Review of Pharmacy Remuneration and Regulation
Submission #118; 20-Sep-2016; Newstead Capital Chemist

Newstead Capital Chemist submission to Harper Pharmacy Remuneration Review

This submission is in light of the recent remuneration changes community pharmacy has seen in recent years and what directions it could move in to maintain sustainability of the services offered by community pharmacy and of the model itself.

We are part owners in a non – discounting pharmacy that offers a full service model. Ours is a medium – large pharmacy that amongst other activities; services some nursing home patients, community care groups, offers opioid replacement therapy, needle exchange, medchecks, home medication reviews, finger-prick cholesterol and glucose testing to name a few. We are open 8am until 8pm on week days and until 6pm on weekends. It is from this perspective that this submission is written.

With the reduction in remuneration due to price disclosure and accelerated price disclosure and the movement toward some more fee-for-services in the most recent community pharmacy agreements there has been several questions posed in the initial review concerning the current remuneration model. Some for discussion are

- Question 15: Is the ‘swings and roundabouts’ approach to remunerating pharmacists appropriate? Does it lead to undesirable activities?
- Question 17: Are the current fees and charges associated with the dispensing of medicine appropriate? In particular, do they provide appropriate remuneration for community pharmacists? Do they provide appropriate incentives for community pharmacists to provide the professional services, such as the provision of medicine advice, associated with dispensing?

My experience is that currently a large amount of services offered to the community, including dose administration aids, deliveries, clinical interventions and pack changes are offered at less than the cost of providing them. Currently we subsidise these from revenue earned from dispensing prescriptions. Under the current and ongoing accelerated price disclosure system this may lead to some undesirable activities as pharmacies will no longer be able to afford to offer these services at a subsidised rate and that would lead to one of two possibilities: the full cost will be passed onto the patient, or the services would no longer be offered by the pharmacy. Both would lead to a reduction of the utilisation of these services.

I think if services and script revenue are to be divorced, the government either through data collected in this review, or by use of the trial funding set aside in the current agreement, should actually determine what these services are worth to them and use that to determine the appropriate level of remuneration. So questions like:

-What reduction in medication related misadventure and thus saving in hospital costs is created by putting a patient on a dose administration aid?

In an example in our pharmacy from last week a patient was initiated on a dose administration aid, and in the process of setting up the pack it was discovered that the patient had been taking: the
wrong dose of an anticoagulant, was taking a tricyclic antidepressant that interacted with her other medication and was meant to be ceased, and twice the dose of an anticholinergic agent that she was meant to. Any of these issues could have had severe medical outcomes for the patient. The pharmacist involved spent over 45 minutes sorting all the correct doses out and talking to the prescriber about the changes. The work and potential harm minimised would definitely not be covered by the clinical intervention claimed under the current funding system.

Another example in the same time period was of a patient discharged from hospital with a request from the hospital and a drug chart for us to prepare a dose administration aid. The patient was charted for an ongoing dose of amiodarone, a drug that controls heart rhythms at, at least 3 times the required dose. This medication has a loading dose to get the levels up to therapeutic range that is only meant to be used for 2 weeks. This medication had passed through hospital discharge checking and the local G.P. (who generated the chart for us) and was ordered as a permanent ongoing order. This medication can have some very serious side effects especially at high doses, so once again significant potential for harm was reduced and a clinical intervention claimed. These sorts of examples happen all the time, prevent significant medication misadventure and are no way near covered in terms of pharmacist time by the current remuneration.

-Can we look at data for patient outcomes for patients who receive clinical interventions; can a value to the health system be determined? We have the data systems to collect this information at pharmacy level through things like guild care.

I believe that if the services are qualitatively and quantitatively assessed and a value placed on them that reflects the value of them to the tax payer, the system will be much more efficient and transparent. This has been determined for Home Medicines Reviews and the clear value demonstrated. The current pool system used for Clinical Interventions, for example, is just a guess and does not reference the value of the services provided to the tax payer, nor acknowledge the true cost of providing them.

As part of this discussion, it is worth noting that there are benefits from service-based pharmacies that cannot be tangibly defined, here is an example: as a needle exchange provider we meet a segment of the community who are using intravenous drugs illicitly. These people at that stage in their lives do not often take good medical care or regularly see any allied health professionals. They do however often visit community pharmacy, and for many of these people this visit to the pharmacy is the only exposure they get to any exposure to health advice. A dollar value cannot be placed on every service.

The development of appropriate funding for services that are separate from dispensing is important, however the continuing fee for dispensing a script needs to also still reflect the skill and processes that the pharmacist must employ to accurately assess and dispense a script, consider interactions, gauge compliance, consider any contraindications and give appropriate counselling. This must also
remain to be considered as one of the primary values of a pharmacist; the safe, accurate and informed supply of medications to the Australian public.

16. Should dispensing fee remuneration more closely reflect the level of effort in each individual encounter through having tiered rates according to the complexity of the encounter? For example, should dispensing fees paid to pharmacists differ between initial and repeat scripts?

18. Currently community pharmacists have discretion over some charges. For subsidised PBS prescriptions, should community pharmacists be able to charge consumers above the ‘dispensed price’ for a medicine in some circumstances? Should community pharmacists be allowed to discount medicines in some circumstances? If so, what limits should apply to pharmacist pricing discretion? If not, why not?

Tiered dispensing fees for PBS subsidised medications currently does occur to some extent with schedule 8 medications and extemporaneous preparation prescriptions which do require additional effort in preparation or in meeting legal requirements. Expanding this tiering system to differentiate between supposed levels of complexity would be difficult to achieve in particular how to determine what should be considered for higher or lower remuneration. The example given of new or repeat prescriptions is possibly not the best example as not all new prescription dispensing’s more complex then repeat dispensing’s and the reverse can often be the case. Tiered dispensing of new or repeat prescriptions could lead to some businesses exploiting this by forcing patients to obtain new prescriptions for each dispensing or at least more frequently than is currently required to increase profits. This already happens with some other medical professions through the reissuing of new referrals which are reimbursed at a higher rate then follow up appointments. This in turn could put more pressure on the health system with these patients needing more doctors’ appointments which will cost the government and tax payers more. The current system may not be perfect & probably undervalues the effort put into many medication dispensing’s but it is the fairest system currently available for both pharmacy and government. The remuneration received for the dispensing fee and pharmacy administration and handling fee will need to be reviewed in light of the continued effects of price disclosure putting significant financial strain on pharmacies. To ensure community pharmacy is able to remain viable to continue to service the medication needs of the Australian people into the future the monetary value of these fees will likely need to increase.

Charges for PBS subsidised medications should be determined at a government level as they have previously been to avoid disadvantaging some patients and encouraging waste in others. Nationally set co-payments ensure that no one is disadvantaged in what they pay wherever they are in Australia or what time of day it is. By setting these levels nationally it is able to strike the right balance between ensuring prescription medications are affordable for patients and ensuring that the co-payments are able to keep the PBS viable. I believe patient outcomes can be negatively affected by individual pharmacy changes to PBS subsidised medication charges through several mechanisms. By being able to lower the price charged to patients for PBS subsidised medications it potentially has
the effect of reducing the perceived value of the medications in the mind of those patients. This could have an effect on those patients belief of the effectiveness and ongoing need for medication therapy. At the same time this may incentivise some individuals to horde medications as they have little or nothing to pay towards them. In turn this can increase wastage and increase the cost to the PBS. Prior to the introduction of the co-payments and the 4/20 day rule there was a great deal of medication hoarding which was potentially because the patients associated no value with the medications as it cost them little or nothing and as a result caused a large amount of wastage and cost for the government. On the other side if the cost of medications was able to be increased in certain circumstances this could lead to certain patients being disadvantaged (depending on increased charge) which could lead to delayed or missed therapy. It could also lead to certain areas being disadvantaged as PSB medications may cost far more depending on where you live; not everyone is able to travel to get a lower price. I also believe this could undermine the purpose of the safety net and act as a way of removing it the future as a cost saving exercise. If government wishes to lower or increase the cost of PBS medications it should do this directly and not make pharmacies chose the price they will charge as this will disadvantage some patients.

Question 75. Pfizer supply direct and do not provide their medications for supply through the CSO. Should all PBS medicines be available through the CSO, or is it appropriate for a manufacturer to only supply direct to the pharmacy.

The companies that supply medications outside of the CSO such as Pfizer have differing service promises, fees and logistics. For example Pfizer has a limit of 8 normal deliveries per month before there is a charge, different cut off times and their own distribution. Currently these suppliers that lie outside of the CSO are more complicated to deal with, take more time, and typically this means it takes longer to get this medications to our patients at a higher cost to the pharmacy. Having a single supplier like Pfizer means that interruptions to supply due to out of stocks are immediate, and not cushioned by having multiple wholesalers with the same stock as per CSO model. The service obligations of being a CSO wholesaler are a wonderful asset to the Australian taxpayer, offering timely access to medications, and access to whichever brand (barring Pfizer!) they want. I believe that if wholesalers are going to operate outside of the CSO, for tax-payer funded medications at least, they should have to meet the standards of the CSO.

Mechanism of accelerated price-disclosure price drops.

The current system of price cuts has the price dropping at the same time to the wholesalers as the pharmacy. As any stock that was bought at the old higher cost represents a loss to the pharmacy or wholesaler at the date of the cut, it means that everyone is trying to reduce stock holdings at the same time, leading to shortages, low stock levels in the pharmacy and ultimately disruption to continuity of supply for the patient. A better method to manage this would be to have a cascading price drop so the drop started at the wholesaler, let them manage their stocks levels appropriately for a period, say a month, then flowed on to pharmacy after that time for another period before the
actual cuts happened. This would mean there was plenty of time to clear the older more expensive stock out at the right price and importantly would mean there was no shortage to the patients.

Pharmacist remuneration.

The current minimum wages paid to early career pharmacists as per the award are very low and do not reflect the time and cost of training and the expertise that a qualified pharmacist has as a medication expert. Paying someone in the low 20 dollar range to accurately dispense and counsel on Australian tax-payers medication is inappropriate and will also lead to/has already lead to: significant disillusion amongst junior pharmacists. These are the people who are meant to be the future of the profession. I believe that many pharmacies have business models or financial pressures on them that lead to them paying only the award. The remuneration to pharmacies, the appropriate fee for pharmacist services and the minimum wage to pharmacists need to be critically assessed in this review. I believe the minimum wage for pharmacists must be lifted to reflect the primary health care role they are doing, this needs to be manageable for the pharmacy owners though and remuneration needs to stay at levels that allow the owners to afford the increase.

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