural area (as the literature reports that this is an important determinant of whether a student will work in a rural area) and students from rural areas who are financially disadvantaged (this addresses the issue of equity of access).

Approximately 72 percent of total Initiative funding is directed to retention strategies and 16 percent directed to recruitment strategies (refer to section 4.1). Given the changing landscape of community pharmacy (refer section 5), it may be important to revisit the investment mix to assess whether there should be greater emphasis on recruitment strategies. KPMG notes for example, the demand for student scholarships from eligible students vastly exceeds the allocated funding. Notwithstanding the attraction of a subsidised higher education, increasing investment in this program activity together with strengthening the obligations on students may generate a greater effect than the current investment mix. KPMG is not in a position to categorically state that the investment mix under the Fourth Agreement was not optimum or that the current mix of programs will not produce the optimum result for the next five years. What is clear is that the investment mix, and thus the strategy balance, needs to be reassessed in light of:

- The changing landscape of community pharmacy;

- (Assuming) the policy aim continues to focus on equity of access, greater focus is required on areas of workforce shortage; and

- Given the expected impact of an ageing workforce on workforce attrition, recruitment will become increasingly more important.

Finding 3: there is no process that explicitly assesses the investment mix against workforce priorities. The implementation of such a process would improve the strategic response to identified priorities.

Program linkages

Effective linkages between relevant programs within the Initiative and between the Initiative and other strategies that also address community need for pharmacy services are essential. Anecdotally (based on stakeholder interviews) and from KPMG's own observation of structures overlaying the programs, there are opportunities to strengthen these linkages. Examples include:

- Between the pharmacy academics and the pharmacy schools: to ensure that there is better understanding between the two groups of their respective roles and to ensure that where relevant, they work together to maximise the benefit of each other's work in clinical placement, student support and research – stakeholder consultations suggest that in some cases, the links are tenuous.

- Between pharmacy academics: while KPMG appreciates that the individuals meet periodically, this is an informal arrangement rather than a mandated program requirement with accountability for the collective group to exchange experiences, innovation and ideas and to collaborate in areas of mutual interest.

- Between the individual programs within the Initiative and other strategies: for example, to seek opportunities to place students in Indigenous communities who would then be supported through other Indigenous programs or to explore through other Indigenous programs opportunities to use the small project program to target and identify innovative solutions for remote Indigenous communities.

Finding 4: there are is no requirement for organisations in receipt of funding, to set up formal mechanisms to collaborate and exchange information with other relevant organisations. Such arrangements could strengthen the Initiative.

Mechanisms to share innovation and learnings

Related to the above issue is the opportunity to maximise the benefits of individual initiatives by ensuring that there are adequate mechanisms in place that proactively promulgate innovation and learnings. Examples include:

- Using more formal approaches and methodologies to promulgate and proactively advances innovation in one area to effect change more broadly – the small projects are a prime example – while individual project reports are made available on the web site, the innovation arising from these projects should be assessed for their broader potential

application and then processes put in place to effect change more broadly across the industry.[59]

- Capitalising on the experiences of students placed in rural areas to identify examples of effective student support that should be promulgated to encourage other pharmacies to adopt similar approaches.

KPMG appreciates that current program funding does not necessarily allow for a substantial investment in highly engaging and proactive processes, but there may be opportunities to redirect funding to the extent that administrative efficiencies can be made to the programs overall (refer to section 7.4).

Finding 5: established processes to share could strengthen rural pharmacy practice and be used to actively promote rural pharmacy.

Innovative solutions

It is clear from stakeholder consultations and KPMG's previous work in many aspects of rural health, that alternative and innovative solutions will be required for areas where the traditional workforce model is not viable. The Initiative largely funds programs that focus on the traditional model and thus it maintains the status quo. While there are other strategies that are funded outside of this Initiative that in part address this issue, consideration could be given to how this Initiative should focus on workforce innovation where the traditional model is not viable.

Specific examples of alternative models are briefly described below, followed by a discussion of workforce strategy implications.

Co-location model: Co-location of a pharmacy service with the local medical practice and any other allied health practitioners in the locality. In a rural or remote community, this combined health service might best exist at the local hospital, or a stand-alone location in the town. A pharmacist, employed by either the local health centre or the health department, would dispense prescriptions in a discrete, secure area registered by the appropriate Pharmacy Board, and be available to provide other clinical services to members of the community and patients of the other health professionals in the facility. All health practitioners would have access to a shared education facility equipped with videoconferencing equipment, a library, and shared administrative support. Student placements and pre-registration training would be offered to pharmacy personnel (and to other co-located professional groups) to encourage pharmacists to join the pool of practitioners willing to work in rural and remote locations.

This model has the capacity to attract pharmacists, as it has the potential to provide a supportive, stimulating work environment and a stable salaried income for pharmacists and students seeking to work in a collegiate way with other health professionals. As an example,

[59] The Collaborative methodology is an example of a proven practice improvement methodology that takes innovation demonstrated in one place and seeks to effect change more broadly in an industry.

the larger regional hospitals in South Australia (Mt Gambier, Port Pirie, Port Augusta and Whyalla) are able to attract and retain pharmacists[60], and it could be argued that the model proposed here would also be attractive to like-minded pharmacists. Indeed, the proposed integrated health services could be formally linked to a large regional, or metropolitan, hospital, and staff could be pooled and rotated between them.

Off site models: In communities where there is no traditional community pharmacy, due either to lack of interest or insufficient dispensing activity and shop sales which render a business non-viable, alternative strategies must be employed to allow the local community to have access to an acceptable level of pharmaceutical services. The use of pharmacy depots, registered by the state or territory Pharmacy Board, provides a mechanism to allow customers access to a limited range of medicines and a point to drop off prescriptions and subsequently to receive dispensed medicines. The use of new technologies has the potential to improve the use of depots through the introduction of videophones to link pharmacies with their depots, allowing the depots to keep a range of pharmacy-only medicines that can be sold under the supervision of a pharmacist in a timely and personal manner using a videolink. In 2003, a Rural Pharmacy Videophone Program was approved in Victoria[61] following a successful pilot[62]. Victoria has 36 depots in towns and communities, of which 27 are pharmacist owned and operated. The installation of videophone facilities will enable a pharmacist in a larger town with a pharmacy to make face-to-face contact and provide essential information on prescription and over-the-counter medicines at pharmacy-owned depots.

This model requires a pharmacist workforce to be maintained in larger regional communities, and the employment of trained support staff (dispensary assistants/technicians) to work in the depots. Training would be similar to that undertaken by the support staff now employed in most community pharmacies and hospital pharmacies in Australia. Recruitment and training of assistants from the local community may be possible, and rotation of these people between the pharmacy and the depot(s) would assist in maintaining standards.

A variation on this model would be to link depots to the larger regional hospital where pharmacists are employed, or to the integrated health service model described above.

Technology enabled services: The third model would make use of the technology described above to link pharmacists in central locations to patients in remote locations where even depots are not considered viable. There are well described models in the USA[63], and some

[60] Interview with previous Chief Pharmacist of the South Australian Department of Health based on his workforce experiences.

[61] Rural Pharmacy Project. Victorian Rural Human Services Strategy. Department of Human Services, 2003. http://www.dhs.vic.gov.au/vrhss/servmod.htm

[62] Department of Human Services Remote Pharmacy Pilot Project Evaluation August 2002. Axten Associates, August 2002 http://www.dhs.vic.gov.au/vrhss/pharmacy/pharmvideoreport.pdf

[63] Telepharmacy reaches out to the underserved. Michele B. Kaufman, PharmD
Jan 20, 2009.
http://www.modernmedicine.com/modernmedicine/Technology+News/Telepharmacy-reaches-out-to-the-underserved/ArticleStandard/Article/detail/575698?contextCategoryId=40159

work has been done in Australia[64] to implement and trial a telepharmacy system involving automated dispensing of a limited range of medicines from secure storage units. While 87 percent of non-pharmacist healthcare workers supported the concept, 58 percent of pharmacists surveyed were opposed or neutral to the use of automated dispensing in remote areas where there was no community pharmacy. Medication reviews conducted using telepharmacy were well received by the small number of patients surveyed. The use of this technology by medical specialists is well established in Australia[65].

There are still workforce issues for the remote sites using this model, with a requirement for images and barcodes of medicines to be scanned to maximise patient safety, and for someone competent to operate the videolink. However the pharmacists providing the services could be employed in any central location, even in another jurisdiction (subject to suitable professional liability cover). This model seems to be suited to servicing remote aboriginal health centres, small communities on remote stations, and the islands.

Notwithstanding that this Initiative is a workforce strategy and that there are other strategies that look at alternative service delivery models, there is still scope for the Initiative to pursue workforce strategies that would support these alternative models such as:

- Using the small projects grants to look at how technology can be used by existing pharmacies to service communities where a local stand alone pharmacy is not viable.

- Liaising with regional hospitals to see how they could recruit pharmacists to service communities where the traditional community model is not viable.

- Collaborating with the (planned) primary health care organisations to pursue strategies that encourage co-location models.

Finding 6: the response to increasing access to community pharmacy services could be strengthened by the funding of innovative workforce options that would address the needs of communities where the traditional community pharmacy model is not viable. This could be a priority for the small projects

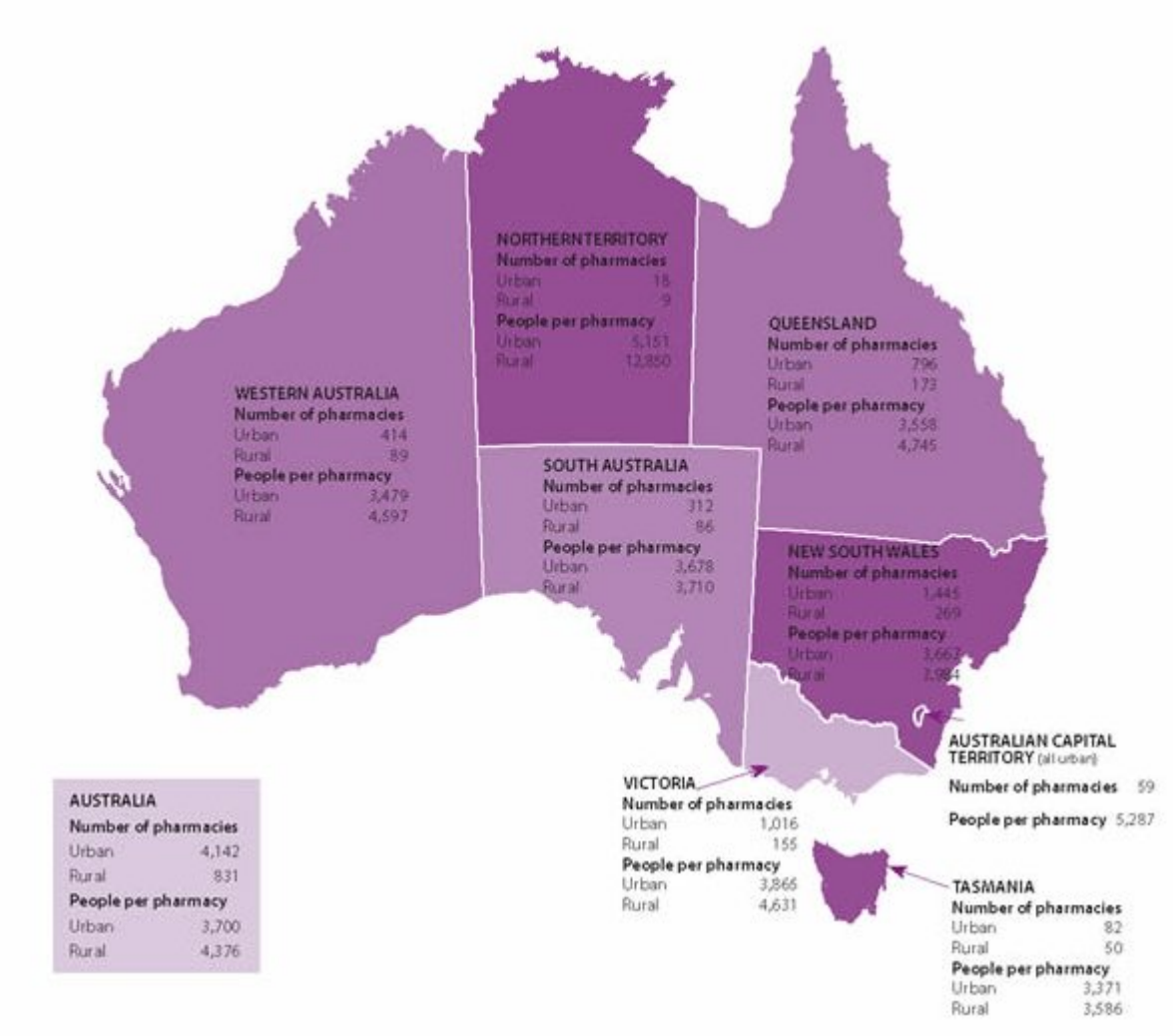
[64]Telepharmacy- enabling Technology to Provide Quality Pharmacy Services in rural and Remote Communities , Michael B Kimber, Gregory M Peterson: Journal of Pharmacy Practice and Research, Volume 36, No 2, 2006. http://www.guild.org.au/uploadedfiles/Medication_Management_Reviews/Overview/telepharmacy%20JPPR06(1).pdf
Kimber, Michael B. (2007) The application of telepharmacy as an enabling technology to facilitate the provision of quality pharmaceutical services to rural and remote areas of Australia. PhD thesis, James Cook University. http://eprints.jcu.edu.au/2087/
Measuring Patient Satisfaction With Telepharmacy. Jayashri Sankaranarayanan, MPharm,PhD. http://www.medscape.com/viewarticle/719950?src=mp&spon=30&uac=104539EK
Telepharmacy project aids North Dakota's rural communities. American Journal of Health-System Pharmacy, Vol. 63, Issue 19, 1776-1780. http://www.ajhp.org/cgi/content/full/63/19/1776
Telepharmacy spreading in the community setting Nov 7, 2005. Fred Gebhart, Contributing Editor http://drugtopics.modernmedicine.com/drugtopics/article/articleDetail.jsp?id=193801
[65]Information technology in medicine. Changing the way we practise. Malcolm Mackinnon, Professor of Telemedicine, Flinders University of South Australia and Director, Health OnLine http://www.mja.com.au/public/issues/xmas/mackinnon/mackinnon.html

funding program.

7.2 Program appropriateness

The Initiative addresses an important and on-going community need, namely, workforce shortage in rural and remote areas and challenges in retaining the workforce in these areas. This was clearly evident at the time when the decision was taken to fund this Initiative as is illustrated in the following diagram.

Figure 13: Number and distribution of community pharmacies in Australia 2006.



Source: Department of Health and Ageing, Annual Report 2005-06.
http://www.health.gov.au/internet/annrpt/publishing.nsf/Content/strategic-directions-0506-2

It is evident from the above that based on the number of people per pharmacy, people living in rural areas generally have less access (note that this is a proxy measure only and does not take

into account distance that rural people need to travel to access a pharmacy). There is however, considerable variation between the states and territories, with people living in rural areas of the Northern Territory having the lowest level of equitable access to pharmacy services, whereas in South Australia there is little difference between urban and rural areas in terms of the number of people per pharmacy – this is not to suggest that there are still not access issues within rural South Australia.

Further, a number of reports have consistently identified both workforce shortages and a mal-distribution of community pharmacists that results in an equity gap for people living in rural and remote parts of Australia. The previous evaluation[66] documented the literature on this subject, the findings of which were consistent with a study of the projected supply of and demand for pharmacists commissioned by the Guild.[67] This study identified that this shortage would continue to occur post the Third Pharmacy Agreement and provided the underlying rationale for the continuance of a range of programs that aimed to redress this problem. KPMG understands that work is nearly completed on updating these projections for the next ten years and that these projections are likely to indicate that the gap between demand and supply will reduce and possibly supply exceeding demand.[68]

The range of strategies funded to address this need (refer to section 3.3 of this report) are consistent with what was the priority need, and the strategies focused on the factors critical to address that need. Most notably, the Initiative included strategies that:

- Address professional isolation and provide emergency relief (factors that the literature recognises as being critical to both recruiting and retaining health care workers in rural and remote areas);

- Encourage both students and post graduates to gain exposure to and experience in working in rural and remote areas (the literature suggests that this is an important factor in influencing the decisions of individual to take up a career in a rural and remote area);

- Target rural people to take up a career in pharmacy (there is evidence in the literature that people with a rural connection are likely to return to rural areas to work);

- Support innovation through funding of small projects; and

- Assist pharmacy owners to ensure that their business remains viable.

[66] Human Capital Alliance (2004). Evaluation of the rural pharmacy initiatives program. Report to the Department of Health and Ageing, Canberra.
[67] Pharmacy Guild of Australia (2003). *A Study of the Demand and Supply of Pharmacists, 2000 – 2010*.
[68] Advice from the Pharmacy Guild and the Department of Health and Ageing.

These and other aspects of the Initiative were an appropriate mix of strategies that are consistent with both the evidence in the literature regarding effective workforce strategies and consistent with widely held views amongst those working in rural workforce strategy about what is required to address the rural and remote workforce need.

KPMG notes that the landscape is changing however, that may require a change in the strategy mix. This is considered in section 5 of this report.

7.3 Program effectiveness

NOTE: Workforce data was not available to enable any assessment of the effectiveness of the program in increasing the rural pharmacy workforce.

Summary findings

The effectiveness of the Initiative relates to the extent to which the associated programs have collectively made a contribution to the overall policy objective by increasing the proportion of community pharmacists working in rural and remote areas of Australia. As previously discussed in this report, the lack of workforce data prevents any direct analysis to determine the effectiveness of the Initiative. There is however, a range of supporting evidence that suggests that the collection of programs have an important role and are contributing to the policy aim. In particular:

- The range of strategies that are funded through these programs are consistent with the generally held view of what needs to be done to build up and retain primary health care workforce.

- The programs have in nearly all cases, met their activity targets and in some cases the demand exceeds the program's capacity.

- There is strong support for the programs amongst stakeholders.

The evaluation has identified a number of factors that have the potential to limit the impact of the programs and therefore, there are opportunities to improve the programs' impact. The evaluation is not able to be conclusive in this regard, but does make the following observations:

- There is no apparent systematic process to identify workforce gaps and therefore to identify strategies to address those gaps.

- There is no apparent program priority given to alternative models where the traditional community pharmacy model is not viable.

- Processes that ensure effective linkages and coordination where these activities would enhance overall program effectiveness need to be strengthened.

The remainder of this section discusses each of these points (both factors that are consistent with the view of program effectiveness and factors that need to be addressed to improve program effectiveness).

Relevant strategies

The range of strategies that are funded through individual programs are consistent with the generally held view of what is required to recruit and retain health workers in rural and remote regions of Australia. While a literature review was not undertaken as part of this evaluation, KPMG is aware that the broad thrust of this collection of programs and particularly those programs that actively engage potential new workforce and those that actively support existing workforce are generally favoured in the literature.[69] These strategies include:

- Student scholarship schemes and rural placement schemes;
- Pre-registration allowances; and
- Emergency locum relief and professional development support.

Much of the literature on this topic seems to focus on general practice (General Practitioners and nurses in general practice). [70] It is likely however, that the findings of the literature with respect to general practical workforce in rural and remote areas are also applicable to community pharmacy.

A related issue concerns whether the 'investment mix' is optimum. That is, whether or not the more benefit can be derived from changing the mix of investments in the various strategies. This is considered in the section on program efficiency (refer section 7.4).

Achieving activity targets

The term 'activity target' is used to refer to the output expected of each program. Section 4.2 of this report provides program output data from which it is evident that with the exception of two programs, all other programs have met or exceeded their activity expectations. The two exceptions being the start up allowance and the succession allowance programs. The take up rate of these two programs is low. Stakeholders consulted did not have a view regarding this matter. There are a number of possibilities including:

[69] The literature review undertaken as part of the previous evaluation of these initiatives provides relevant references.
[70] Kamien, M (1998). *Staying in or leaving rural practice: 1996 outcomes of rural doctors' 1986 intentions*. MJA 1998; 169: 318-321.

- Low level of demand – e.g. potential for new community pharmacies to be set up may be limited (either due to economic viability or location rules).

- Potential users are not aware of the program – programs are not targeted or marketed.

- Business rules governing the program are prohibitive.

In some respects, the low take up rate is not surprising given the passive nature of the programs – "they exist but are not proactively used to address issues".[71]

The demand for one program, the rural pharmacy scholarship program far exceeded the funding available notwithstanding that there are rules that limit the application of the scheme. On the one hand, this level of demand is not surprising given that it does not commit the student to following on in a career of pharmacy or to continue on with undergraduate studies.

There is also a potential hidden unmet demand for the rural placement allowance. Participating universities acquitted all funding under this program. What is not known is whether other students indicated an interest in rural placement but were not able to be supported through this program because the full funding was expended.

Strong stakeholder support

A detailed discussion of the survey responses is contained in section 6 of this report. It is clear from the sample of recipients who did respond to the survey that there is overwhelming support for the programs, and a high level of satisfaction with the programs. While there is a potential for (positive) response bias, there was also the potential that the survey could have been biased by those who were disappointed with the program. Given the extent of the support and positive feedback, response bias is unlikely to account for this overall outcome. It is important to note the following however:

- Notwithstanding that many of these programs have been in existence for several years, some are still not well known. For example, 40 percent of respondents who reported that they had used the CPE allowance, indicated that they found out about the allowance from 'word of mouth'.

- The availability of the various incentives is an important factor in determining individuals' decisions to work in a rural or remote area, but not as important as 'Lifestyle', 'Existing connection to the area', or 'Placement experiences as a Pharmacy student or pre-registration student'.

[71] Stakeholder comment

Finding 7: assessment of how current strategies that promote the Initiative could be improved to ensure that potential recipients are aware of the programs for which they are eligible to receive assistance and support could streamline promotion activities and enhance stakeholder awareness of programs.

Inadequate data

While the lack of relevant workforce has constrained this evaluation, it also potentially has constrained the capacity of the Initiative to be fully effective. The lack of data has meant that it has been difficult for those responsible for various aspects of the Initiative to identify areas of workforce need in any systematic and on-going basis. Ideally data would be readily available that allows for not only workforce shortages to be identified, but also then the impacts of implemented solutions monitored. KPMG is aware that this may be rectified given the national registration process that will take place from 1 July 2010 for all health care professionals including pharmacists.[72] Further, KPMG understands that the new authority will collect data as part of the new national scheme that will not only provide workforce data but data at a level of detail that will allow the type of analysis required to assess the distribution of workforce required to identify areas of workforce shortage. It is critical for that this data be harnessed for workforce planning, to direct program funding and to monitor the impacts of workforce programs.

Finding 8: there is no process or structure that allows the collation of workforce data required to assess workforce shortages and to monitor the impacts of program funding this limits the Initiatives ability to identify strategic priorities and respond to need.

7.4 Program efficiency

Program efficiency is considered from two perspectives:

- Administrative efficiency – is the proportion of total funding expended on program administration too high or are there opportunities to reduce this proportion.
- Recipient burden – is the level of burden placed on recipients in either applying for or being accountable for the use of the funds too high.

[72] http://www.ahpra.gov.au/index.php

Administrative efficiency

Administrative efficiency considers whether the expenditure on program administration can be reduced for a given level of program delivery effort. There is firm benchmark as much depends on what administration is required as some programs require little effort and others much more. For example, programs that are transactional in nature (such as recurring payments based purely on eligibility criteria) require minimal administration, whereas programs that require assessment of individual applications are more intensive. KPMG is aware from its work across many government departments involved in program funding of the non-government sector, that the default benchmark is in the order of four percent for transactional programs and in the order of ten percent for programs that require more intensive administrative input. The latter can be much greater where there is a high risk that requires a greater involvement of the administrators in program delivery.

Across the entire Initiative, administrative costs represent approximately five percent of total program funding (refer Figure 3 in section 4.1.1) while the Guild funding is equivalent to ten percent of the program funding that it administers which is broadly in the range of what would normally be expected, albeit possibly towards the higher end of what would be expected – some of the programs administered by the Guild are transactional in nature and others require more effort. Further, given the nature of the program activity being funded, they would represent low risk from a grants management perspective, thus suggesting that administrative costs of ten percent appear to be on the high side. KPMG was not required to undertake an independent analysis of these administrative activities and thus is not able to be more definitive regarding administrative efficiencies.

Perhaps the greatest opportunity for improvement in administrative efficiency relates to the opportunities to merge programs into a single funding stream thereby reducing the level of reporting and accountability required by both the grant funder and the grant recipient. Such opportunities exist where different programs fund the same recipient or programs have similar purpose. Examples within this Initiative include:

- Research and development orientated programs that could be merged with similar programs within the Pharmacy Agreement.

- Clinical placement programs that potentially could be administered through the University Departments of Rural Health who share not only a common interest but also receive funds for the Pharmacy Academics[73] who have a responsibility to support people who are placed in rural areas for experience and training in pharmacy.

Finding 9: there may be opportunities to merge related programs to improve administrative efficiency and potentially improve program effectiveness.

[73] Note that funding for the Pharmacy Academics at University Departments of Rural Health (UDRHs) is provided to the Universities not direct to the UDRH.

Stakeholder burden

There does not appear to be any onerous requirements placed on participants and other stakeholders who have an explicit role in the administration of the programs. All participants (recipients of program funding – who were surveyed, and organisations interviewed) were explicitly asked whether there were any material issues associated with the administrative program procedures. The overwhelming majority of recipients reported that they were satisfied or very satisfied with the administrative requirements (section 6.3) and only on one occasion during interviews with other stakeholders[74] was this issue raised as a concern. Moreover, it appears that moving to on-line application has proven effective and beneficial for all stakeholders (refer section 4.2.2).

KPMG has not undertaken an independent review of these procedures and thus is not in a position to comment on whether there are any opportunities to improve process efficiency for individual programs.

[74] Interviews with Academics and Pharmacy Schools.

A Stakeholders consulted

Detailed below are the stakeholders consulted during this Evaluation. Note that a number of other stakeholders were identified for consultation that declined to participate when contacted.

Name	**Organisation**
Karalyn Huxhagen	PSA
Helen Howarth	University of Tasmania
Chris Thompson	UniSA - Whyalla
Professor Beverley Glass	James Cook University
Associate Professor Lyndall Angel	Charles Sturt University
Associate Professor Pascale Dettwiller	Charles Darwin University
Dr Michael Angove	La Trobe University
Professor Alan Everett	University of Western Australia
Bruce Sunderland	Curtin Uni - CHAPANZ rep
Gordon Gregory	NRHA, SARRAH
Fiona Mitchell	Pharmacy Guild of Australia
Michelle Quester	Pharmacy Guild of Australia
David Pearson	DoHA
Marcelle Noja	DoHA
Suzy Saw	DoHA

B Survey questions

Evaluation of RPWP – Online Survey Questions

1	Please enter your post code

2	Are you • A registered pharmacists • A pre registration pharmacist • A student • Other please specify

3	Are you currently working in a rural pharmacy If you are currently working in a rural pharmacy how long have you worked in rural pharmacy? please indicate what attracted you to work in rural pharmacy (tick all that apply) • The lifestyle • Existing connection to the area • Availability of incentives • Placement experiences as a Pharmacy student or pre registration student • Other please specify

4	Which of the following rural pharmacy programs have you accessed in the last five years (please select all that apply) • Rural Pharmacy Maintenance Allowance • Rural Pharmacy Start up Allowance • Rural Pharmacy Succession Allowance • Emergency Locum Service • Continuing Pharmacy Education (CPE) allowance • Pre Registration Incentive Allowance • Rural Placement Allowance (students) • Rural Pharmacy Scholarship Scheme (students)

The following questions were repeated for each of the programs the respondent has accessed

5	How did you find out about the *Insert Program Name* program • Rural Pharmacy newsletter • Rural Pharmacies website • The Pharmacy Guild of Australia • Word of mouth • Another pharmacy publication (please specify) • Medicare Australia

	• University publication or communications (please specify) • Careers Counsellor • Other please specify

6	Please indicate to what degree the *Insert Program Name* program has helped you in the following areas				
		A lot	Some what	Not at all or very little	N/A
	All respondents				
	Continue or commence practicing as a rural pharmacist				
	Network with other pharmacists				
	Access education opportunities I could not otherwise accessed				
	Pharmacy owners only				
	Hire more staff				
	Open longer hours				
	Provide a wider range of services to the community				
	Meet the ongoing costs of running my Pharmacy				
	Open a new pharmacy business				
	Other please specify				

7	Please indicate how satisfied you were with following aspect of the *Insert Program Name* program				
		Very satisfied	Satisfied	Not satisfied	N/A
	Application process				
	Timeliness of payments / service response				
	Ongoing reporting requirements				
	Meeting my expectations				

(note if a respondent selected not satisfied the survey prompted the respondent to provide more information)

8	Do you have any other comments about Rural Pharmacy Programs?

C Individual program detail

C.1 Pharmacy allowance schemes

C.1.1 Rural Pharmacy Maintenance Allowance

The Rural Pharmacy Maintenance Allowance is a payment scheme available to rural and remote pharmacists in operating in PhARIAs two to six. Payments are made according to the Pharmacy's remoteness classification under PhARIA and its prescription volume and are designed to provide the most funding to smaller pharmacies in the most remote locations. The payment matrix is provided in the table below.

Table 47 Payment matrix for the Rural Pharmacy Maintenance Allowance

Prescription volume range Based on median script volume of 30926		PhARIA category				
		2 Accessible (group 1)	3 Accessible (group 2)	4 Moderately accessible	5 Remote	6 Very remote
0	30926	$10,935	$13,669	$20,777	$31,166	$41,555
30927	38658	$9,842	$12,302	$18,590	$27,885	$37,180
38659	46389	$8,748	$10,935	$16,403	$24,605	$32,806
46390	54121	$7,655	$9,568	$14,216	$21,324	$28,432
54122	61852	$6,561	$8,202	$12,029	$18,043	$24,058
61853	69584	$5,468	$6,835	$9,842	$14,763	$19,684
69585	77315	$4,374	$5,468	$7,655	$11,482	$15,310
77316+		$3,281	$4,101	$5,468	$8,202	$10,935

Maximum payment

Minimum payment

C.1.2 Rural Pharmacy Start Up Allowance

The Rural Pharmacy Start Up Allowance is a payment scheme designed to assist the establishment of new pharmacies in remote and very remote locations (PhARIAs five and six) in Australia. The allowance provides $100,000 paid in three instalments over two years to eligible new pharmacies.

In order to be eligible to receive the Rural Pharmacy Start Up Allowance the new pharmacy owner must:

- Have obtained an Australian Community Pharmacy Authority (ACPA) recommendation for approval for new pharmacy in a rural location;

- Demonstrate that the new pharmacy:
  - Will result in an overall increase in pharmacy services available in the rural/remote location.
  - Does not result in the reduction of services in another rural or remote area serviced by that applicant;
  - Will have a registered pharmacist in attendance for no fewer than 20 hours a week over at least four days per week;
  - Has broad community support for its introduction (including evidence of community consultation);
  - Is sustainable in the longer term; and
  - Be open at a minimum of 35 hours per week over a minimum of five days.[75]

C.1.3 Rural Pharmacy Succession Allowance

The Rural Pharmacy Succession Allowance is designed to assist in the sale of rural and remote pharmacies where the owner has been unable to sell their pharmacy for a period of two years or more by providing a financial incentive payment to support the new payment to support the operation of the Pharmacy.

The Allowance pays $60,000 in three payments over two years to pharmacists purchasing a rural or remote pharmacy that:

- Is located in PhARIA categories four (moderately accessible) , five (remote) and six (very remote);
- Has been on the market for more than two years;
- Is not located with in 10km (shortest lawful access route) of another pharmacy; and
- Had an averaged PBS/RPBS script volume of 3,000 per annum in the three years prior to sale.

[75] DoHA n.d. *Start Up Allowance Business Rules*, document provided by DoHA

C.2 Rural Pharmacy Workforce Agreement

C.2.1 CPE Allowance

The CPE allowance provides financial support to pharmacists, pre registrants in rural and remote areas to assist them to access professional education and development opportunities. Financial assistance under the program is provided for reimbursement of:

- Travel and accommodation costs associated with
  - Recognised CPE activities,
  - Pharmacy workforce re-entry courses and other courses that assist re-entry
  - Attendance at conferences and seminars where there is direct relevance to rural health service delivery.
- Costs associated with obtaining locum relief (i.e. locum travel and accommodation) while undertaking CPE/professional development, but not including locum wages.
- Travel and accommodation costs associated with travel for trainers and professional educators to travel to rural and remote areas to deliver professional education to rural and remote pharmacists.

The maximum amount a pharmacist can claim per allowance is $2,000. There is no cap on the number of times a pharmacist or pre registrant can apply for the allowance.

The program is administered by the Guild. In administering the program the Guild has responsibility for the:

- Acceptance and assessment of applications for the allowance;
- Reimbursing successful applicants for incurred costs;
- Development of a Project Plan and Business Rules for the program; and
- Promotion of the program and the provision of a promotion plan to the Department.

C.2.2 Emergency Locum Service

The Emergency Locum Service assists pharmacy owners in PhARIA categories two-six in sourcing a locum in emergency situations such as:

- Where the pharmacist is unable to undertake dispensing duties or to fully and effectively operate the pharmacy due to illness or injury;

- Where a family emergency requires the pharmacist to be present at an alternative location, or take action that renders him/her unavailable to undertake dispensing duties or to fully and effectively operate the pharmacy; ("family emergency" is defined as illness or injury to a member of immediate family; illness or injury to a dependent relative; bereavement due to death of a member of immediate family).

Financial assistance up to $2,500 is provided to cover travel and accommodation costs of the emergency locum. There is no limit to the number of times a pharmacist can access the program.

Assistance in sourcing a locum is provided via a website and 1800 number that rural and remote Pharmacists can access. Access to the website and telephone number has been expanded to include PhARIA one Pharmacies however no financial assistance is paid to these pharmacies in relation to the locums travel and accommodation costs.

The program is administered by the Guild with the service sub-contracted to an external provider.

C.2.3 Rural Pharmacy Scholarship Scheme

The Rural Pharmacy Scholarship Scheme provides financial support to pharmacy students from rural and remote areas. Scholarships of up to $40,000 ($10,000 per academic year) are awarded to successful applicants who meet the following criteria:

Have a connection to a rural area by:

- Having resided in a defined rural area for five consecutive years or eight cumulative years from the age of eight; and

- Being a member of the student Rural Health Club or a member of the Universities affiliated Rural Health Club or indicates intention to join a rural health club.

Scholarships are awarded based on a scoring system that considers the applicants degree of connection to a rural area and financial hardship including the following three criteria:

- Rural experience (how long they have lived in rural areas);

- Attendance at rural primary school (attending a rural primary school for at least one year adds an additional loading to rural experience); and

- Financial need (based on assessable income).

Under the program scholarship students are connected with a mentor to support their learning and development and help them to develop a learning plan. Mentors are practising rural pharmacists. An incentive payment of $220 is paid to mentors each year.

Scholarship holders report against their Learning Plan and on the rural activities they have undertaken during the academic year.

C.2.4 Rural Placement Allowance

The Rural Placement Allowance Program provides funding to 16 pharmacy schools across Australia for the provision of allowances to students undertaking placements in rural and remote areas as part of their pharmacy course work.

Universities that are funded under the program include:

- University of Tasmania
- University of Sydney
- University of Queensland
- Monash University
- Latrobe University
- Charles Sturt University
- University of South Australia
- Curtin University
- James Cook University
- University of Newcastle
- University of Canberra
- Griffith University
- Charles Darwin University
- Murdoch University
- Queensland University of Technology
- University of Western Australia[76]

Funding levels to universities are determined using a funding formula that takes into account the number of placements undertaken in the previous academic year.

The program guidelines provide high level eligibility criteria for students undertaking placements in rural and remote areas, primarily relating to the PhARIAs in which they are undertaking the placement to receive the allowance. The guidelines also prescribe the maximum payment allowance per placement which is $3,000. Universities may overlay these broad guidelines with the universities own policy regarding the provision of allowances.

The program is administered by the Guild, however individual universities administer the payment of allowances to students.

[76] University of WA has opted out of the program due to constrained administrative resources

Administrative requirements under the program include:

The Guild

- Entering into formal agreements with each university
- Payments to universities for the administration of the scheme (three payments per annum – 2008 moved from an annual payment)
- Publicising and promoting the scheme
- Developing reporting formats for universities and receiving biannual reports from universities
- Reporting to DOHA

Universities

- Publicising and promoting the scheme
- Managing student application and allowance allocation process
- Reporting to the Guild

C.2.5 Administrative support to pharmacy schools

Administrative support to pharmacy schools provides $20,000 per annum to the universities participating in the Rural Placement Allowance Program.

C.2.6 Pharmacy Academics at University Departments of Rural Health (UDRH)

The Pharmacy Academics at University Departments of Rural Health Program provides funding to universities for an academic position to:

- Raise the profile of rural pharmacy within Pharmacy Schools and University Departments of Rural Health, and to increase rural content in rural curricula so that pharmacy graduates will be equipped with the necessary skills to practice effectively in rural areas;
- Ensure that pharmacy graduates will have an awareness of the relevant issues involved in the treatment and care of rural populations and to encourage them to practice in rural and remote communities;
- Provide advisory, mentoring and developmental support to pharmacists practising in UDRH areas and to increase the number of trained preceptors to supervise students in the area; and
- Provide academic support and mentoring to students on internship placements in UDRH areas.

The program provides $80,000 per annum to fund an academic position at the following UDRH's.

- Broken Hill UDRH;
- Mount Isa Centre for Rural and Remote Health;
- Alice Springs Centre for Remote Health;
- Shepparton UDRH;
- Tasmanian UDRH;
- South Australian Centre for Rural and Remote Health;
- Combined Universities Centre of Rural and Remote Health at Geraldton;
- Greater Green Triangle UDRH in Warrnambool;
- UDRH Northern New South Wales in Tamworth; and
- Northern Rivers UDRH in Lismore.

C.2.7 Rural Pharmacy Promotion Campaign

The Rural Pharmacy Promotion Campaign promotes rural pharmacy as a career option to:

- High school students;
- Pharmacy students; and
- Pharmacists.

The program is administered and actioned by the Guild which is required under the Rural Pharmacy Workforce Agreement to:

- Undertake market research to determine the most appropriate promotion campaign;
- Development and actioning of an implementation plan for the undertaking of promotion activities; and
- Development of promotional materials.

C.2.8 Rural Pharmacy Newsletter

Under the Rural Pharmacy Workforce program funding is provided to the Guild to develop and distribute a biannual rural pharmacy newsletter via the Guild website and a mailing list of subscribers. The intent of the newsletter is to publicise rural initiatives under the rural pharmacy workforce program and create networking and distribution opportunities with other organisations.

C.2.9 Small Project Funding

The Small Project Funding program provides up to $20,000 for the exploration of innovative ideas and service development in rural and remote communities that:

- Demonstrate capacity for ongoing benefits to the community after the completion of the project;
- Demonstrate involvement of a pharmacist or pharmacy related organisation in the development of the proposal;
- Do not duplicate existing resources or initiatives[77].

Projects must include the involvement or a rural pharmacist. Funding is provided for:

- Staff and personnel required for the project;
- Essential equipment that would not be reasonably supplied or available to the project team;
- Administration costs of the project;
- Official travel for conduct of the project;
- Printing, phone and fax costs; and
- Other expenses as justified and accepted by the Selection Committee.

C.2.10 Rural Commissioned Projects

The rural commissioned projects program provides funding to explore priority research issues identified by PPSAC.

[77] *Small Projects Scheme Eligibility Criteria and Guidelines*, September 2008 and *Rural Pharmacy Workforce Program Funding Agreement, Fourth Pharmacy Agreement between* DoHA and PGA, 20 February 2007

C.3 Pre Registration Incentive Allowance

The pre registration incentive allowance provides funding to rural and remote pharmacies employing a pre registration student for a six or 12 month placement.

In order to receive an allowance under the Rural Pharmacist Pre-registration Incentive Allowance, applicants must meet the definition of an Approved Pharmacist or an Approved Hospital Authority and the following criteria:

- must be an Australian citizen or permanent resident of Australia;
- must have completed a pharmacy course approved by an Australian Pharmacy Board and be eligible to undertake pre-registration training requirements;
- must be employed by the Approved Pharmacy for a minimum period of six continuous months;
- must agree to participate in longitudinal studies to evaluate the effectiveness of the allowance;
- must agree to the reporting requirements in these Rules; and
- must consent to disclosure of personal information for the purpose of monitoring and managing the allowance.

Pharmacies eligible for the allowance must be located in PhARIA categories one-six (PhARIA Category one excludes capital cities and suburbs and some large regional cities). The pre registrant must also be:

(i) The applicant must be located in the PhARIA categories of:

- PhARIA 2 – 6, or
- PhARIA 1, excluding the following areas:
    - Sydney & suburbs
    - Melbourne & suburbs
    - Adelaide & suburbs
    - Perth & suburbs
    - Brisbane & suburbs
    - Hobart & suburbs

- Canberra & suburbs
- Cairns
- Sunshine Coast
- Gold Coast – Tweed
- Townsville
- Geelong
- Newcastle
- Wollongong
- Queanbeyan

The PhARIA index applicable as at the date of the application or the commencement of the engagement of the Pharmacy Pre-Registrant, which ever comes first, will be used to determine eligibility;

(ii) The applicant must meet the appropriate State or Territory Pharmacy Board preceptor requirements, and

(iii) The applicant must agree to the reporting requirements in these Rules.

Allowance payments are made to the pharmacy employing the pre registrant. Five thousand dollars is available to pharmacies employing a pre registrant for six months and $10,000 is paid to pharmacies employing a pre registrant for 12 months.

Allowances to pharmacies are paid in instalments as follows:

- Six month placement:
  - First instalment $2,500 within 28 days of approval of the application; and
  - Second and final instalment $2,500 on completion of the placement and the Guild's acceptance of the final placement report by the pharmacy.
- Twelve month placement:
  - First instalment: $5,000 within 28 days of approval of the application;
  - Second instalment: $2,500 on completion of first six months of the placement and the Guild's acceptance of the mid placement report by the pharmacy; and

- Third and final instalment: $2,500 on completion of the placement and the Guild's acceptance of the final placement report by the pharmacy.

Pharmacists and pre registrants are required to provide the Guild with mid placement and final placement reports containing the following information:

- Mid placement reports contain prose regarding: how the allowance has assisted the pharmacist in employing the pre registrant and the experience of the pre registrant in working in a rural area.

- Final placement reports include:

  - Future intentions of the pharmacy to employ other pre registrants, and general comments about the program; and

  - The pre registrant's experiences and future intentions/considerations about working in rural pharmacy.

D PhARIA classification and categories

D.1 PhARIA classification

PhARIA was designed to provide a comprehensive, standardised measurement of the physical and professional remoteness of pharmacies throughout Australia, for use in the determination of rural and remote pharmacy allowances.

The concept of remoteness used in this categorisation draws on previous work undertaken by the Department of Health and Ageing and GISCA, to create the Accessibility and Remoteness Index for Australia (ARIA), which quantified geographic remoteness based on the road distance people have to travel to reach a range of services.

The Pharmacy ARIA is a composite index, which incorporates measurements of general remoteness, as represented by ARIA, with a professional isolation component represented by the road distance to the five closest pharmacies. The locations of more than 13,850 populated localities were used in the development of the index.

Within the index, spatial rules have been applied to ensure that anomalies do not occur in the treatment of areas closely surrounding urban centres. These apply a 'buffer zone' around a centre so that any location falling within that zone will receive the same index as that centre. This zone consists of a 30 km radius around the external boundary of major centres (greater than 250,000 population), and a ten km radius around the external boundary of remaining population centres with a population of 18,000 or more.

A further refinement was included to ensure that all urban centres with a large number of existing pharmacies were classified as highly accessible.

D.2 PhARIA Categories

The index values range from 0 (high accessibility) to 12 (high remoteness), that are then used to form six categories as follows:

Category	Index number	Classification
Category 1	0 - 1	Highly Accessible
Category 2	>1 - 2	Accessible (Group A)
Category 3	>2 - 4	Accessible (Group B)
Category 4	>4 - 6	Moderately Accessible
Category 5	>6 - 9	Remote
Category 6	>9 - 12	Very Remote

The index provides an objective basis for rural and remote payment arrangements as well as being a useful analytical and policy tool which could aid the further analysis of the provision of pharmacy services in remote areas.

The following table illustrates the number of pharmacies in each PhARIA category.

PhARIA Category	Number of pharmacies
Category 1	4,282
Category 2	251
Category 3	315
Category 4	136
Category 5	122
Category 6	71

E List of Abbreviations

RPWP	Rural Pharmacy Workforce Program
UDRH	University Departments of Rural Health
ASGC	Australian Standard Geographical Classification
ASGC-RA	Australian Standard Geographical Classification –Remoteness Area
PhARIA	Pharmacy Accessibility/Remoteness Index of Australia
DoHA	Department of Health and Ageing
CPE	Continuing Professional Education
PPSAC	Professional Programs and Services Advisory Committee