Review of Pharmacy Remuneration and Regulation
Discussion Paper

Comments on the 140 Question

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Question 1: **Ratio of pharmacies to population**

This is a very crude management indicator. In rural and regional Australia, the number is meaningless if the next pharmacy is 40 or 140 kilometres from your pharmacy options.

In a former lifetime I was president of the Remote and Isolated Pharmacists Association of Australia RIPAA. I also worked with the Pharmacy Guild in the establishment of the Rural Pharmacy Maintenance Allowance as well as the Pharia structure.

In many communities in rural Australia, the community may be as few as 1000 people and many will be on property up to 20 to 40 kilometres from town. The pharmacies are an essential component of the health care of these communities.

In the past decade the dramatic change to the commercial nature of pharmacy has complicated the viability of these small rural community pharmacies. Their essential nature is not recognised by government the same way as GPs are in such communities.

Question 2: **Ratio variability**

As stated above, community health delivery varies greatly between city suburban and rural Australia. Centralised referral hospitals concentrate resources of hospital, specialists, allied health and GP in these areas.

Systems are coordinated by State governments to enable patients/clients to attend these services. Pharmacy services due to the Commonwealth funding and private ownership are excluded from any complementary services.

Services such as Dose Administration Aids, Home Medication Management reviews are not a profitable as larger metropolitan and regional centres. Also the difficulty in accessing locum, specialist and/or relieving pharmacists are generally not readily available nor a viable option.

A formula to address this discrepancy would be complex due to the multiple variables. A gross single support payment may not necessarily result in better service delivery. The formulae used for GPs is generally “rorted” or “abused” by some who are concentrating only on their next move into the regional or metropolitan areas.

The issues that should be addressed:

- Prescription remuneration should be constant Australia wide, including access to all PBS items at consistent prices and frequency of delivery, including companies that will only supply direct.
- Pharmacy services funded under the CPAs should have a premium based on the Pharia location. However, a maximum number at the higher premium would be applied.
- The Rural Pharmacy Maintenance Allowance would continue, however would be expanded to include:
  - Location allowance to cover access to locums and other staff services, plus
  - A five yearly access to special grants to adapt, change, enhance the pharmacy to meet the new services. These grants would be based on a business proposal and feasibility.
  - A grant proposal to cover travel and accommodation as well as locum to attend approved CPD events. Again grants would be limited to minimum CPD requirements and isolation as well as suitability of event as assessed by PSA/PGA. These grants
would be available to pharmacy owners as well as pharmacists who spend more than 40 weeks per annum in designated Pharia.

Question 3: Retail space Vs Professional Space

Pharmacies are the most frequently accessed health service in Australia. One of the significant reasons for this is the “low threshold” of entry. A customer does not feel threatened to enter the pharmacy due to the range of merchandise available.

This factor has changed in recent times with the expansion of commercial services expanded by certain pharmacy models.

The difficulty with certain models in that the balance between professional and commercial has shifted more to the commercial. The Pharmacy Legislation demands that there must be a “Pharmacist in Charge” at all times. A pharmacist cannot be “in charge” of commercial sales the expense of their availability for their professional services.

The legislation needs to be changed to address the maximum number of staff a pharmacist may be “in charge” of.

Question 4: Remuneration model

As mentioned above, the remuneration model should be consistent. However, the maximum units should be assessed.

Question 5: CPA

The move from the supply function to a more professional service function is a positive one. The CPA should however further move to Community Pharmacy Practice Allowance (CPPA).

This would include issues outlined in Question #2 above where, the CPPA would be directed at professional services, it would however extend to practice development grants and direct funding of specialist staff within a designated practice model.

Question 6: Medicine distribution

The National Health Act in the 1960’s committed to universal access to “essential” medicines at an agreed patient co-payment/fee. The changes to various co-payments including the latest “discount” option on co-payments have “muddied the water” in this element of the legislation. This is particularly relevant in rural areas where the various mega-retail options are not available.

The fact is that some PBS items have several price points which can vary for the same patient depending on where they have the prescription written.

The basic tenet of one month’s supply for regular medication with some long term medication have three month’s supply, dictates a frequent visit the pharmacy. This is reinforced by the 20-day rule.

The 20-day rule and the “authority quantity” rule do complicate issues for people isolated from a pharmacy in rural areas. Certain times of the year (harvest, shearing and farm work), certain climatic events (rain and drought) and certain schedules for trips into town (sale day, supply pickup) can limit access to a pharmacy. This will impact on the cycle certain people can access their medicines.
There is a significant complementary cost of this is the frequency of visits to GPs for minor reviews for the sole purpose of obtaining repeat prescriptions.

Pharmacists should have a great role in the Health Plan to work with the patient, their GP and/or other health professionals to ensure that there is a continuation of their medication.

**Question 7: CPA limited to Community Pharmacies**

The basis of my premise is that community pharmacy is a hub for a range of services to assist the community in their health management. Being linked to the distribution and supply of prescription medicines makes these services integrated and consistent.

Therefore, community pharmacies are the best location to provide the CPA services.

Health care in a community pharmacy has a combination of delivery models, all of which are customer focused.

**DIY: Do it yourself**

This is the most traditional way people have approached their health-care needs. If they notice something is wrong with themselves or the person they are caring for, they will seek out a solution from a number of resources; Dr Google, their own knowledge base, a text book or will ask someone, generally a nurse or a pharmacist.

These same people will manage their medication as prescribed by their doctor or may select a product from the pharmacy. The Community Pharmacy DIY Health products are:

- Prescriptions
- Over the Counter medications
- Pharmacist prescribed medications
- Wound Care etc.
Like all DIY products, most are appropriate, reliable and affordable. Whilst others are potentially dangerous and contra-indicated in certain circumstances.

DIY suppliers, like Bunnings, offer solutions from an extremely wide range of products. The onus is on the purchaser to choose correctly and fully understand the implications of the item selected. Their staff demonstrate only those items which are not subject to installation rules.

For example, Bunnings will sell specialised electrical switching equipment designed to be installed by an electrician or particular components that are part of projects which require approval by Councils and certifying bodies. They make no distinction between purchases or those who select such products because their customer base is a mix of professionals and amateurs.

Community pharmacies however must provide all scheduled medicines (pharmacy only and pharmacist only) “In a manner and for a purpose as defined in their TGA approval”. Therefore, all pharmacy staff must be trained for this purpose.

When a community pharmacy is open, an appropriately accredited pharmacist must be on duty and available to assist and supervise all transactions.

**DIFM: Do it For Me**

This expansion of pharmacy practice began in the 1980’s and 90’s with the introduction of computers and computer records and the development of dose-administration aids.

Community pharmacies have digital records of medications, compliance/concordance status, interactions and contra-indications checking to assist in the more accurate dispensing of prescriptions, from all sources.

As medications became more sophisticated with multiple disease states managed simultaneously, generic substitution (complexity to remember names), and multiple daily dosing regimens, dose administration aids are the DIFM solution.

Since 2010, the 5th Community Pharmacy Agreement (5CPA) remunerated pharmacists to provide a complete range of services to ensure the safe and proper use of medicines. This process also extended other services;

- Blood pressure monitoring with a reporting mechanism to GP
- MedsCheck, a scheduled consult to update client/patient on their medications and discuss any issue relating to their medication, their diet and/or other non-prescribed supplements.
- Staged supply for certain medications requiring additional storage conditions for safety or cold chain requirements.

The 6th Community Pharmacy Agreement (6CPA) extends these services, however remuneration is dependent on significant research demonstrating the “cost benefit” of such services.
DIWM: Do it With Me (A pharmacist managed Care Plan)

This is an extension where the client becomes the control executive in the process. This involves a contract with the pharmacist and others to achieve a desired health outcome. Because of the frequency of contact, the pharmacist is the operations manager of this process. This increased contact makes the rural community pharmacy and the pharmacist a better mix.

Just like in a company board, the directors contribute various expertise. The chair (the patient or primary carer) has the casting vote and approves the plan and implementation strategy.

A DIWM project would have all the same elements;

- Approved plan including timeline, budget and outcomes.
- Implementation schedule and resources
- Manpower and
- Contracts

**Question 8: Negotiation with Guild**

As stated above the most appropriate location for a CPA delivery centre is a community pharmacy. The Pharmacy Guild is the body representing the majority of pharmacy owners. As such it is reasonable and logical that it is involved directly in these projects.

The Pharmacy Guild and the Pharmaceutical Societies as well as the universities and other independent suppliers have opportunities to tender for the delivery of the agreed services.

**Question 9: Negotiations for supply contracts**

As stated in answer to Q8, there should be one agreed document representing all community pharmacies.

Tenders to supply services in this agreement should not be limited and could be contracted/tendered by various suppliers.

**Question 10: Business model**

Pharmacy Acts around Australia started to change ownership rules in 1988. From a single pharmacy ownership to a partnership of up to three pharmacies to now incorporated, multi-state, multi-pharmacist ownership.

The changes to the business model, has not necessarily been in the patient/customer/client interest. As has been demonstrated by the duopoly in supermarkets, their locations and service model is defined by shareholder interest.

Pharmacies are still recognised as the most accessible health professional. Their distribution is vast across the nation.

The large foot-print, mega-range stores are only suitable for highly populated areas. Likewise, hospital and specialist services are restricted geographically.
Experimentation in the 1980s of publically owned pharmacy services providing solely PBS and related services were unsuccessful due to low visitation rates and the high “threshold” level of access. This was due to such entities being not convenient and not providing the full range of services and as such had to attend other sites/pharmacies as well.

Research in 1996-98 by RIPAA found that entities with no on-site pharmacist owner, particularly in rural and remote areas, in the main provide a less integrated service. This was confirmed by the National Rural Health Alliance at conference in Perth in 1998.

The alternative approaches would be to assist pharmacists to own rural pharmacies, to expand the ranges of services so as to integrate other health professionals, including visiting health professionals.

**Question 11: Access to Medicines**

The argument used most by media commentators is that price is the sole determinate of “access”. This does not ring true to rural and remote patients. The determinates are; timeliness, convenience, support and price.

Community pharmacies must be able to have access to all medicines on the PBS, including s100 items as and when required by their communities. The access price should/must be identical with all other pharmacies and hospital suppliers.

Community pharmacies who are providing a specialised low frequency service should be supported by specific designated training and mentorship so as to provide the most appropriate support.

**Question 12: 6CPA limitations**
The assertion that all proposed 6CPA services must demonstrate a community benefit and a cost benefit limits access to small targeted projects.

The focus has now been limited to a small range of broad demographic services such as diabetes management. This in itself is most beneficial. Most smaller projects could not be constricted as a clinical trial to achieve the scientific or fiduciary rigour to qualify.

Projects such as;

For Example

**Plan Title: Blood Pressure Control Care Plan**

Plan: Reduce BP (eg from 150/100 to 130/85) by DD/MM/YY

**Plan Elements:**
- Medication compliance and side-effect monitoring
- BP monitoring
- Weight control
- Stress triggers and management

**Plan Team**
- GP or specialist
- Pharmacist
- Dietician (Sky-Clinic)
- Exercise physiologist (Sky-Clinic and SMS text)
- Counsellor (Sky-Clinic)

**Plan Resources**
- Pharmacy clinic room
- Audio Visual equipment
- Digital data collection
  - Scales
  - BP meter
- Personal activity meter
- Reporting software

Other items which may me suitable for such an activity

This type of project could not be funded under 6CPA in 2016 because there is no financial plan that demonstrates its benefit.

I believe the 6CPA should be innovative and any application for funding should be assessed on the specific proposal and the benefits gained by the community. These could be direct or indirect benefits.
Question 13: Paper prescriptions

I believe the question raised does not address the “patient” issues in general.

The major demographic who have prescriptions dispensed are over 55 years. Many of these people have limited access to the electronic network and have difficulty managing the various rules relating to their access to their medicines.

Many people have engaged a system in the pharmacy which devolves their responsibility for managing their paperwork to the pharmacist. However, the majority, in my experience, want to be able to see and reconcile their accessed medications.

As stated above, the complicating issues with many people is the conflicting rules for timely access to their medications.

When a patient visits their GP for a medication regimen, for example for BP. They have a Care Plan with a 6 monthly review. However, some of the medications have restricted repeats that will not last for the 6 months or alternatively due to standard pack size and scheduled regimen, the 20-day rule may be invoked.

There should be much better integration, where elected by the patient/consumer/carer between the prescribers (GP, specialists, clinic nurses), support staff (allied health, transport and residential services) with the pharmacist in a community pharmacy to deliver the Care Plan. NOT just the paperwork.

Question 14: Pharmacy legal protection

The catch 22 is that with the ownership legislation changes that have led to a significant extension of the commercialisation of community pharmacy. These mega-enterprises are loosely covered under the current legislation.

The impact of this development is that fewer pharmacists are in fact pharmacy owners. Pharmacy numbers have increased only slightly over this period.

The legislation in 1980 introduced the registration of pharmacies as well as pharmacists. This provided a register of pharmacy interest. By 2005, the number of pharmacies an individual pharmacy may own in each state increased to five either solely or in a partnership or corporation of pharmacies. By 2016, the development of mega-chains with extended hours coupled with a larger number of graduates completing their registration has concentrated the ownership even further.

Based on my experience on the Pharmacy Board of NSW between 1988 and 2001 as well as data provided in the review document and the APRHA registration board papers, her is the approximate change in relationship between employed pharmacists and pharmacy owners.

PBS pharmacies actually declined in the early 1990s due to the “Buy Back” scheme introduced by the Hawke Labor government.

The mega-stores in 2016 are incorporated practices with a large number of partners, many with minority shareholdings.
During the 1990s the number of absentee owners in rural and remote Australia was limited. This has, based on anecdotal information increased to almost 33%.

Is this present scheme the best option?

As stated above, the present development of the ownership structures of pharmacies has been for the benefit of the minority (<30%) of pharmacist as owners. If this was extrapolated to include only those pharmacists with a majority shareholding in multiple sites and multiple states, these pharmacists would be between 5% and 10% of the total pharmacist owners.

Therefore, I am convinced that the present system is not in the majority of pharmacists’ interest and by extrapolation against the public interest.

Megastores and corporations will not necessarily improve consumer access to medications, particularly in rural and remote Australia.

Business models could be developed that met a set of criteria based on location and community need that will encourage ownership, improve viability and expand the role of the commpyty pharmacy.

**Question 15: Broad Brush Remuneration**

The NHS Legislation determines that all Australians have access to the full range of PBS medicines at a single negotiated price.

This is a broad-brush approach.

Certain medications and certain locations have lower delivery costs. However, many specialised medications have the direct opposite to these. A pharmacy, for example an afterhours business adjacent to a bulk-billing medical clinic may have a concentration of low cost single use medications, which can be highly profitable.

Whereas another pharmacy may have a concentration on highly specialised medications, which require additional service levels and lower percentage margins, which may not be as profitable.
As stated above, my recommendation is that the base remuneration be supplemented by a range of services funded by the CPA and delivered by community pharmacies.

**Question 16: Reward for Effort**

The dispensing of prescriptions (original and repeats), like a standard visit to a GP, should be set and reviewed annually.

Coupled with this, as stated above, there should be a range of additional services a patient can elect to receive. These can be funded by patient in full or as a co-payment or by the government (CTG and SN).

In Canada in 1998, there was a program introduced that paid pharmacists for prescriptions that “declined to dispense”. This was a function where a patient presented a prescription which was contra-indicated, duplicated, outside agreed therapeutic guidelines or unnecessary (excess supply). This scheme relied on a centralised data base and was designed to give pharmacists and incentive not to over-supply and to react more vigorously to clinical interventions.

A pharmacist was paid double the standard dispensing fee (Canada did not have a mark-up on item) if they “declined to dispense”. This required the patient to sign a document confirming the pharmacist’s action. It did save considerable funds at that stage according to the documents available to me at that time (supplied by the Pharmacy Board equivalent of Canada at Conference in Sydney in November 1999).

We need to have a much more inclusive role in managing both the supply (standard administration cost) and the management (specific role fees or item numbers) of medications.

**Question 17: Adequate Remuneration Level**

See answer to Q16

**Question 18: Price and Discounting**

As stated above PRICE is only one element of the equation. GPs have the option of charge above the recommended fee.

In early 2014, there was a discussion on AusPharmlist regarding the role and remuneration of pharmacists. These were my comments

Whilst I accept that Professor Zellmer is a world authority on pharmacy from his base in the USA, which does not have a universal pharmaceutical benefits scheme, I do agree in principle with his view on pharmacy.

In America, the supply of medicines is controlled very differently to what happens here. There are a large number of pharmacists working in mega stores, mega-mail orders, mega-online businesses. Their function is vastly different to those of the majority of Australian pharmacists.

His view therefore “… it was universally acknowledged that the focus of a pharmacist’s professional activity must change from a supply function to a service function this may not be enough to ensure the profession survived and prospered. He argues that pharmacists must become more ‘deeply committed to helping people make the best use of their medicines’…. ” must be considered in that light
There was also the regular contribution by Mark Nicholson (accountant), who comes from a service industry, that gets paid for the “advice” and “commentary” he provides, who tells us that customers can differentiate between service levels and price.

His comment that “.. it means customers will not pay a premium for service(s) levels that do not exceed those of lower priced competitors including those online. Being able to navigate a store and find what they want easily is considered a key component of service. Price differences of over 10% on KVI (known value items) matter, and pricing cannot be a set and forget exercise”.

Customers demand a level of quality service. There is no substitute.

Customers also can differentiate between “opinion” and “advice”. There is some evidence to say consumers will pay for “advice” from a pharmacist. There is also evidence that beyond a small price premium, consumers will not pay for most pharmacist services. The consumer value most “opinion” provided by a pharmacist as no different from say a ‘colour consultant’ in the paint department at Bunnings.

Yet they will pay a fee to other ‘consultants’, such as tax agents, travel agents, design consultants and even other allied health professionals.

My views are unchanged. There should be an option for pharmacists to provide above the basic service for an additional fee.

Discounts are only a device used by certain entities to attract business, “Down Down..” for the corporation benefit, not the consumer and not the producer, cf $1/L Milk.

**Question 19: RPMA**

My experience both personally (Owner in Pharia #2, #3 and #4) and as president of RIPAA confirms that the RPMA is an essential building block for rural and remote Australia.

The RPMA however should not be a simple Broad Brush approach to a complex problem. In 1996 when the current system was reviewed, the cost of administering the payments was 125% of the actual payments. By 1998 when the PhAria changes were developed and the program revised as part of 2CPA the balance was better but not perfect.

In 2016, with PBS OnLine and electronic medication records, much better management of the additional cost of Regional, Rural and Remote Australia can be measured.

The key issues are;

- Professional staff, particularly locum and short term relief. Most pharmacies are open between 45 and 55 hours per week. This requires a minimum of 1.1 to 1.2 FTE pharmacists. In metropolitan and most regional centres locums are available for the 8 to 10 hour period. In most rural and all remote areas, this is not an option.
- CPD, is difficult to access due to travel and locum issues.
- Training of community pharmacy staff is also more costly and less available.
- QCPP accreditation costs
- The practical cost of developing resources and infrastructure in the pharmacy are also more difficult and less viable than in most regional and all metropolitan areas

The RPMA was designed to address only the professional staff issue. The CPD subsidised were addressed by a grant program managed by the Pharmacy Guild.
The ability to recruit and retain staff was another issue. This was assisted by the changes to the Visa requirements of overseas trained pharmacists who had a two-year window to work outside the major centres.

The recommendations for the RPMA are;

1. Review the PhAria allocations introducing additional elements into the calculations, particularly the transport options. The actual payments to be increased to reflect the differentiation in cost for provision the basic service level.
2. Provide a more accessible funding for CPD (now mandated)
3. Provide a partially funded staff placement process for full time positions as well as locums
4. Provide an expanded access for staff training
5. Provide a specified period for infrastructure funding based on detailed plans and costings
6. Access to subsidised specialists via Video Conference and on-site for professional services in the pharmacy

Question 20: Internet access

Rural and Regional Australia are rapidly changing to the NBN, which will increase the number of and range of services available in a community pharmacy.

This technology and support resource are not generally available in small rural communities.

The need for funding to optimise this system should be borne by the Commonwealth (as they do for GPs).

Question 21: Premium Fee Incentives

Generic prescribing is now at maximum levels (80%) in most pharmacies. This premium fee was another Broad Brush approach to a complex problem. The main issue now is the variable availability of certain brands.

These issue impact significantly on a pharmacist’s time. This should be remunerated as a higher rate. As stated above a pharmacist should be able to record such interventions and be remunerated for their actions.

Question 22: Payment Settlement time

Settlement times should be consistent. The cost to everyone to manage and monitor payments with variable schedules would out-weigh any benefit.

Question 23: Very High Priced Medications (>$/7K unit cost)

The National Health Act dictates that each item must be available to every Australian, regardless of location to every item listed on the Pharmaceutical Benefit Scheme.

The introduction in 2016 of items with very high value has compounded the issue of managing the wholesaler distribution and the attached credit limits on said accounts.

A solution is for a direct to manufacturer/distribution payment to cover bulk of the cost. Pharmacies have a fixed handling fee and wholesalers have a fixed handling fee for said items. Once the PBS authority prescription is dispensed and automatic payment is scheduled to the approved pharmacy AND the manufacturer. The wholesaler would have charged the pharmacy and the pharmacy would
pay the wholesaler with the normal settlement. The wholesaler would maintain an appropriate stock level as agreed with the manufacturer.

For example: Item with a current PBS listed item with a price of $20,000 (ex GST) plus PBS dispensing fee plus wholesaler handling fee. Under my proposed scheme

- Wholesale price to pharmacy is $45
- Pharmacy price on PBS is $115
- Government payment to manufacturer $19,900
- Government payment to pharmacy $115 in normal 7-day cycle
- Pharmacy payment to wholesaler $45 in normal trading terms

This scheme would take the risk out of distribution and could possibly reduce the overall cost of the PBS.

Question 25: Pharmacist services

Community pharmacies have the potential as outlined above to deliver a large range of services. The patient/client contact is considerably higher than for most other health professional. Pharmacists should not be seen as a quick, cheap alternative to attending a GP. They should be seen a part of the whole patient health management program.

Community pharmacies have a role in;

- Patient care plans, not just the medication but the data management and resource management, eg
  o Healthy Heart: a program designed to not just measure the BP of a patient, but to provide a regular report to the patient’s GP/Specialist based on their Goal BP, the exercise regimen, their weight management and other issues. Utilising the location of the pharmacy, AV and direct contact with exercise physiologists and dieticians. With electronic reports supplied to patients and GP/Specialists in a timely manner.
  o ShedIT: a program designed to monitor weight to a program specified by the GP. Working again with other allied health people.
- Medication management should include proving e-prescriptions to cover the interval of reporting of the care plan for each patient. Could be monthly, quarterly or yearly, provided the care plan criteria was met.

Community pharmacies would have to be structured differently. The pharmacies would be required to provide suitable resources to achieve the above.

We have already established a model for the following programs. Based on our client base we have rated the relevance to our client base, the importance for their health outcome, the range of clients we see and assist as well as the percentage of the prescriptions we dispense assist these clients.

<table>
<thead>
<tr>
<th>Sky Clinics Programs</th>
<th>Relevance</th>
<th>Importance</th>
<th>Pharmacy Clients</th>
<th>% Rx Dispensed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shed-IT</td>
<td>Weight Loss</td>
<td>High</td>
<td>Medium</td>
<td>Blood Pressure, Heart, Cholesterol, Diabetes, OTC Vitamins</td>
</tr>
</tbody>
</table>
Question 26: Product range

Pharmacies already voluntarily do not sell cigarettes. The clinical benefits of e-cigarettes are not yet clear and currently the supply of inhaled/vapoured nicotine is unregulated and unknown.

Also the supply of “medicinal cannabis” is subject to review. Pharmacies will need to be included in the supply of these products.

On the other hand, the range of items available in the pharmacy should be balanced against the services in the pharmacy. The importance of this balance is to lower the threshold of entry so as to encourage as many people to feel comfortable entering the pharmacy.

Professional products supplied in the pharmacy must meet professional standards. Other products can be included, provided the balance is maintained and provided they do not make quasi-medical or other health claims (eg homeopathic medicines)

Once inside the store there should be sufficient professional pharmacist staff to assist customers in their pharmacy needs. The “pharmacist in charge” should have limits of staff they have to supervise.

Question 27: Solely Dispensing Pharmacies

This as I stated above would be counter-productive. Pharmacy is a multi-stream delivery of health care.

- Prescription only and controlled drug dispensing
- Pharmacist prescriber and supply medicines
- Pharmacy only medicines
- Non-scheduled medicines and medication aids
The concentration on a single stream of this function would restrict customer access and contact with the pharmacist.

**Question 28: Business Model**

As I have outlined above the pharmacy business model should change from being a separate entity from other health professionals to being part of the “Health Hub” in their community.

This is very relevant in rural and remote communities where the community pharmacy could include;

- Access to other allied health professionals as outlined in Question 25 above
- Access to professional resources regarding health matters (instead of Dr Google).
- Managing and coordinating with suppliers of “in-home” services such as home nursing and meals
- Community health programs, such as
  - Baby and maternity programs
  - Health awareness
  - Immunisation
  - Transportation

Again based on this a community pharmacy could provide the current retail setting and within this structure could construct a specialised area for the above programs and clinic rooms for visiting “specialist pharmacists” as well as for nurses and other allied health professionals.

The retail setting makes this customer convenient and accessible. The annexes would provide the privacy and resources to achieve these goals.

**Question 29: Fee for advice**

In March 2010 as part of the 4th CPA, the recipients of grants presented their findings of their various research programs. I had one such paper relating to a program we designed for single pharmacist pharmacies in small rural settings.

There were a large number of papers presented relating to pharmacist services and the remuneration for these said services. This data should be available to the reviewers as my resources are limited to those I obtained copies.

The programs ranged from the simple practical ideas, through to the very expensive specialist programs.

The key points were that consumers see “information”, “advice” and “counselling” very differently to most pharmacists. The term “counselling” as used by pharmacists was very different to that used by the consumer. There was even some quantification as to how much the public would pay for each of these categories.

- **Information**: was categorised as general product information, including demonstration for use and re-enforcing information on the packaging. There were no records retained and the contact was made in the public area of the pharmacy. There was no fee attached to this process.
- **Advice**: was information tailored for the patient and includes additional supporting documentation (could be hand written) and took place in a designated semi-private area of
the pharmacy. The advice may or may not be associated with a prescription, medication or appliance. There were again no specific records retained. The consumers in this research considered a fee between $5 and $10 was reasonable.

- **Counselling**: was a session with a pharmacist on a specific topic including medication review, dose management, health check (BP or BG) or other health related topic. This event took place at a scheduled time in a designated place. Records were kept, documents were provided and reports prepared for others, were all part of the description. A fee of up to $20 was considered reasonable for a ten to fifteen-minute consult.

I believe the program should be revised as part of QCPP where an audited practice fee could be paid to pharmacies who provide the designated professional services. Each service would have a co-payment schedule similar to that with the PBS.

**Question 30: MBS service item number fee for advice**

As included in my answer to Q29, provided the pharmacy met the QCPP standards, there could be a designated fee paid via MBS.

The key would be to clearly define what is the “value consumers would place on this advice”.

**Question 31: MBS other item number fees**

As stated above the review should not limit the services to those items attached to a prescription. The list provided to my answers in Q25, should be covered by MBS item numbers with appropriate co-payments.

**Question 32: Identified service**

Q25 answers show how we have matched our “Better Health” model to our customer base.

This is particularly relevant in regional, rural and remote communities which in the main do not have many of these services other than as “FIFO” services.

**Question 33: Pharmacy service accessibility**

For a pharmacy service to be available they must be practical and financially feasible. The pharmacy is accessible and if any service with a community benefit is to be provided consistently and continuously, the service must be financially viable.

The viability is the key.

Resources in rural and remote community pharmacies could be provided with sufficient planning and balancing of the community needs.

**Question 34: Program design and Fee Structure**

There should be flexibility in the community need and priority. Not all communities are the same, the demographic, the geography and the resources vary markedly.

As outlined in Q25, we have targeted a range of programs based on our community needs. Some have higher operational costs, with lower numerical involvement however with a very high need, for example the stroke program.

Pharmacies may engage a range of contractors either onsite or via tele-health to achieve the goal.
The question of how the service is delivered should not be the reviewers priority. The questions to be answered are:

- Does the service meet the community need?
- Can it be delivered in the community pharmacy? And
- Is financially viable for both the provider and the funder?

**Question 35: Non-medicine services**

This question has been answered as part of several contributions above.

Yes, this is a natural extension of the community pharmacy role. Health and lifestyle are all relevant to an appropriately resourced pharmacy with suitably qualified staff.

**Question 36: Remuneration models**

As outlined above, pharmacist services and community pharmacy services should have a combination of MBS item numbers (when referred by GP/Specialists), Customer co-payment and third party payment (e.g. insurance).

Pharmacies providing approved programs need to have audited accreditation.

**Question 37: Cost barriers**

The answer provided in Q29 relates to research done in 2010.

Consumers may often refer to price being a restriction or limitation for the access to a program, the issue is more complex as access it also limited by availability, transport and relevance.

The research done in 2010 demonstrated that a large number of the programs developed were not viable because of all of the above reasons.

The programs and relevance of the programs we have developed have a range of funding/cost barriers. At this stage these cannot be assessed.

**Question 38: Clinical Value and Patient Outcomes**

Any service approved must comply with a demonstrated community benefit, community need and an a demonstrated cost benefit.

The issues that impact on the success of the operation of any pharmacy service are;

- Good management and business model designed to deliver the service
- Professional relationship with other health providers
- Appropriate resources
  - Environmental design and structure
  - Electronic network (NBN)
- Adequate training and availability of specialists

**Question 39: Remuneration model**

The NDIS has reconstructed the federally funded models of service delivery. This is similar in some manner to the insurance funding of programs such as return to work. It is vastly different to the MBS and PBS.
I believe that certain long term conditions could be funded similarly to the NDIS. Items such as stroke victims who have a combination of needs, from accommodation, mobility, medical and medication. These could be assessed and funded in the same way the NDIS works.

For all other services, I believe there should be funded as a referred service by a GP/Specialist if they are to be funded by the MBS item # process.

Pharmacist initiated services can also be funded by the MBS item # process, based on a patient care plan.

Consumers can of course contribute in full or in part for these programs.

**Question 40: Part or Full payment**

As with all MBS item # processes, these can be “Bulk-billed” or include a surcharge. Based on our designated programs, the following designations are provided as examples:

<table>
<thead>
<tr>
<th>Sky Clinics Programs</th>
<th>Outcome</th>
<th>Funding Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shed-IT</td>
<td>Weight Loss</td>
<td>Minor</td>
</tr>
<tr>
<td>Move Again</td>
<td>Stroke</td>
<td>Fully funded</td>
</tr>
<tr>
<td>Healthy Heart</td>
<td>Heart</td>
<td>Partial</td>
</tr>
<tr>
<td>Lung Action</td>
<td>Cardio Pulmonary</td>
<td>Partial</td>
</tr>
<tr>
<td>Rubiks cube</td>
<td>Musculoskeletal</td>
<td>Minor</td>
</tr>
<tr>
<td>Feelin’ Good</td>
<td>Pain Management</td>
<td>Partial</td>
</tr>
<tr>
<td>Keep on your Feet</td>
<td>Falls Prevention</td>
<td>Minor</td>
</tr>
<tr>
<td>Sugar Fix</td>
<td>Diabetes Management</td>
<td>Partial</td>
</tr>
<tr>
<td>Movers and shakers</td>
<td>Parkinson’s Disease</td>
<td>Fully funded</td>
</tr>
<tr>
<td>Exercise is Medicine</td>
<td>Cancer</td>
<td>Partial</td>
</tr>
</tbody>
</table>

- Minor: MBS item # funding would be limited to high risk clients only
- Partial: funding limited to high risk clients and pensioners/DVA clients
- Fully funded: All people who qualify however a co-payment would apply based on PBS status.

**Question 41: Innovation**

The current PBS model and the downward pressure on prices, limits innovation.

The pharmacy of the future as I see it will be:

- Approximately 300 square metres;
  - 75 square metres to dispensary
  - 35 square metres to clinic rooms for professional services
  - 75 square metres to professional products
  - 75 square metres to consumer items, patient/client service and waiting areas
  - 40 square metres for admin and staff areas
- Pharmacy product range would be focussed on health
- The pharmacy would have
  - Pharmacists on duty
    - Dispensary pharmacist
Question 42: Location rules

As a recipient of a Ministerial discretionary approval in the relocation of a PBS approval number into a Pharia 5 community, I can relate a detailed and expensive problem.

In 2010, a number of members of the community contacted my daughter and I to discuss the proposal to open a pharmacy in Moree. The town with a population of approximately 12,000 and a shire of almost 15,000. Moree had two pharmacies, both owned by the one owner. The pharmacies were strategically located to prevent another pharmacy opening due to 1.5K limitation. A third pharmacy was located in Mungindi some 100K away right on the northern border of the shire.

The rules at that stage consider there would be no community with only two pharmacies and fewer than 8000 people.

The ACPA rules could not be complied with so it involved an application to the Minister. Actually it required some six applications to the ACPA, two applications to the Minister and then defence at the Federal, the Appeal and High Court.

The major issues with the application of the location rule were;

1. The process is so slow and so costly
2. The rules are based on rigid rules which cannot and do not necessarily address community needs.
3. Price/Affordability is not the only consideration that should assessed
4. Viability is also an inexact science

Question 43: Location rules impacts

The location rules and pharmacy number restrictions were introduced by the Hawke Government’s Hon Peter Staples as Minister for Health, with the sole aim to change the funding formula for the PBS.

Since that time there has been six Community Pharmacy Agreements which have seen even greater financial benefits for both the Commonwealth and the community.

The location rules don’t have any impact on the affordability of pharmaceuticals.

The access to pharmaceuticals is impacted by the location rules.

In rural and remote Australia, research showed that the major issue with consumers was the issue of privacy and confidentiality. They saw the staff at events on social and familial meetings. They have however accepted that this was an essential part of rural life.
There are approximately 170 one pharmacy towns, approximately 120 communities with either two or three pharmacies and a further 200 plus larger regional centres.

The geographic trends in rural Australia is for a decline in population. The growth areas are centred on the coastal regions. The only exception to this is the now in decline mining areas, with new towns being built. These towns generally have large FiFo work forces and the demographic is generally not those who support a community pharmacy, the 35-45 male demographic.

Therefore, except where there was previous manipulation of the location rules, the change or cancellation of the rules would have limited implication on consumer access.

The only change that I would recommend is that the ACPA which manages the location rules is devolved the “Discretionary” powers. This would enable a more thorough and open review of the application.

**Question 44: Removal of location rules**

In rural medical clinics, the issue of competition is not mentioned. The issue for community pharmacies, as stated in the answer to all the questions 25 to 30, involve the viability and minimum standards.

The majority of the one pharmacy towns have fewer than 3000 clients in total. In almost all of these communities there is one medical practice, many with only one GP.

The viability of a second pharmacy in almost all of these areas would mean that the removal of the rules would have minimum impact on access but could change the value of the pharmacy and therefore the ability to maintain a pharmacy in that community.

Any change to the location rules could radically impact the value of pharmacies and therefore the viability of the industry.

Flexibility could be achieved by allowing the ACPA more discretion.

**Question 45: Pharmacy Ownership Rules**

The group who would benefit by changing the State and Territory ownership rules would be the current owners of pharmacies.

The benefits to the community would be limited.
There could be some benefit in some isolated communities where, like they have done for medical practices, the community could own the pharmacy and employ the pharmacist.

The community benefit needs to be assessed in light of all the above changes as discussed. The structural changes to medical clinics have had limited impact in rural and regional Australia, with the major beneficiary being the practice owners.

In most communities the GPs are on high rotation based on their visa requirements. As soon as this element is over, they relocate to their communities in the city.

The benefit to the community for pharmacy ownership and location rules being opened would be limited and would neither increase access and would be most unlikely to achieve increased professional services.

**Question 46: Short Distance Relocations**

Commercial centres in most communities are long standing. In a few cases, particularly in growing communities, the development of new shopping centres, new medical centres and improved retail spaces should enable a pharmacy to take up these opportunities.

Again as mentioned above, this could be solved if the ACPA had great discretionary powers.

In 2007, we had a pharmacy in an older style shopping centre. The shopping centre was scheduled for renovation. The new owner had developed and approved plans but was struck down by the GFC in 2008.

The renovations stalled but we could not get out of the position, wait for the development to be resold. It took a further four years for the centre to be rebuilt.

The pharmacy became unviable and we were fortunate to sell the approval for a long distance 106 relocation for a considerable loss.

If a rule was available for short relocation, we had the option to move into a medical centre in the area. This would have been most practical for the medical centre as well as financially viable for ourselves.

**Question 47: Shopping centres**

The ACPA discretionary powers could resolve these problems based on submissions and consultancy by an independent party.

The rules don’t need to be changed.

**Question 48: Medical centres**

See answer Q47

**Question 49: Government Selling PBS# for new sites**

There should be a balance of supply and demand. If the position is viable for an additional pharmacy, the market should be able to relocate an existing or open in a greenfield site.

The ACPA rules should be such that competition is not compromised.

The ACPA discretionary powers could resolve these problems based on submissions and consultancy by an independent party.
Question 50: Competition and Pharmacy viability

There is conflict between the premise of this question and early questions regarding community access to pharmacies.

Pharmacy viability should not be solely dependent on the PBS. Pharmacy professional products and services contribute to the viability.

The proponents of the move to extend ownership are the mega-stores and larger “chain” pharmacies. This proposal is also supported by developers looking for strong tenants in their centres. Their proposal is not about extending community access.

Furthermore, the number of pharmacies has worked in the government’s favour in negotiating lower margins for pharmacy dispensing fees. This same formula should not be used to make pharmacies generally unviable by extending consumer expectation for lower fees and prices.

The PBS rule stated aim is equity of access, not necessarily equity of price. The MBS does not apply the same premise in its formula.

Question 51: Isolated Pharmacy Location rules

The premise of this question is false. The delivery of service/s in an isolated community is not solely dependent on the pharmacy or pharmacist. In many small communities the community pharmacies already provide a whole range of services, not necessarily listed as “professional services”. Most if not all are unpaid services associated with outside providers and local services.

The opening hours for access to the RPMA is a condition. Whilst this is a minimal number of trading hours there should be a balance with viable trading hours.

Manilla is a small (3,000) rural community 45k from Tamworth (55,000). I have owned and operated that pharmacy for 31 years. We have traded 49 hours per week all that time. The viability of extensions to these hours would not support any extension.

Barraba and Bingara are both north of Manilla both pharmacies shut for lunch, again a reasonable proposition in these communities.

The following is part of a proposal under 6CPA to expand the roles and funding of community pharmacies in isolated areas, not change the rules for minimal if no benefit.

Vision:

Community Pharmacy as Primary Health Resource in Rural Communities

Objectives:

1. Maximise the resources of the most accessed health facility in rural communities
2. Expand linkages with all health providers in communities through association with NRHA, HealthWise and local networks
3. Expand the resources within the pharmacy structure
4. Build outreach facilities to people in isolated communities or properties
5. Upgrade the skills of all staff within a community pharmacy, and
6. Develop a man-power policy to recruit, retain, reward and relieve pharmacists in rural communities.
Community Pharmacy

Australia’s population has just exceeded 24 million. The majority of the population lives in the capital cities. The chart below is based on the latest census data from the ABS.

Regionals include the major centres including;

- Newcastle, Central Coast and Wollongong
- Gold and Sunshine Coasts, Townsville and Cairns
- Geelong, Bendigo and Ballarat
- Launceston
- Barossa
- Freemantle and
- Darwin

The remote sites are communities with between 2,000 and 25,000 people.

Community pharmacy distribution is almost consistent with this population split.
Based on statistics from The Guild Digest, on average the community pharmacy is visited every 14 days by community members for prescriptions and other items. Making the pharmacy and the pharmacist the most accessed health service.

According to the APHRA website and reporting, pharmacists are the third largest group of health professionals outside the metropolitan area. Nurses are the overwhelmingly largest group, followed by GPs and then pharmacists.

The many roles of nurses have not been dissected in these statistics. Distribution may obviously vary between regions and States.

Health delivery models also vary, particularly in the more-to-very isolated areas. Community pharmacy does have limitations in these areas as an Approved Pharmaceutical Benefits Scheme (PBS) pharmacy must be fixed to a specific “bricks and mortar” physical address.

In most remote communities with one or two pharmacies, population 2,000 to 6,000 and more than 25k from a regional centre (>25,000) and more than 500km from State capital, provide a great opportunity to incorporate community health services into these locations.

Most of these communities do not have fully serviced, State funded health services. An adequately resourced community pharmacy could accommodate many of these services for the benefit of these communities as well expand the roles and employment within them.

Services like;

- Baby health clinic
- Community nursing coordination
- Aged care in the home support services
- Public health programs and resources management
- Video and tele-conference, consults and contacts
- Transport access

Based on research done with Remote and Isolated Pharmacists Association of Australian (1995 to 2000), the following issues were highlighted;
1. The average length of stay by pharmacists in their community was second only to nurses.
2. The connection between GPs and the pharmacy provided an optimal health monitoring environment.
3. Rural community members saw the pharmacy as part of their health care team.
4. Rural community members accepted a perceived large of “privacy” as a concern, however was out-weighed by the ease of access to a health professional.
5. Community pharmacists were constrained by legislation from leaving the premises during business hours (except when another pharmacist was available) to attend meetings with other health colleagues.

In more recent updates it was reported that community pharmacies provided a cost-effective resource for Aboriginal Medical Services in provision of the QuMax (Quality use of Medicine in the Aboriginal and Torres Strait Islander Communities) as part of the Closing the Gap Program.

Health care in a community pharmacy has a combination of delivery models, all of which are customer focused.

Question 52: Multiple pharmacies with single owner/s in a community

The location rules should be framed in such a way that this proposition can be challenged. As stated above the ACPA should have the flexibility to examine this proposition.

There are also many sites where this situation has been “forced” on the current owners. For example, in Moree Plains Shire in the 1990s, the government buy-back of PBS numbers presented options to certain pharmacies to sell their number back to the Government.

The Mungindi Pharmacy was owned by a pharmacist for many years and was looking to retire. However, because of the uncertainty the pharmacy was impossible to sell as a going concern. The pharmacist accepted the government’s offer and closed his pharmacy. The nearest pharmacy was 100K away.

In Moree itself there were four pharmacies owned by three separated pharmacists. Two were in partnership in three pharmacies. They chose to amalgamate to concentrate and improve services in two of their three pharmacies, funding the process by the sale of the PBS#. The third pharmacy continued. Eventually the owner of the fourth pharmacy died and the pharmacy was not viable for sale.

The ownership of the continuing two pharmacies was not an issue initially due to the stagnation in the community and the lack of business expansion. The community satisfaction of services were in line with similar communities around Australia.

It was not until these pharmacies were sold and resold, that the situation changed. The location rules, plus the changed economics and value of pharmacies meant that outside pharmacists applied to install new pharmacies. The then owner of these businesses considered “defending” his profitable position.

Trading hours and services were able to be demonstrated to be below equivalent standards.

This situation should have been permitted to be proposed to the ACPA, rather than the extensive administrative, political and legal processes to counter this situation.

Question 53: Pharmacy included in Supermarkets
This question was raised in the 1988 NSW Pharmacy Act amendments. The proponents of any change to this location rule were non-pharmacist interests.

As outlined in many questions earlier, the appropriate of certain products and services provided by pharmacists should reflect their professional nature.

Supermarkets sell both tobacco and alcohol, both of which have been excluded by pharmacist and pharmacy legislation.

Pharmacies can be contiguous to a supermarket but must have clear differentiation. This is a similar rule in NSW to alcohol sales.

**Question 54: Hospital pharmacies PBS medicines and services**

The public “on average” visit a hospital once or twice a year. The pharmacies in public hospitals are geared to service in-house and occasional out-patient requirements.

In rural communities, the hospital is generally a “health service” without any pharmacy service. The referral or base hospital is generally 50-100 kilometres from their home.

The only proposal would be the including of suitable discharge packs.

In Tamworth my experience is with the Friday afternoon clear-out of wards, particularly cardiac wards. The specialist has visited all patients and agreed to the discharge. He/she has delegated the role of the paper-work to the intern.

By the time they get to the prescription paperwork, the lowest priority in their eyes, for cardiac patients they produce a six item prescription

- 1x beta-blocker
- 3x warfarin strength (because it will vary)
- 1x blood thinner (generally an authority requiring Rx without necessary paper work)
- 1x ace inhibitor

The patient presents at the pharmacy, usually pale and wearing the wrist band. As this was not a planned trip to hospital and they have just lost a week’s work and are now worried about their future, money is always an issue.

When presented with the above prescriptions and a bill for between $75 and $100, they are almost ready for another emergency trip after a new heart attack.

Hospital pharmacies, are for hospitals. They should only be involved with in-house and discharge services.

**Question 55: Private Hospital Pharmacies**

The limited application and benefit of such service would make it impractical.

**Question 56: Hospital Pharmacy Services in Rural and Regional area**

Hospital pharmacies exist only in regional cities.

In all rural and remote communities there are NO hospitals, they are health services or MPSs.

The pharmacy services are provided remotely from the regional hospitals or are contracted to the local community pharmacy.
The proposition is not only unviable it is totally impractical.

Any funding for the perceived short-fall in services should be directed to the community pharmacies in the area to contract to provide such professional services.

**Question 57: Hospital purchasing arrangements**

Section 100 medications and other hospital program funded medications should be distributed through the pharmacy for an agreed administration/dispensing fee.

As part of the current arrangement, certain blood products on the s100 list are supplied only by the regional hospital pharmacy. The pharmacy does not have a prescription.

The hospital sends the item to the pharmacy by a courier, who receives a fee. The pharmacist has limited instructions other than a phone or fax message that a person will be in to collect said package.

There is no paperwork, no guarantee that the correct person/patient collects the item and no feedback to the hospital pharmacy.

The community pharmacy does not have this item listed on the patient history and is unaware of the regimen and administration assistance that may be required.

The proposal is that the pharmacy has access to the same system to ensure the patient has equity of access and timely management of the medication.

**Question 58: Hospital’s community dispensaries**

Based on the answer to Q56, there would be minimal benefit for large cost in all rural and remote communities.

To compete with an existing community pharmacy, the hospital would be required to operate in excess of 38 hours per week. The staff and structural costs would be huge.

The resources already exist in the community pharmacies, the hospital pharmacies as stated in Q57, should work with or contract to the community pharmacy for the benefit of the community. NOT try to duplicate services.

**Question 59: Hospital post-discharge services**

As answered in Q54, hospitals should focus on in-patient and discharge services. The post discharge services should be contracted to the patient’s community pharmacy as outlined Q56, Q57 and Q58.

There may be a small number of very specialised items which require additional training, specialised handling and storage that will need to be addressed separately. However, where ever possible the community pharmacy should be suitably resourced and reimbursed so that they can be involved.

**Question 60: Community dispensing of “hospital” medications**

As answered above the answer is that in rural and remote communities, this is the most appropriate method.

**Question 61: Greater “supply” options for PBS medicines**

The premise of this question is that a better more coordinated stock acquisition and management scheme could reduce costs.
The governments always have these options.

The NHS however does define equity of access and the co-payment rules. These are the rules which impact on community pharmacy.

**Question 62: Aboriginal Health Services**

The resources of the AMSs and AHSs vary greatly. The NACCHO policy of “community controlled” does not preclude, in principle, the services or non-aboriginal health providing specialists.

Medication is an integral part of the AMS’s roles. The right medication, in the right delivery/dose form, in the right place at the right time is critical for the success of any regimen.

The critical elements of this are;

- The AMSs are generally servicing between 50 and 250 clients with high medication management needs.
- In the majority of these cases he communities are within or contiguous to large multi-cultural communities where community pharmacies share services.
- The QUM needs of the communities are also shared
- Limitations by the AMS to certain programs like the Opioid Substitution Program and 6CPA funded programs
- Seven day services by community pharmacy.

The most practical option in most AMS/AHS is to contract to a community pharmacy or pharmacies to provide a range of services.

The expanded service could improve the range of services available to be provided by the AMS. It could include a pharmacist being contracted to be directly involved with medication management and education programs within the AMS.

**Question 63: Further Scope for pharmacist services in AMSs**

The following proposal has been developed in Moree in conjunction with the AMS (PiusX) administration staff, the AMS GP and the pharmacy staff.

**Executive Summary**

The Moree Discount Drug Store (Moree DDS) proposes a collaboration to deliver a range of pharmacy based services for the benefit of the clients of PiusX and its staff.

Moree DDS was a start-up pharmacy in May 2011. In March 2012, we were granted special approval by the Minister for Health to operate as a Pharmaceutical Benefits Scheme (PBS) pharmacy. In 2014, one of the partners Patrick Mahony, relocated to Moree to oversee this proposal.

Moree DDS has a team of dedicated and experienced staff familiar with the proposed services, the expansion into satellite communities will require building on this base.

**Objectives**

To provide a seamless, time-efficient, cost effective delivery, management and control of prescriptions and other medications to the clients of PiusX to ensure quality use of all medicines.
Mission Statement

**Engaging care for everyone**

Description of Proposal

To optimise access to medicines and services by Pius X Aboriginal Medical Service with “Closing the Gap” and “QuMax” by the association with Moree Discount Drug Store. The Sixth Community Pharmacy Agreement (6CPA) provides an opportunity to improve medication management for better health outcomes. The focus is on sustainable service models and innovation.

In this proposal we will take the opportunity to propose, deliver and research a comprehensive service delivery model, with the view to maintain and/or improve the health of all PiusX clients.

**Proposed Services**

1. **Dose Administration Aids:** To supply weekly individually packed medication for each client in accordance with prescriber’s signed requirements.
   a. PMP (single use fully identified packs) single use pack with full details see below
   b. Weekly delivery or pick-up for each client with feedback on compliance
   c. Staged Supply; part supply of standard prescription quantities on a scheduled basis
      i. Scheduled non-packed items (eye drops, asthma inhalers and topicals)
      ii. Temperature controlled (Insulins and Thyroxine)
      iii. Pain meds (particularly Codeine)
      iv. Special management items (potent and narrow therapeutic range)
   d. RUM (return for destruction of unwanted medicines)

2. Special access meds, S100 and private medicines. New access schemes available under 6CPA.

3. OSP: Methadone and Suboxone and Naltroxone access schemes (previously outlined to Dr Page)

4. Medschecks and HMMR for all clients. As per a schedule and GP requirements

5. Online, real time ordering and medication requests via dedicated intranet portal.
   a. Prescription changes
   b. New requests

6. Supply and service items
   a. Diabetes consumables
      i. NDSS (Test Strips, Needles)
      ii. Devices (Monitors and other consumables eg Lancets) agreed contract prices
   b. Continence Aids
      i. CAPS scheme supply
   c. Mobility aids
      i. Wheel chairs/ walking frames
      ii. Walking sticks
   d. Service and training
      i. Calibrating Diabetic devices
      ii. Cleaning and replacing filters for Nebulisers
      iii. Testing Blood Pressure monitors
   e. GuildCare services
Collaborations

The 6CPA provides scope for innovative practices for rural and remote Australia involving Aboriginals and Torres Strait Islanders. Preliminary discussions with Indigenous Allied Health Australia and the Pharmacy Guild have indicated Moree is a target for these projects. There are opportunities to build a sustainable, cost effective collaboration of services which link together to provide a more seamless service for the community.

1. Remote community services to be discussed
   a. Medicine supply
   b. Impress system for clinics

2. Allied Health Clinics
   c. On site and in the pharmacy
   d. Video and telephone consultations

The plan will be to develop a working party to sketch out a proposal which Moree DDS would develop into a Grant Application. Planned start date in first half 2016

Management

Moree DDS will provide the management and coordination of the above listed services in consultation with PiusX. A monthly administration meeting would be scheduled.

Start-Up/Funding Summary

Qumax funding to be sourced from 6CPA budget. Moree DDS would provide all the resources for the above listed services, including covering the initial cost of the proposed 6CPA grant application;

- Qumax Funding for 50 clients at $___ per client per month
  - Client initiation
  - Packing and consumables
  - Delivery
  - Changes
- Pharmaceutical Benefit Scheme to cover most prescriptions
  - No charge for CTG eligible clients with Health Care, Pension or DVA card
  - $6.10 co-payment (2015) for CTG eligible clients on general benefits (SN for >60 Rx)
- Section 100 items available via PBS and/or Hunter New England Health
  - No Charge
- Private prescription items at pre-agreed costs with prescriber

Moree DSS to fund

- DAA packing costs
- Delivery and returns
• Computer network charges
• Reports to prescribers
• MedsChecks and HMMR (funded separately)

Strategy and Implementation
Moree Community has an opportunity to be a leader in community health services. PiusX has a long history of providing this guidance.

The 6CPA budget is now available for Qumax. Pius has an opportunity to allocate this funding to achieve the best outcome for its community. Once the budget is allocated, Moree DDS is ready for immediate start;

Stage #1: (September 15)
1. Allocations of clients to Moree DDS: proposal based on 50 clients
2. Setting up clients and confirming profiles with GP
3. Setting delivery schedule with PiusX management
4. Online portal
5. Staff discounts

Stage #2: (September and October)
1. Staged supply
2. Supply and service of items
3. MedsChecks and HMMR
4. 6CPA proposal

Personal Medication Planner (PMP)™

Webstercare's award winning Personal Medication Planner (PMP)™ Solution offers a whole new generation of options.

The PMP includes a wealth of personalised medication information in one handy pack.

The complete medication profile is printed inside the cover, providing privacy while protecting medications from light, moisture and damage.

The Personal Medication Planner (PMP) is perfect for people on the go who want to keep on top of their daily medication needs.

The PMP features:

• Patient photo printed in colour for identification
• Complete medication profile, including pill images, packed, non-packed and PRN medications
• Signing record of administration grid with reason codes
• Space for Cautionary Advice Labels (CALs)
Question 64: Remote Dispensing

Again I need to clarify my views on “dispensing” in this circumstance.

Dispensing is not simply of the adherence of the correctly typed label onto the correct container. The pharmacist’s duty of care extends to ensuring the medication is correctly recorded and any issue with administration is addressed.

Mail-order dispensing in the DIY mode as outlined above may be acceptable in some circumstances. Distance e-Dispensing may be suitable with the assistance of Aboriginal Health Workers in many other circumstances.

However, these situations do not cover every prescription in every circumstance. Therefore, a combination of services would be required.

As outlined above to reach our proposal above we have addressed a full range of options that are currently legal, however we have also discussed some potential options when regulations and technologies are updated.

Question 65: s100 programs

In line with above answers, the primary issue is the patient must be the primary focus.

If the patient is in a rural, remote or isolated community and they need access to s100, the best and simplest solution should be available. This step should not be prescriptive as a range of options may be available.

Question 66: AHS’s pharmacy business

The issue of access to NHS is critical in this question. I believe that if a community is available in the community and can make arrangements with the on-site community pharmacy, this should be the priority.

There should be contracts available that outline specifically what is required.

It should NOT be limited to the “closest” community pharmacy. The AHS should be able to negotiate with the most viable and practical options to suit their requirements.

Question 67: QUM services

The short answer is that not all services will be able to be the same level of quality in all areas.

The balance and range of services have to be coordinated with available resources and priority. QUM is not possible to be delivered to national standards in all areas.

The main issue is that the key selected QUM services are delivered.

Question 68: s100 and CTG

As outlined above, the local community pharmacy must be included in the convenient delivery of s100 prescription PBS items as and when required. If the patient is eligible for CTG, this must also be available.

Question 69: Variable access to s100 items via CTG
A patient on s100 medications must have the same level of flexibility to access their medications wherever and whenever required CTG.

Specialists can claim CTG for in-patient as well as out-patient clients

ER doctors should not be required to differentiate regarding CTG.

**Question 72: Tendering to supply to AHSs**

As outlined above this must be adopted.

**Question 73: Wholesalers**

No comment

**Question 74: CSO rules**

The opportunity in rural and remote areas to access all medicines in a timely and convenient manner has been compromised in some circumstances due to minimum order values, frequencies of orders and delivery schedules.

It is understandable that certain minimum conditions must be required of both supplier and consumer (community pharmacy).

**Question 75: Pfizer**

The Pfizer PBS market has shrunk due to generics and is growing less important with every price reduction.

Pfizer should not be given any exception to the CSO for their exclusive or “originator brand” listing on the PBS.

**Question 76: s100 and normal CSO arrangements**

As outlined regarding access by community pharmacies in rural and remote Australia, all s100 items required by a patient should be available.

**Question 77: CSO and MOQ**

Any item listed on the PBS must have universal access as defined in the NHS Act. If an originator brand is listed on the PBS, it must be available to any pharmacy in any quantity at the listed PBS price.

**Question 78: CSO 24-hour rule**

Many rural and remote pharmacy deliveries are close to or in excess of the 24-hour rule.

- Bulk orders are frequently over 24 hours.
- Cut-offs are 1pm with delivery drops in late afternoon.

Patient access is not necessarily compromised if details of the delivery schedule is well known. The main issue is with weekends and public holidays.

**Question 79: Trading terms**

Every pharmacy must have access to all PBS items at listed wholesale price
Question 80: 72 hours for top 1000

Most pharmacies may be able to manage the stock levels of their top selling lines. The major issue is that certain items and product ranges (e.g., Metformin XR) become unavailable on short notice. The alternative that is available may not be a top seller in a pharmacy but is in the top 1000, as such availability may be compromised.

Consumer access will be compromised.

Question 81: MOQ and efficient ordering

Every pharmacy must order efficiently. The wholesalers should provide suitable training and resources to order to such arrangements.

Question 82: Short dated stock

Yes

Question 83: Trading terms

Community pharmacies must negotiate trading terms above and beyond the minimum PBS listed cost.

Question 84: Wholesaler Mark Up

No comment

Question 85: CSO alternative

Other than the fact that any system must provide a maximum price and minimum order level equivalent to the PBS approved unit cost, there is no comment.

Question 86: CSO delivery on Manufacturers

If an item is listed on the PBS, the same conditions of price and delivery must be met across Australia. If a manufacturer elects to have a product listed on the PBS, there should be 100% compliance with universal access.

Question 87: CSO universal access

If a community pharmacy has a PBS approval, the CSO obligation must be met

Question 88: Tendering model

Consistent with previous answers the NHS Act and therefore the PBS is universal. Any tender cannot exclude certain difficult to access areas.

Question 89: Hospital tendering

There are significant differences between the hospital systems and the PBS, namely the range of items, variation in prescription quantities and number of outlets.

A hospital will have only one brand of a listed item as well as specified medication groups and will be supplied in individual daily dosed. A community pharmacy on the other hand must offer the originator brand in a standard PBS quantity or multiple as required or prescribed by a doctor.
The New Zealand option is not only limited to brand by medication class which may be switched based on availability.

The tendering process would require significant changes to the PBS and would require vast public education.

Question 90: Pharmacy regulation

The most significant change would be the “Pharmacist in Charge” regulation.

Traditionally the term “Pharmacist in Charge” is for the sole pharmacist taking responsibility for the pharmacy whenever it is open.

The pharmacist in charge may be the pharmacist manager/owner.

There should also be a limit to the maximum number of staff the pharmacist in charge must supervise.

Question 91: Unnecessary regulations

The issue of compounding has made redundant most items involved in “extemporaneous” prescriptions.

Prescriptive details of reference materials being required are also unnecessary as access to data can be arranged on an “as required” or “paid access” via the internet.

Question 92: Pharmacy data base

Pharmacy has a long-standing accurate data-base which could be accessed. The limitations must be acknowledged;

- Prescribed dosages may not necessarily meet actual dose
- GP details may be slightly different
- Brands may vary
Community pharmacy has been paid to supply medications and whilst history is maintained, the relevance and importance of this history is different to the GP. This does not mean that the data is wrong, just different.

Combining the data could allow for the extraction of much valuable analysis of the patient’s health management plan.

**Question 93: Community Pharmacy and Patient management**

Given the opportunity it is a most practical solution the complexity of a patient health management. We have developed a model we call “better health” as it combines not only GP services and pharmacy services with allied health for maximum transparency and benefit.

There is a collaboration with the patient to deliver a health management plan, where a range of objective measurements are set. This system links the community pharmacy directly with the patient and a range of services delivered by the pharmacy and others.

**Question 94: Data Collection**

The NBN access is critical
Question 95: Patient Services

In regional and metropolitan areas, there are frequently easily accessible resources to keep the patient or their carer/s aware. In rural and remote Australia, these services are only generally available on-line or via the phone.

The description and access condition of these services are not generally known. As outlined above, this is a potential service for a “Community Health Pharmacy” in rural and remote Australia.

Question 96: Consumer/patient access complaints

Community Health Pharmacy provides a resource that could keep the patient informed and direct them to the appropriate service or complaint process.

Question 97: Changing Pharmacist/Pharmacy

RIPAA conducted surveys in a number of one pharmacy towns trying to answer this question. The survey uncovered the following:

- Many (less than 30%) were concerned about confidentiality regarding their medical conditions and treatments.
- Pharmacists were considered relatively safe and understood that they shared data with their GP, however
- Most (> 60%) considered the convenience of access compensated for such lack or potential lack of privacy.

Unlike GPs there is neither a computer software based solution to transfer medication history between pharmacies if requested. Safety Net details are shared manually only.

Patients can elect to move as they desire with informing either new or old pharmacy.

Question 98: Dispensing standards

State Pharmacy Act and regulations set minimum standards. PSA set professional standards. QCPP set process standards.

These are well documented and recognisable by patients.

The delivery of professional services as outlined above are not necessarily documented to the same degree and do vary between pharmacies.

The process of developing Continuous Quality Improvement as part of QCPP is not being implemented.

Question 99: Consumer expectation

A consumer may be the best to answer this question from their perspective. Some consumers’ expectations however would be limited by what they have received in the past.

The experience in our pharmacies are;

- Medication dispensed in a timely and convenient manner
- The pharmacist available to be asked questions and or seek confirmation about the medications
- A range of dose administration aid services available
- Access to scheduled 2 and 3 medicines with advice and recommendation
- Professional services
  - BP testing
  - Wound care services
  - Immunisation
  - Connection with other health professionals
- Other non-medicine related services
  - Blood pressure and Diabetes supplies
  - Work place absence certificates
  - Mobility and continence aids

**Question 100: Minimum service level**

The patient’s minimum service level from my experience are;

- Accurate interpretation of the prescription or medication request
- Confidential presentation of their medication or advice
- Clear and professionally presented “package”
- Timely and convenient availability of medication
  - Trading hours
  - Stock available as required
  - Suitably stored and within date
- Staff are polite and conscious of their responsibility wrt their request and/or medication
- Pharmacist provides accurate professional standard recommendation and where appropriate documentation.

Every contact between the patient and the pharmacist/pharmacy should be treated as the same standard.

**Question 101: Consumer cost effectiveness**

The answer provided in a much earlier question is based on the March 2010 research from many different programs. At that particular time, the consumer/patient/carer indicated a range of values for various services.

Since that time the CTG program has expanded to cover many additional people and services. This has changed some expectations.

- Prescriptions are expected to be at the standard co-payment.
  - CTG should be free
  - Safety Net entitlements are also well understood and regarded
  - General PBS medication are price monitored and
  - Private prescriptions, particularly for CTG patients are frequently not collected
- Professional services have a range of perceived values
  - BP checks have limited or no “value” and are expected to be free or minimum cost
  - Contact with the pharmacist to seek advice or ask question is also expected to be free
  - Contact with the pharmacist with documentation
    - General patient (eg Medical certificate) $15- $20
    - Flu immunisation benchmarked to CWK $10 -$15
- High medication user (eg MedsCheck) free although co-payment could be considered
  - Other services we have listed above have a co-payment of between $10 and $50 per month depending on the level of service and the access to MBS item numbers.

**Question 102: eRx and eHealth**

eRx and eHealth does have significant benefits overall. However, in many small rural communities with few medical practitioners and limited number of patients in the community, the pharmacy records are and always have been a complete record.

Where the internet access is poor, these services are time consuming and provide limited benefit.

In other rural communities with a highly mobile population, like our Moree store, many patients are travellers through inland Australia. The eRx system is a huge benefit to ensure maximum accuracy to details.

The eHealth records have the potential to make a huge difference once uptake and network speed is improved.

**Question 103: Non-dispense medication data checks**

Dispensary computers were originally (1980s) favoured because they could print the repeat forms for pharmacist, thus saving time. Since that time their role has expanded to include significant interaction, adherence and accuracy checking.

At the same time, the margins in the dispensary have been shaved and the time saving has been compensated by higher dispensing speed.

The 4, 5 and 6 CPA programs have been designed to expand the role of the pharmacist in the education and support of the patient with regard to their medicines and health generally.

The non-integration of these systems with the dispense process has made it difficult to optimise this service.

The new initiatives by the Guild to streamline these services, improve training and expand the roles is still curtailed because of the structural issues within the pharmacy and within the dispensary more importantly.

Significant capital work is required to re-engineer the dispensary in the majority of pharmacies to achieve these goals.

As stated above, in metropolitan pharmacies, the cost of these changes can be amortised much sooner. In a rural community, where rents may be lower and space not an issue, design and construction costs are significantly higher. Part of the RPMA should include a grant process to assist in this re-engineering. Any proposal would need to be assessed individually with the patient outcomes being the sole metric.

**Question 104: Standard Variation**

Yes. There are different standards between pharmacists, between models and within a single pharmacy.
Consumers already differentiate between standards. Some actually select lower standards to meet their particular needs, eg purchase of dispensed Viagra/Sildenafil many males elect to attend a pharmacy where family is unknown and where fewer questions are asked.

Many consumers elect a higher standard pharmacy or pharmacist when seeking particular advice about a health issue.

A variation in standard exist in all professional services.

This does not necessarily make the service less important.

**Question 105: Discount price and lower service**

There a several discount models. These target a range of customers. The issue of “discount” has become a consistent element in pharmacy since the expansion of the Mega-Chains and the pseudo-pharmacies within Coles and Woolworths.

The pharmacies that have elected to match prices and retain loyal customers do not necessarily do so at the expense of service levels and professional services in particular.

The Mega-Chemists have utilised a weakness in both the award structure and the pharmacy regulations where their professional staffing levels are relatively reduced. This anomaly as outlined above gives them a fiscal advantage.

In 2008, my daughter and I became aware of the threat to our business by the introduction of a Mega-Chemist into Tamworth. We examined our options to counter this threat.

We examined a range of “discount” models and selected Discount Drug Stores because of their focus of professional services. By being established in Tamworth before the arrival of this threat, diluted their impact.

Patients and customers were shared with the Mega-Store, however we know they always considered our professional service levels more valuable.

Consumers and patients do differentiate.

**Question 106: Pharmacy Service Quality**

My experience on the Pharmacy Board of NSW and the National Association of Boards of Pharmacy, the predecessors of the APHRA, has provided a vast experience in trying to measure the issue of “Quality”.

Furthermore, our Manilla pharmacy was the tenth pharmacy in Australia accredited to the QCPP standards when they were first released.

Standards measurement are generally a quantitative measure of a number of selected topics. The standard can be met at the time of assessment, it may exceed this standard at other times and may fall below this standard at others. The pass-mark is simply a subjective, transient measure.

The standard that suits one patient does not necessarily suit another.

Continuous Quality Improvement is the goal for every professional. Even with improvement, there will be shortfalls or perceived shortfalls at all times.

**Question 107: Consumer Expectation**
Many businesses use “Exceeding our customers’ expectation” as a vision statement. It is important that you know and understand these expectations.

As part of the first QCPP accreditation and research into professional standards, we conducted a number of surveys in Manilla and similar sized rural communities.

These were multiple question surveys repeated several times in each location. Unfortunately, they were not well statistically based, however they did find a number of issues that consumers considered important. Importance was not necessarily the frequency which they were identified, but the importance an individual placed on the topic.

The most significant findings were;

1. Access to their medicines and prescriptions on a reasonable timeline
2. Understanding of their needs and the access to schemes such as DVA and SN (just started)
3. Friendly understanding staff
4. Culturally aware and language consistent environment
5. Privacy of their personal information.

Price was not a significant influence at that stage as all medicines were consistently priced.

In most rural communities at the time of these surveys, the professional population were mainly older white Anglo-Saxon males. The café owner was most likely of Greek extraction. The overwhelming language at home was English. There were several locums or new regular professionals who were Asian starting to work in these areas.

Whilst the communities welcomed these professionals, many could not understand them very well and identified that many did not understand how a rural community worked.

The privacy issue seemed very much in conflict with item #3, where the friendly nature was considered important. This issue was more deeply explored. The outcomes of this were;

- Patient information must be kept secure
  - Access to information on computers were controlled
  - Staff were required to new standards of confidentiality
  - Any paperwork with names and medicines were to be destroyed securely.
- Conversations were to be balanced to the patient’s preference
  - Advice about OTC medicines could be conducted on the floor in the presence of others
  - Advice about prescriptions was to be delivered personally by the pharmacist, directly to patient within easy ear-shot but without others directly overhearing.
  - Advice about medical conditions were to be delivered in a more private area.

**Question 108: Discounting Co-Payment**

Like all compromises, the outcome is also compromised.

The reason the discount was agree is simply because the Mega-Chain wanted to be able to scrap the co-payment on certain items all together.

The economic rationalist view is that the consumer benefit must be high. However, the system was already designed to protect the more seriously ill members and families in the community. The
Safety-Net system was set in place by then Senator Graham Richardson, the then Minister for Health on the introduction of the co-payment.

That system worked and still works. The Mega-Chain was not interested in that cohort of patients. Their aim was market advantage.

As stated in Q107, consumers have price as a consideration, however it is lower down their preference list when compared to access and consistency, the NHS legislation provides

The introduction on 1 January was purely a market disruptor. The Minister is trying to express this as a government benefit it is providing, when it is a direct cost to pharmacists. Not simply in the loss of profit, but also the additional time and continued effort to manage the Safety Net for the chronically ill.

As with Coles $1 per Litre milk. The market benefits were sold as consumer benefits. What has been recognised in more recent times is that Coles and Woolworths have negatively impacted seriously on the supply chain. Producers are being squeezed for the market advantage.

**Question 109: Price variations**

The price of a packet of cigarettes varies. The price of petrol varies. The price of apples varies.

The prices of PBS medicines are consistent.

Certain private prescriptions have vastly different prices. Pfizer have created a multi-tiered wholesale price for Viagra which could mean the wholesale price may be 200% to 300% above the discounted dispense prices in the Mega-Chain. The CSO prevents this for PBS items.

Furthermore, many discounted prices quoted do not necessarily meet best practice supply standards as outlined above.

Most pharmacies provide a price match guarantee and have regular checks of websites.

Price variations are a fact.

**Question 110: Pharmacist Control over prices**

Many consumers are confused about generics. The names are often more difficult to pronounce and in some cases their GP or specialist have told them that they must only have the originator brand.

In practice many patients are willing to pay an unnecessary premium, based on a range of issues including past experience and false press reports. Others just don’t like change so are happy to pay such premium.

Many manufacturers pack the same product in separate packages to charge a premium on the “originator”.

In the past 24 months, many brands and forms have been unprocurable. The various reasons for these shortages have meant that patients have had to change brand or form.

Pharmacists and pharmacy staff have had to become highly skilled in assisting patients in these matters.

**Question 111: Advertising Restrictions**
Advertising of prices and prescription products are for the benefit of the pharmacy and manufacturer.

Advertising of the benefits of a new product is now elevated as a news item on most TVs.

Dr Google etc have provided a large range of opportunities to promote product benefits and even product adverse impacts.

The problem is that a 60 second info-mercial or 100 work report extract does not provide a full picture of the benefits or disadvantages of a product.

The current commercialisation of certain medicines and quasi-medicines means that consumers and patients are frequently mis-informed by advertising.

Cough and cold medicines, analgesics and certain brand-ambassador-ed vitamins all create unrealistic expectations to the consumers.

**Question 112: Pharmacist ONLY and Pharmacy ONLY**

There are variations between states in both the range and procedures for all these medicines.

In practice the availability of the pharmacists on the floor and the training of the staff to ask appropriate questions so as to refer customers is a minimum standard of QCPP.

The Pharmacist only range has had a number of changes in the past decade. All of which have been handled for the consumer benefit.

The issues of Pseudoephedrine and Codeine have been handled successfully.

- Appropriate access to these medicines have been maintained at a reasonable cost to the consumer
- Over use and in some instance abuse of these medications has been controlled and limited.

**NB.**

1. The major abuse of codeine based products in our areas is confined to authority prescriptions for 30mg Codeine and Paracetamol not just OTC.
2. The referral of Codeine over users to a GP for a Suboxone withdrawal program should be expanded with the pharmacist.

**Question 113: Improvements**

See above

**Question 114: Pharmacy Income from s2 and s3**

In our pharmacies the range of medicines represent approximately 12% of total sales and 30% of OTC sales.

In our departments we include certain items that were previously scheduled but are now also available in supermarkets.

As the full title of these two Poison Schedules as Pharmacy ONLY and Pharmacist ONLY, these are both incredibly important to community pharmacy. Not simply because of their contribution to income, but more importantly their contribution to the professional pharmacy “offer”.
Consumers are confident to enter the pharmacy and source a product, knowing that if they wish to seek further information about the product or their symptoms, this service is available.

Just yesterday a young lady presented at our “triage” counter and was referred to the pharmacist. She had an uncomfortable area on her hip. She had searched Dr Google and was seeking the advised remedy.

After asking other questions, I discovered that the issue was not in fact her hip, but her back that was the issue. The neuropathic pain would not been resolved by Dr Google and I suggested some non-medication exercises and referred her to a physio or her GP for follow-up.

The sum result was a happy customer but nil income.

This is not an uncommon event in a pharmacy BECAUSE we have these two markets.

**Question 115 and 116: Complementary Medicines**

As with my answer above, access to the professional services of the pharmacist can assist a customer/patient in the appropriate use of complementary medicines.

Many complementary medicines make unsubstantiated claims. These claims may achieve a placebo effect and provided they do not cause harm, they could and can be consider innocuous.

There are other more significant claims and demonstrated benefits for many complementary medicines. These products are broadly available in the community and it is also reasonable that pharmacies stock these items.

The most frequent question raised in our pharmacies of the pharmacist, is “will this product have an impact on my prescription medicines?”.

We could not answer that question unless we knew everything on the prescription regimen and the ingredients of the said complementary medicine.

A community pharmacy is ideally suited for this purpose.

There are fine balances most pharmacists have to weigh up regarding the stocking of demonstrated un-ethical products such as homeopathic “medications”. In the main we have de-stocked this range except for a few items which are identified and “not recommended by the pharmacist”.

**Question 117: Pharmacy Advice on Complementary Medicines**

Complementary medicines as the name states are considered “medicines” by many consumers. The access to health stores, particularly in rural areas is limited to certain specialist area, eg body builders. The supermarkets stock a wide range however do not provide any advice.

As stated in Q115 and Q116, the consumer both benefits from and appreciates the availability of pharmacist advice on complementary medicines.

**Question 118: Retail environment**

The underlying premise of this question is that the consumer cannot distinguish between access and service. If a pharmacy stocks and item they must necessarily wish to sell you this item even if it is completely inappropriate.
A pharmacist’s professional duty of care is that any medicine recommendation must be “in a quantity and for a purpose consistent with it therapeutic standards”.

Traditionally pharmacy markets included many non-professional lines, eg photography.

In our rural areas we stock a range of veterinary medicines (not pet care) which are scheduled and unscheduled. Access to these lines are critical to many small farmers.

The “retail” environment lowers the threshold for entry into our stores. Males and females, young and old, Australians and New Australians, English speakers and non-English speakers all visit pharmacies because they respect our professional standards.

The balance will vary depending on location. In many small rural communities, the pharmacy may also be the Postal agency, the gift store even the newsagency.

The pharmacy must be viable and in many communities where the population has collapsed and the other services have become unviable, the pharmacy has incorporated these into their business model.

As stated above, there are many opportunities in these small rural communities to incorporate “community health” services within the business model for the benefit of the community.

**Question 119: Patient co-payments**

Yes, consumers should be aware of their contribution to their medicines as well as the Commonwealth’s contribution.

**Question 120: PBS Safety Net**

The system is adequate. The low income consumers would access medicines at the lowest co-payment and if Aboriginal or Torres Strait Islander decent would have access to Closing the Gap options.

The area of most concern is for items not covered by the PBS. The removal of Paracetamol 665 from the PBS on 1 January 2016 created a two stream system. Pensioners and concessional card holders who were not CTG were required to pay retail price AND it was not included in their Safety Net options.

This is despite the current recommendations for chronic pain management of 180-186 tablets per month, two boxes.

Other non-PBS medications which contribute to consumer costs are topical treatments for skin infections.

Patients with high pharmaceutical needs also have high medical needs. The cost of attending a GP or specialist is more significant than that of the PBS. Non-bulk billing services, travel and accommodation costs, opportunity costs (loss of work/leisure hours) and stress are the most significant component of the patient’s costs.

The PBS Safety Net schedule means that the benefits accrue from January and expire in December. The patients with newly diagnosed high needs may miss out due to these rigid schedules.

Possible solutions:
• Technology and online PBS means that the Safety Net schedule could be more flexible with timeline. A registration system coordinated by the pharmacist could establish the start and end date (12 months) for each client.
• Medication plans should be part of the Safety Net registration so that the list of items eligible to be counted are identified. This will eliminate certain 20-day rule exclusions.
• Concordance reports are also recognised so that all prescriptions are counted.
• Multi-person SN management needs to be better identified in the medication plans. This is particularly important where one member has different “entitlement” from the others.
• Review the medication profile of the SN card holders. Set up a profile which will trigger the chronic health medication plans stated above. The GPs and the pharmacists will be able to initiate this step so as to better manage the patient’s PBS medication requirements and costs.

**Question 121: PBS Value**

As stated above regarding co-payments. Most consumers/patients believe that what they pay is the full cost of the medication, even if it is zero.

Whilst some may hear about the cost of the PBS in Billions of Dollars, they do not understand, their own cost to the PBS.

The medication plans suggested in Q120 would include a global cost.

![Health Budget](chart.png)

When you compare the global budgets as outlined in various reports and separate out the costs into input costs, practice management costs and the return to the practitioner, it shows a very interesting picture.

If the patient and the general public were aware of these breakdowns it would assist in understanding their contribution to each scheme.

**Question 122: Co-payments**

As stated in several answers above, the co-payment is important but more importantly, the total cost of the medication is essential. The co-payment by itself is not a price signal.
The expansion of 6CPA professional services, funded by the Commonwealth, should also have co-payments.

These co-payments should match the PBS co-payments, for the exact same reason.

This additional funding would enable expansion of these professional services and possibly remove limits on the number of services available.

The fundamental principle I propose is that the patient must understand that there is a cost for every service they receive. That payment is not “free” but subsidised in full or in part.

Discounts are innocuous and are not necessarily a consumer benefit. Such discounts cannot be universal.

Furthermore, when compared to all other health practitioners, pharmacists are the only group where “discounting” as opposed to “surcharging” is promoted.

**Question 123: Additional Co-Payment Discounting**

See Q122 above

**Question 124: Afterhours Access**

What is after hours? The standard working week for most office workers in 9am to 5pm Monday to Friday.

The Pharmacy Award identifies 8.30am to 6.30pm Monday to Friday and Saturday 8.30am to 1.00pm as normal trading hours.

Does this mean that outside these hours are “after hours”?

In rural and remote Australia, the trading hours are set by viability. In the various health services the afterhours services are “on-call” at considerable extra cost to the health budget.

A pharmacy which offers in excess of 50 hours per week normal trading hours could not viably provide an on-call or extended afterhours service. As previously stated a 50 hour week in a standard pharmacy (<1200 Rx/week) would be 1.25 FTE pharmacist employment.

It is impossible and impractical as well as unviable to operate this as a 2.0 FTE position due to the availability and cost of pharmacists.

In practice the existing trading hours and options to medicines are well managed in these areas. Practical solutions have been adopted by all concerned.

**Question 125: Afterhours services**

As an operator of a sole pharmacy in a rural community for more than 30 years. Many of these years as the onsite pharmacist living within the town. I have experienced the full range of afterhours services required;

- The most common access on Saturday afternoon or Sunday were veterinary
  - Mastitis injections for animals
  - Bandages and injections for horses
- Headache and acute care for adult and children
- Infant antibiotics
• Asthma and allergy treatments
• Emergency contraception pill.

When the GP and I discussed the access for AH services, we addressed the concerns with Asthma, particularly children acute asthma episodes.

We identified three issues we could manage that prevented these, namely well documented management plans and spacers for the inhalers as well as making the decision early, not at 9pm.

Within 3 months we achieve a huge reduction of AH calls to Manilla hospital (as it was then) and within 12 months our reviewed showed that any AH call-out for an Asthma related event was either a patient of an outside GP or went to a pharmacy outside Manilla.

If pharmacists and GPs were adequately paid to address these issues we could significantly reduce a patient’s need for after hours.

**Question 126: Access in Rural and Remote Australia**

The National Rural Health Alliance published a chart in 2016 regarding the uptake of services in the more isolated areas. This data shows that people in small communities do not access as many services as in metropolitan and regional areas.

This data does not take into account people travelling to regional or metropolitan areas to access many health services.

The miss-match of services, health providers and other resources means that on a “per-capita” basis, the amount of money spent on health services is “under-spent” in Rural Australia. The raw data provided by the NRHA shows that all professionals fall into the under-spend whilst Hospitals actually appear as on over-spend.

The Hospital figures do include Multi-Purpose Services which expand their role to take up services normally included in other categories. It is also expected that certain more specialised services are treated in major centres and capital cities due to the costs.
Allowing for the possible anomalies in the data, it demonstrates on this simple metric, that as much as $2 Billion is underspent in Rural Australia. This equates to between $150 to $250 per person per annum less on health care.

Whilst there is no documented correlation, there is other evidence in various health reports which record lower health status in Rural Australia, everything from:

- Mental Health, including suicides
- Men’s health
- Obesity
- Heart Health
- Diabetes, etc

In all of these issues Australian Rural Community Pharmacy can play a part.

One of the basic distortion of the broader health budget figures is that the GROSS figure does not necessarily reflect the professional’s cost in delivering these services.

As outlined above, there are a large number of options that can be expanded utilising the community pharmacy as the conduit.

The key objective will be to provide a patient centric model as opposed to a provider centric or a funder centric model.

**Question 127: Specialist services**

No.

In any other delivery model (health, legal, vehicular service, agriculture even tourism) are all tailored to suit the needs to each community.

**Question 128: Alignment of services**

Specialist needs will vary. These may be transient needs or long-term needs.

As system needs to be in place and suitably funded to enable these services to be delivered in a rural community.

Consistent with previous recommendations, a process of application made with a suitable business plan to address specific needs in the community could be made by the community pharmacy. Such services may involve training, resources or FIFO specialists.

**Question 129: Access Procedures**

See Q128

There needs a re-design of the whole model which may include structural changes within the community pharmacy.

A new system may in fact make a community pharmacy viable in areas previously without a pharmacy.

**Question 130: Population inequities**
The biggest problem is that when we address small samples, the variant may make the proposed solution impractical. I quote the example of Toomelah Aboriginal Station.

The following is a presentation I prepared for a group, to outline the premise that we can treat everyone the same.

**Equal, Equality, Equity**

\[
2+2 = 4: \quad 1+1+2 = 4: \quad 3.99 +0.01 = 4
\]

This 4 = that 4 = that 4, Therefore must be the same

QED

We all tend to look at the world in these terms

- All Chinese people look the same
- All people with body art must need their head read
- All black people are the same

We are quoted statistics on the news all the time

- NAPLAN results show Australia has slipped to 14th in the world, although reading improved, writing declined.
- The average house price in Sydney is now $$$

Recently I was trying to imagine what it would be like to be an unemployed aboriginal male living on Toomelah Station. Toomelah as you probably know is about 125 K nne of Moree just east of Boggabilla.

Everything about this community has been measure and valued by authorities to a national scale.

You could say it is a dysfunctional society; high levels of violence and petty crime, high unemployment is above the national average, school attendance poor and their NAPLAN results...well.

I describe Toomelah like a boil on your backside. It is sore and painful, but you can hide it (well no one wishes to see mine). However, when you are run down, the staph infection takes over, the body pumps in lymph fluid to protect you. Eventually as the pressure builds up, like Mount Vesuvius it erupts, send puss and muck down your leg and through your clothing. People begin to notice and ask questions, for you however it only relief as the pain starts to ease.

Likewise, in Toomelah, many if not the majority are very normal people. They eat drink and sleep just like us. They are kind, family orient, health conscience, culturally aware, well informed people. They are just trying to get on with their lives.

The Toomelah story has been well documented in a royal commission. For the decade after this report and the process revitalised, the community was reformed, rebuilt, reenergised.

The whole community worked for the dole on everything in their community. The streets, so the story goes, were so clean you could eat off them. Schools were full and the sporting teams were practically unbeatable.
Then... Someone in Canberra advised the Minister that the program was running over budget. The concept needed review so that savings could be made.

Shortly afterwards we had a new election, a new government, a new minister, a different party in power, but the same message from the advisors.

As is most appropriate a new advisory consultancy board was established to draw up new boundary lines. Straight lines, clear statistical logic, fully researched assertions and consistency across the nation.

Budget targets must be meet.

The only problem was that the new rules did not accommodate Toomelah.

As it is only 18K from the Queensland border and Goondiwindi, the formula fell over because all its services were being directed from Sydney 800K away.

As a result of these changes, coupled with 5 years of drought, changes in farming workforce and fewer employment opportunities, the community feel back.

The formula and circumstances were wrong for the “average” Toomelah resident.

This whole episode has changed my thinking.

I have always been the one to analyse data, draw charts, create pivot tables in Excel, look at the fine detail of matters. So much so that sometimes I miss the whole picture and get the wrong answer.

Because being EQUAL does not necessarily mean that we are ALL the SAME.

Thank you

The answer as outlined above is that each proposal needs to be managed. There should not be an attempt to make anything a global solution nor should a solution be a provider based solution.

**Question 131: Service Availability Promotion**

Assuming a service is to be provided and suitable resources are available and it is patient focussed, then promotion should not be an issue.

The visitation rate to a community pharmacy is relatively high and by targeting the group, local area marketing, social media and signage should all be utilised to attract patients/carers to the specialised services.

**Question 132: Engaging patients**

I believe that if a professional service is to be provided the fundamentals must be accepted by the patient. What I mean by this is that the service must be more than was previously provided on an ad hoc basis.

If we are to expect a patient to pay a co-payment for a service, eg medication management, then there needs to be a professional looking location where this service is being provided, there are resources available, the appointment is scheduled and on time as well as the outcomes meet certain standards.

The 4CPA research report in 2010, provided an excellent summary of all the research undertaken in up to six projects. The consistent answer was as I outlined above.
Therefore, if a range of services are to be expanded in community pharmacies, there is no shortcut, the following must all be included;

- Structural design
- Adequate training
- Technical and practical resources
- Reporting and
- Administration

**Question 133 to Question 140**

We have no experience in these areas in our pharmacies.
Curriculum Vitae

Patrick Thomas Mahony

B Pharm
FPS
JP
Doctor of Health Studies (honoris causa) CSU

Present Position:
- Owner and Partner in three pharmacies in Tamworth, Moree and Manilla
- Fellow of the Pharmaceutical Society of Australia
- Associate Fellow Australian College of Pharmacy
- Member of Pharmacy Guild of Australia

Previous Positions
- President and founding member of the Remote and Isolated Pharmacists Association of Australia (RIPAA) 1988 to 2003
- Member of the Pharmacy Board of New South Wales 1987 to 2000
- Member of the NSW Branch of Pharmacy Guild of Australia 1993 to 1997
- Pharmacist representative National Rural Health Alliance 1995 to 1998

Background
- Graduated Sydney University 1967
- Work in pharmacy since registration
  - 1967 to 1970 as pharmacist manager in various positions in Sydney
  - 1971 to 1975 as pharmacy owner in Sydney
  - 1975 to 1980 as consultant to pharmacy Modern Management Services/Feros and Partners
  - 1980 to 1985 manager of Micro Computer Division of Australian Pharmaceutical Industries
  - 1985 to present Pharmacist owner in Manilla and Bingara (1990 to 1995)
  - 2000 to present also pharmacist owner in Tamworth and Moree (2012) with pharmacist daughter
  - Tutor Pharmacy Graduate Training Course
- Rural pharmacy interest
  - Establishment of RIPAA (Remote & Isolated Pharmacists Australia Association)
  - Guest lecturer CSU Wagga, UQ, University of Sydney on Rural Pharmacy
- Key Rural Pharmacy projects
  - $100 access scheme for rural pharmacies
  - Establishment of Pharmacy School at CSU Wagga Wagga
  - Emergency Locum service
  - Rural Pharmacy externships at all universities
- Key professional areas
  - Competencies for assessment of Graduates with international recognition
  - Electronic messaging standards for medical records
- Expert Witness and court assigned mentor
  - Peter Ng (2010-2012)