



Response to the
**Review of Pharmacy
Remuneration and
Regulation – Interim
Report**

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Federal President**

**The Society of Hospital Pharmacists
of Australia**

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The Society of Hospital Pharmacists of Australia (SHPA) is the national professional organisation for pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia’s healthcare system.

SHPA members are progressive advocates for clinical excellence, passionate about patient care and committed to evidence-based medicine.

SHPA is committed to facilitating the safe and effective use of medicines, which is the core business of pharmacists, especially in hospitals. SHPA supports pharmacists to meet medication and related service needs, so that both optimal health outcomes and economic objectives are achieved for Australians, as individuals, for the community as a whole and for healthcare facilities within our systems of healthcare.

Foreword

SHPA welcomes the opportunity to comment on the Interim Report of the Pharmacy Remuneration and Regulation Review. Our comments build on the foundation of the principles we espoused in our original submission in October 2016, which inform our commitment to achieving the goals of the National Medicines Policy. These should be read as key to all recommendations throughout our response to the Interim Report.

1. Funding for services provided by pharmacists should focus on the delivery of health outcomes rather than the processes to provide the service.
2. Policy and remuneration planning should incorporate the significant linkages of hospital and community pharmacy, and hospital pharmacy's contribution and role in clinical innovation.
3. SHPA represents the expertise and experience of the hospital sector where more than 17 per cent of the Pharmaceutical Benefits Scheme (PBS) is expended, and therefore SHPA is a key stakeholder in contributing to further agreements associated with remuneration of services.
4. Remuneration for pharmacy services must reflect the four key elements of the model for clinical care: appropriately skilled pharmacist, appropriate setting, correct clinical information and collaboration with patient, carer and medical team.
5. Healthcare services by healthcare practitioners, in this case pharmacists, must be provided in settings conducive to the delivery of professional services. The community retail pharmacy setting must be significantly reformed to enable this to consistently occur.
6. The credentialing of pharmacists with additional skills and experience in cognitive services is useful in determining remuneration for delivery of more comprehensive cognitive services.
7. Cognitive pharmacist services should not be linked to the supply of medicines and should be remunerated separately.
8. Individual pharmacists should be remunerated directly as a provider of a cognitive service in line with other health professionals.
9. The dispensing of medicines has three components: clinical review, medication labelling and patient education and these should be recognised and remunerated as distinct activities.
10. Any review of hospital and community remuneration within the PBS should acknowledge the differences in existing hospital remuneration and deliver a single funding model.
11. Where need exists hospitals should not be prevented from dispensing to the community.
12. Manufacturers should provide a guarantee of continual supply of a PBS medicine.
13. All remunerated services must be evaluated periodically to ensure quality of service delivery and achievement of outcomes.
14. SHPA believes that it is imperative for the profession that future programs and services seeking to optimise the contribution of pharmacists should build on the unique expertise of the profession and healthcare needs of the community.

SHPA represents a committed expert pharmacy workforce. Our members, and our organisation, welcome opportunities to work with other pharmacy stakeholders, healthcare providers and professional bodies, to improve the access of all Australians to comprehensive pharmacy services.

Your sincerely,



Professor Michael Dooley
Federal President

Policy discussion

The interim report of the Review of Pharmacy Remuneration and Regulation ('the Review') provides a comprehensive assessment of the delivery of pharmacy healthcare in the Australian community. SHPA was pleased to see the priority of the Review described as 'consumer access' – the safe, efficient and effective distribution of medicines listed on the PBS to Australians who need them, regardless of location – consistent with the National Medicines Policy. SHPA understands this to include consumer access to medicines at times of key importance such as discharge from hospital, during treatment at a day clinic, or when an outpatient as funded by the PBS.

SHPA notes that the vision expressed in the interim report has narrowed from the earlier discussion paper, with the underpinning vision specifying 'an integrated and sustainable community pharmacy sector' rather than the 'community pharmacists and pharmacists in primary health care' as previously discussed. This narrowing of focus is understandable given the complexity of the pharmacy sector, and is reflected in key recommendations in the Review such as the restructuring of the Community Pharmacy Agreement (CPA). The proposed CPA would aim to focus exclusively on community pharmacy settings, and engage only community-pharmacy-related stakeholders.

With a membership comprised of pharmacists working in public and private hospitals, primary healthcare, and as pharmacy consultants, SHPA does not intend to comment on the proposed funding of community pharmacies, apart from how conditions might affect pharmacy services and patient care more generally. However, this CPA approach is a significant change, given past iterations have previously dictated funding for pharmacy innovation, delivery of pharmacy services by independent and consultant pharmacists, accreditation of pharmacists and funding of PBS dispensing. **The recommendations made in the Review have the potential to seriously impact the funding of medicines in hospitals and the access of all Australians to medicines and pharmacy services. Given this risk, SHPA believes it is essential any negotiation of the CPA and discussion of the PBS includes the SHPA to avoid unintended gaps in service, increased costs to consumers and threats to the highly regarded, quality clinical care for which the Australian healthcare system is renowned.**

In addition, SHPA believes enhancing the continuity of care for patients transitioning to community care by harnessing hospital pharmacy services should be more widely considered by the Panel. As hospital pharmacists, SHPA members hold the unique position of sharing the same undergraduate training as community pharmacists, and therefore have a good understanding and appreciation of pharmacist skills and capacity, while having simultaneously gained in-depth understanding of the acute care sector, in which the most unwell patients are treated. These patients are typically also those at highest risk of a wide range of poor outcomes including adverse drug reactions, medicine mismanagement and rehospitalisation^{1,2}, and derive the most benefit from clinical pharmacy interventions – in hospital environments where these interventions have been proven to be hugely cost-effective (with a ratio of cost saving of \$23 returned for each \$1 spent), as well as clinically valuable³. This expertise also has great potential to benefit patients outside a hospital building.

Hospital pharmacists are an expert resource available to provide optimal care through difficult terrain in the patient journey. SHPA agrees with the Panel's assertion that in the future 'there will be a need for a greater focus on integrated, rather than episodic, care [and that] the pharmacy sector must take a shared responsibility for its own future if the system is to remain sustainable'. Yet the Review's own recommendations do the opposite, ignoring the role of non-community pharmacy expertise and non-community settings.

SHPA recognises that, as hospital pharmacists, the role of our members has the potential to successfully straddle primary healthcare and acute settings. This is already happening in many locations where pharmacy services have 'branched out' from both hospital and primary health services, meeting in the middle. The opportunity to address a known 'gap' in the continuum of care with pharmacist-led cognitive services in a range of settings is discussed further in this document. The delivery of pharmacist-led cognitive services such as medicine review demonstrates the benefit of advanced pharmacists' skills and care⁵, given the growing need of high-risk consumers⁴. SHPA welcomes the responsibility of supporting strategies which optimise pharmaceutical care as outlined in SHPA's continuing professional development content, Standards of Practice and other member materials.

As part of this advocacy for pharmacy, SHPA believes the evidence base demonstrating improvements for patients in blood pressure and cholesterol control, diabetes, and medication management, resulting from pharmacist-led medication review, justifies the expansion of the Home Medicine Review (HMR) program for high-risk patients⁵. Additional strong evidence supports the widespread introduction of a hospital referral pathway with a study showing patients aged 51–65 years exhibited a 25 per cent reduction in hospital readmissions⁶. SHPA supports the Interim Report's recognition that accredited pharmacists are best placed to provide HMRs in the community.

In this document, we respond to the options presented by the Interim Report, however many key policy points were not specifically mentioned in the discussion options. To ensure that important pharmacy policy improvement opportunities are not lost we have listed the key changes SHPA believes should be made to significantly improve consumer access and patient care:

Patient-centred care

1. Prioritise the development of hospital initiated referral pathways for Home Medicine Reviews to enable independent accredited pharmacists to support patients who have recently attended the acute care setting. As well as hospital initiated referrals other valuable referral sources could include the Royal Flying Doctor Service and Royal District Nursing Service. An adaptable model for delivery of these reviews that are targeted to patients with commensurate needs, instead of arbitrary and restrictive rules, is the HARP (Hospital Admission Risk Program) Medication Management Services.
2. Support the development of electronic prescribing and electronic prescription records, interoperable with hospital-wide electronic medical records, in a hospital setting to ensure current and accurate records can be provided to and accessed in primary care settings and community pharmacies. A financial incentive for software

vendors could drive improvement, and support rapid adoption in hospital pharmacies.

3. Build on the quality of care mandated in the Public Hospital Pharmaceutical Reform Agreements and the Australian Pharmacy Advisory Council's *Guiding Principles for Achieving Continuity in Medication Management* to support care for patients transitioning from hospital into community.
4. Introduce an MBS item number for clinical review and advanced pharmacist consultation to support greater utilisation of clinical pharmacy skills; clinical review is beneficial for all patients, and especially so for those at high-risk of poor patient outcomes.
5. Remove the cap for high-risk patients to avoid inequitable access to Home Medicine Reviews. SHPA believes it would be appropriate for pharmacists to complete up to 10-15 HMRs per week, to allow for all elements of the HMR service to be conducted effectively, such as the patient interview, medication review and establishing the Medicines Management Plan in collaboration with the patient's GP.
6. Enable hospital pharmacies to supply Dose Administration Aids with the same funding conditions as community pharmacies to prevent high-risk patients having delayed or disrupted access to medicines when discharged from hospital.
7. Provide support for consumer access to pharmacy services that recognises, in some circumstances, access to a hospital pharmacy, rather than a community pharmacy, is preferable. This is most relevant for patients requiring complex medicines in rural and regional areas or suffering complex, highly morbid but less common conditions that may 'concentrate' in hospital outpatient clinics.

Professional sector development

1. Reform of the CPA that affects reimbursement for PBS medicine dispensed through hospitals will have significant impact of hospital funding of pharmacy services and the access to these services for patients. This necessitates greater consultation with SHPA regarding the CPA and examination of potential implications which affect the 17 per cent of PBS expenditure⁷ as required in Federal Government negotiation⁸.
2. Given the importance of supporting innovative and flexible pharmacy services, clarification regarding the management of funding outside the CPA is urgently required. Future pharmacy innovation should be encouraged in all pharmacy settings through a process independent of signatories of the CPA
3. Any reform that includes changes to the PBS including reforms of the PBS medicines in hospitals program, should build on the Key Performance Indicators listed in the Australian Pharmacy Advisory Council's *Guiding Principles for Achieving Continuity in Medication Management* as mandated in the Pharmaceutical Reforms Agreement.

4. Align funding for community pharmacy services with the delivery of other allied health services and focus on patient outcomes. This would also support the delivery of cognitive pharmacist services by independent appropriately skilled and credentialed pharmacists.
5. Ensure policy and remuneration planning for community pharmacies supports greater liaison with hospital pharmacies for the benefit of patients, rather than being limited to non-collaborative dispensing or patient counselling.

Evidence collected by the Review's qualitative and quantitative reports indicates pharmacy healthcare remains a poorly understood component of primary and acute healthcare, and that work must be done to increase consumer understanding. SHPA has consistently supported the Review as beneficial for both the sector and the broader community through enabling greater understanding of how pharmacy works, as well as what pharmacy can do for the community.

SHPA is particularly pleased to see the value the Review has attributed to the development of a pharmacy sector which is 'adaptive to the inevitable changes in healthcare given Australia's ageing population, rapid advances in technology and ongoing PBS reform'. These concepts align closely with SHPA's values as a progressive, passionate and patient-centred membership organisation. SHPA would appreciate greater insights into the Review's commitment for the cognitive services that will support the sector's responsive innovation.

Looking forward twenty years, SHPA envisions a pharmacy profession recognised as an essential element of both primary and acute healthcare, with a strong evidence-base for patient-focused clinical pharmacy services, contributing to better health outcomes for Australians and the Australian healthcare system. We believe our members will be working collaboratively with community pharmacy colleagues, in a consistent remunerated framework for the benefit of patients.

Response to ‘Summary of findings and options’

Chapter 2: Consumer Access and Experience

OPTION 2-1: PRICING VARIATIONS

The payment made by any particular consumer for a PBS-listed medicine should be the co-payment set by the government for that consumer or the dispensed price for that medicine, whichever is the lower. A community pharmacy should have no discretion to either raise or lower this price.

SHPA supports Option 2-1 and agrees with the Pharmacy Remuneration and Review Panel (‘the Panel’) that medicines are not normal items of commerce. As noted in SHPA’s original submission to the Review⁹, significant variations exist with co-payment amounts and processes, across a variety of settings. The differences reported in the interim report regarding metropolitan and rural locations are particularly concerning as they exacerbate the poor access of people in rural areas. With fewer community pharmacies accessible in regional and rural areas, our members have indicated that hospital pharmacists often go to great lengths to supply medicines to people in remote locations, such as posting medicines to patients, or establishing shared care arrangements with local health services.

Competitive discounting by community pharmacies can provide unintended impacts on pharmacy practice and patient outcomes by introducing perverse incentives to dispense. These practices can reduce service quality and are not conducive to patient-centred care. SHPA recognises that Option 2-1 proposed by the Interim Report would lessen the confusion currently experienced by consumers, and may motivate community pharmacies to compete on models of care revolved around professional services as opposed to medicine price and this would be beneficial for quality service. We also note the potential negative impact of Option 2-1 on consumer affordability, and thus medication adherence and access.

A reduction in medicines adherence by community-based patients may lead to patients mismanaging their conditions, treatment failure, and increasing the likelihood of representations to the local GP practice or hospital readmissions, and increased health costs^{10,11,12}. Such adverse outcomes are key drivers for hospital pharmacies to absorb non-payment of co-payments for key patient groups (i.e. patients eligible for Closing the Gap prescriptions, those on Community Treatment Orders and those with mental health conditions). Balancing these competing concerns is an ongoing challenge for pharmacy providers in all settings.

SHPA also believes that Option 2-1 does not mitigate practices that could void achievement of its intent. For example, given the large number of PBS medicines below the general co-payment, pharmacies are able to dispense PBS-listed medicines as private prescriptions and continue to engage in price competition. As such, this Option 2-1 should replace the words ‘PBS-listed medicine’ with ‘pharmaceutical benefit’.

OPTION 2-2: \$1 DISCOUNT

The government should abolish the \$1 discount on the PBS patient co-payment.

SHPA supports the broadest access to PBS medicines for patients especially for those facing barriers. SHPA recognises that the \$1 discount, when provided, would benefit concessional patients at the time of purchase; however, as it is not included in their Safety Net expenditure, it also slows their progression towards the threshold. This policy implementation is therefore contradictory – encouraging access in one way and discouraging it in another. Significant evidence presented in the Interim Report suggests that the discount is disproportionately offered in metropolitan areas as compared to regional areas. A consistent application of PBS patient co-payment prices would be more appropriate than the \$1 discount currently offered.

OPTION 2-3: PBS SAFETY NET

In relation to the PBS Safety Net, the government should:

- a. require the PBS Safety Net to be managed electronically for consumers. This expectation should be automatic from the consumer's perspective**

SHPA supports electronic administration of the PBS Safety Net, noting this would have considerable benefits for patients who receive medicines from both hospital and community pharmacies.

These patients may be currently unaware they can include their discharge medicines in the cumulative benefits they record on the Safety Net and miss the opportunity to offset this cost. Enabling pharmacists to view a patient's PBS Safety Net contributions in real-time would also increase the efficiency of liaison between hospital and community pharmacies. My Health Record may be an appropriate platform for a patient's progress towards PBS Safety Net to be recorded.

- b. investigate whether the PBS Safety Net scheme can be adjusted to spread consumer costs over a twelve-month period**

While SHPA stated that current PBS Safety Net arrangements is adequate for most Australians in our original submission, we are sympathetic to concerns that the administration of the PBS Safety Net is burdensome and inequitable for consumers, especially those with chronic conditions. Hence SHPA supports an investigation to determine whether the scheme can be adjusted to spread consumer costs over a floating twelve-month period if that would better assist consumers to manage their conditions.

- c. provide sufficient transparency in the way a patient's progress towards the PBS Safety Net is collated, including information on any gaps in how it is calculated**

SHPA supports transparency in healthcare and consumer control of their own health and care, including access to information about their Safety Net claim. We envision that transparency in a patient's progress towards the PBS Safety Net would be beneficial and could be achieved with electronic administration of the PBS Safety Net. My Health Record

would potentially be an appropriate platform for a patient's progress towards PBS Safety Net to be recorded.

d. investigate and implement an appropriate system which allows payments for opiate dependence treatments to count towards the PBS Safety Net.

SHPA supports the implementation of a system allowing for opioid replacement therapies to count towards the PBS Safety Net. SHPA notes that patients undertaking opioid replacement therapies usually pay a fee to the community pharmacy, however these fees both vary, and do not count towards the patient's PBS Safety Net. This is inequitable given the important treatment function of opioid replacement therapies and their cost burden.

SHPA recognises that, while unusual, there are precedents for items on the PBS that are not for medicines, but for services. Patients eligible for the Repatriation Pharmaceutical Benefits Scheme (RPBS) can have an Authority prescription for 26 weeks that is 'dispensed' by the community pharmacy each week they provide a dosage administration aid (DAA) service to the patient¹³. SHPA would also support consideration of other community pharmacy scenarios where more frequent dispensing is required and paid for by consumers and not included in the threshold expenditure i.e. staged supply of medicines.

OPTION 2-4: LABELLING

All PBS medicines provided to patients should be appropriately labelled and dispensed. Where there is a system in place that involves 'remote' dispensing or 'bulk supply' then this system will require appropriate monitoring to ensure the quality of medicine supply.

SHPA supports Option 2-4 noting that 'medication preparation and labelling', is one of three core elements of dispensing, the other two being 'clinical review', and 'patient counselling'.

The provision of accurate and patient-specific labelling is core to medication safety and fundamental to good pharmacy practice^{14,15}. Technological developments such as remote dispensing or bulk supply improve access to medicines must not be at the expense of high quality service provision by pharmacists. SHPA does not support the provision of non-patient specific labelling of medicines.

OPTION 2-5: PHARMACY ATLAS

There should be an easily accessible and searchable 'atlas' of all community pharmacies in Australia that provides key patient information, including the services and programs offered by that pharmacy, the opening hours of the pharmacy and any specific accessibility services of the pharmacy (e.g. multilingual staff). The 'atlas' should be easily accessible to consumers (e.g. through mobile-friendly applications)

SHPA supports the proposal of an 'atlas'/web directory of remunerated services provided by PBS-approved pharmacies, including hours of operation and pharmacy services, given the important role community pharmacies play providing after-hours care and as a triage and referral service. Hospital pharmacies offering remunerated services should also be included. Currently many hospital pharmacy departments list the types of services that are offered to

outpatients on the hospital's website, as the availability of certain outpatient clinics, outpatient pharmacy services, and medical specialties differs between hospital networks. SHPA feels strongly that remunerated services and other professional cognitive services should be included. Any "atlas" must be governed, structured and evaluated to ensure that the information provided does not extend into marketing and promotional information.

OPTION 2-6: CONSUMER MEDICINES INFORMATION

A Consumer Medicines Information (CMI) leaflet should be offered and made available to consumers with all prescriptions dispensed in accordance with Pharmaceutical Society of Australia (PSA) guidelines. The PSA guidelines and the distribution of CMIs to consumers need to be audited and enforced to ensure compliance. Pharmacists and the pharmacy industry should continue to work on the improvement of CMIs and the use of technology to make medicines information more available to consumers

SHPA strongly supports the consistent supply of consumer medicines information (CMI) for dispensed medicines in resource form and as important component of face-to-face patient counselling as outlined in SHPA Standards of Practice for Clinical Pharmacy¹⁶. SHPA notes that the Therapeutic Goods Administration (TGA) recently released the MedSearch™¹⁷ app which allows consumers to view the CMI leaflet for any medicines that is registered on the Australian Register of Therapeutic Goods. This is in addition to similar information provided online by NPS Medicinewise. Technological developments such as this may reduce use of traditional leaflets for many patient groups, however they remain an important tool. Increased attention to the provision of CMI materials for generic medicines and medicines sourced through foreign suppliers would also be beneficial. The TGA should review standards to ensure companies act to improve the readability of CMIs by using plain English, noting the poor health literacy amongst Australians.¹⁸

It is unclear whether the Panel expects the provision of CMI to be included in standard dispensing as outlined in future CPAs, or whether these constitute a separate professional service. Printed CMI is only one aspect of the patient information delivered during the dispensing and patient counselling process.

OPTION 2-7: ELECTRONIC PRESCRIPTIONS

The government should initiate an appropriate system for integrated electronic prescriptions and medicine records as a matter of urgency. Under this system the electronic record should become the legal record. Participation in the system should be required for any prescriber of a PBS-listed medicine, any pharmacist wishing to dispense a PBS-listed medicine and any patient who is seeking to fill a PBS prescription.

SHPA supports the implementation of electronic prescriptions and medicines records as a matter of urgency as flagged by the Interim Report. The Interim Report specifically identifies the hospital setting as a challenge for implementing electronic prescribing due to barriers for hospital doctors and specialists. SHPA is aware that several hospitals are in the process of implementing electronic medical records and electronic prescribing. SHPA would be pleased to work with the Department of Health in supporting work in this area.

SHPA members are very supportive of electronic medicine records and have made many submissions in efforts to advance adoption. Whilst individual hospitals are trialling approaches, there are significant barriers to widespread uptake. SHPA believes that financial incentives, similar to those received by community pharmacies, could be paid to hospital pharmacies to encourage greater adoption. Incentives could also be offered to software vendors to develop a comprehensive solution as the inconsistencies in patient care and discharge medicines supply across Australia inherently cause problems for systems designs. Implementation would also be simplified if the PBS was adopted nationally for discharge medicines. To avoid further fragmentation of healthcare information any electronic record must also be linked to the patient's My Health Record and be interoperable with hospital-based systems.

OPTION 2-8: ELECTRONIC MEDICATIONS RECORD

The electronic personal medications record should cover all Australians and ensure appropriate access by, and links between, community pharmacy, hospitals and all doctors. This record should also include a vaccine register

SHPA supports Option 2-8 as having a complete medication record is a key clinical pharmacy objective as outlined in SHPA's Standards of Practice for Clinical Pharmacy Services¹⁶ and commonplace in hospital pharmacy. SHPA believes that developing these records in an electronic format should be a national pharmacy priority. We are aware of multiple hospitals currently in the process of implementing electronic prescribing or electronic medicines records.

As discussed previously barriers to the development and implementation of these systems are numerous. However, we are aware of positive reports from community pharmacists beginning to utilise the My Health Record services in regions where participation has been on an 'opt-out' basis.

SHPA also supports the Panel's recommendation that the medication record should include a record of a patient's immunisations, noting that Department of Human Services – Medicare currently administers the Australian Immunisation Register on behalf of the Department of Health.

OPTION 2-9: ELECTRONIC PRESCRIPTIONS – CONSUMER CHOICE

The choice of where a consumer has an electronic prescription dispensed should remain a decision for that consumer. The consumer may request that the electronic prescription be directed to a particular community pharmacy for dispensing (including an online pharmacy if that is the consumer's choice). For avoidance of doubt, a prescriber may not direct an electronic prescription to a particular community pharmacy for dispensing. This will require appropriate oversight and enforcement by professional bodies.

Whilst SHPA supports the high priority given to consumer choice in Option 2-9, we believe it is worth acknowledging the clinical necessity for 'channelling' a discharge prescription to a specific pharmacy such as the hospital pharmacy, or a specific community pharmacy, in some situations. Key considerations include the provision of non-PBS medicines - many

hospital discharge prescriptions are for medicines not listed on the PBS and therefore must be dispensed by the hospital pharmacy. High cost medicines may not be stocked by all community pharmacies resulting in delayed supply affecting adherence. Some hospitals have contracted specific community pharmacies to supply discharge medicines to ensure a consistent level of cognitive service is provided.

SHPA does not object to discharge prescriptions for PBS medicines being dispensed by community pharmacies. For many hospitals, this is a useful strategy for increasing dispensing capacity and improving patient flow. However, for some prescriptions it is clinically appropriate to 'direct' where it is dispensed such as within the hospital. Further consultation at the jurisdictional level regarding processes within public hospitals is necessary to inform this option..

Additionally, SHPA would like to see an integrated electronic system which would end the lack of reciprocal dispensing between community and hospital prescriptions. Whilst hospital prescriptions are frequently dispensed in the community, hospitals are unable to dispense any community prescriptions. Whilst SHPA recognises that most hospitals do not wish to provide community pharmacy dispensing services, the regulation preventing dispensing in any circumstances is a barrier for family and friends of patients, and hospital staff. It also prevents innovative hospital pharmacy services from choosing to provide medicines for patients in Aged Care facilities co-located within, but not part of a public hospital, essentially protecting community pharmacy from competition. The regulation enforcing this prescribing practice is contradictory to the Review's aim of enabling greater medicines access.

OPTION 2-10: MANAGING MEDICINE RISKS FOR PATIENTS UPON DISCHARGE

Hospitals should work closely with community pharmacies to ensure patients have access to the medicines they require upon discharge. Consistent policies and procedures are required to ensure each patient has access to the medicines they require as well as appropriate education and information relating to their medications. This may involve the hospital providing a 'discharge pack' with an appropriate level of patient medication to allow the patient to safely access a community pharmacy and their community health practitioner without running short of medication.

SHPA supports the development of greater liaison between hospital and community pharmacies to enable an optimal transition of care for patients returning home or moving into residential services¹⁹. The transition for patients leaving hospital and returning to community care is well-known as an important risk period for gaps in care resulting in poor patient outcomes¹. We note that both hospital and community pharmacists are strong patient advocates, and provide a range of services appropriate to quality patient care and patient needs. SHPA recognises that pharmacist-led transitional care, involving formal collaboration between hospital and community pharmacists has not yet been officially established in Australia, unlike other countries such as the United States where specialty transitions of care residency training is offered²⁰. In Australia SHPA believes that systemic barriers such as funding incentives and medicine regulation are the major obstacles to the delivery of improved transitional care.

As outlined in Option 2-10 SHPA agrees with the Interim Report that hospitals should work closely with community pharmacies to ensure patients have access to medicines they

require after a hospital stay. However pharmacy standards and guidelines identify that medicines supply is only one element of the pharmacy services necessary for a successful transition of care¹⁶. SHPA would expand this option to support to the provision of clinical pharmacy services as required by patients during periods of high risk of medicine misadventure. Hospitals have long been innovators in the delivery of services that address this transition period such as HARP, Outreach and most recently a collaboration with the RDNS to provide services in Eastern Melbourne's Primary Health Network.

The Interim Report recommends hospital pharmacies provide 'discharge packs' containing around three to four days of the patient's medications so that they can access community based health services without running short of medication. This recommendation shows a lack of understanding of current hospital pharmacy practices. SHPA is surprised the Panel has not referred to current public hospital pharmacy discharge practice which ensure patients receive either a 30-day supply of PBS medicines, or (after review by a clinical pharmacist) a prescription for 30 days of medicines to be filled at a convenient community pharmacy. This flexibility tailors use of precious hospital resources dependent on patient need and enables efficient patient flow. Provision of 30 days of medicines avoids increasing the patient's risk of poor medicine adherence through insufficient supply and suits the convenience of month-long medicine packs as manufactured. This dispensing practice is similar in private hospitals in most cases who provide patients with the remainder of the medicine pack dispensed at admission, or dispense a new month-long supply at discharge.

Under the current Public Hospital Pharmaceutical Reforms Agreement ('the Reforms'), hospitals in participating PBS states/territories commit to provide patients with access to a month's worth of medicines upon discharge with appropriate counselling and clinical review. Prior to the Public Hospital Pharmaceutical Reforms, hospitals were typically supplying two to seven days of discharge medicines, which was not sufficient to ensure continuity of care, especially for patients in rural and regional areas where access to GPs can be challenging. This contributed to poor patient outcomes related to medicine management and rehospitalizations²¹.

It is possible that the 'inconsistency' the option refers to reflects the lack of participation of some states and territories in the Pharmaceutical Reforms rather than any explicit pharmacy practice. In states and territories who have not signed up to the Reforms (notably New South Wales and the Australian Capital Territory) public hospitals provide substantially fewer medicines, generally three days' worth. (It should be noted that while the Northern Territory is a signatory to the Reforms, they have not implemented the discharge medicines element due to the difficulty of collecting co-payments with a large highly disadvantaged population). It is the experience of SHPA members nationally that providing a minimal amount of medicines commonly leads to poorer medicine adherence, increased pressure on General Practitioners and inequitable access to essential medicines. Sometimes it can result in very unwell people leaving hospital with no medicine at all, and having great difficulty in obtaining it. As noted by ACT Health, where patients receive medicine for three days only, it is incumbent on the patient to "*make an appointment as soon as possible with [their] general practitioner to ensure the continuation of [their] medication supply*"²². However, there is ample evidence demonstrating that this leads to reduced medicines adherence due to patients not seeing their GP within the restrictive timeframes or not having their medicines dispensed in the community.^{23,24} This is a significant factor contributing to the 230,000

medicine-related hospital admissions in Australia, at the cost of \$1.2 billion annually to Australia's healthcare system.²⁵

SHPA members in New South Wales and the Australian Capital Territory have stated that joining the Public Hospital Pharmaceutical Reforms would do much to improve the quality of patient care during transition into community settings. Joining the Pharmaceutical Reforms Agreement would also reconcile shortcomings of NSW hospital pharmacy services as identified in the *Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals* (the Garling Report)²⁶ where non-adoption of the reforms contributes to inpatients not receiving the full breadth of clinical pharmacy services such as medication reconciliation on admission, medication review and counselling on discharge. Furthermore, NSW hospital pharmacists are often unable to participate in ward rounds, that are common in other states, to inform the quality of care they provide. These are all risks and inadequacies that the Garling Report notes should be rectified. NSW Health notes in their submission to the Review, that improved funding would allow pharmacists to provide services at the full extent of their scope of practice, as occurs in other Australian states and territories. National participation in the Reforms would also assist consistent engagement with technological developments in healthcare such as electronic prescribing and the implementation of the My Health Record project.

The benefits of national PBS implementation for patients transitioning from hospital to home are in addition to any improvement in hospital and community pharmacy liaison, which SHPA believes can be substantially strengthened through policy initiatives such as increasing the access of high-risk patients to medicines review through funding hospital initiated HMRs. International examples of successful solutions to improving transitional care demonstrate the importance of addressing this complex area of care in both hospital and community settings, and with hospital and community pharmacy workforces.

The review should note the existing policies and procedures which direct the transition of care from a hospital setting. These include the *National Safety and Quality in Health Service Standards*²⁷ and *Guiding principles to achieve continuity in medication management*²⁸ - both mandated for hospitals by the federal government, as well as SHPA's Standards of Practice for Clinical Pharmacy¹⁶. Internationally the clinical practice guidelines²⁹ produced by the American Medical Directors Association may be useful.

Chapter 3: The Role of Community Pharmacy in Medicine Supply

OPTION 3-1: COMMUNITY PHARMACIES – MINIMUM SERVICES

The government should establish a process to determine the set of minimum requirements that a community pharmacy must meet in order to receive remuneration for dispensing. The government should initiate procedures to enforce these requirements and to have them updated at regular intervals. These requirements should be promoted by being incorporated within the Community Pharmacy Service Charter.

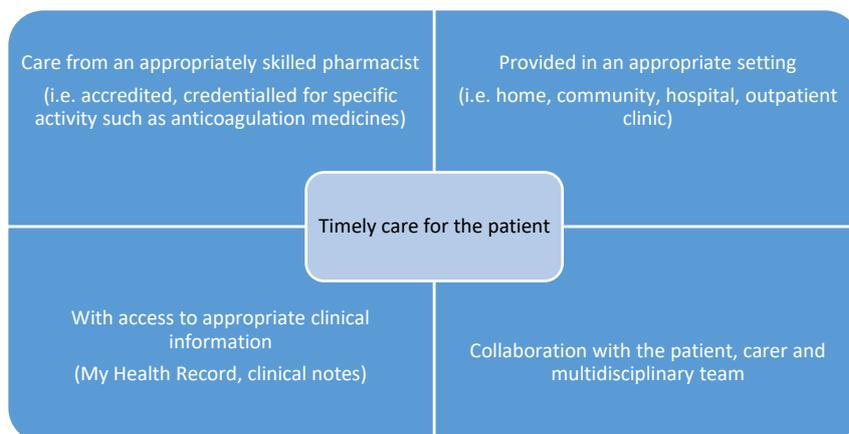
SHPA supports the development of criteria to determine minimum requirements for all pharmacies to receive government funding for the provision of healthcare services such as medicines.

As discussed in our original submission, SHPA support the provision of healthcare services by pharmacists as healthcare practitioners, in settings conducive to the delivery of professional services, as necessitated to meet the requirements of the Australian Charter of Healthcare Rights³⁰. Feedback from members, and reports from the broader community, in many cases the community retail pharmacy setting must be significantly reformed to enable this to consistently occur. Criteria identifying the minimum requirements would assist community pharmacies in meeting these expectations.

As outlined in SHPA's Model of Care⁹, the minimum services required for all pharmacy are those that deliver care:

- from an appropriately skilled pharmacist
- in an appropriate setting
- with access to appropriate clinical information
- in collaboration with the patient, carer and medical team
- in order to deliver timely care for the patient.

Image 1. SHPA Model of Care



SHPA believes that all pharmacists should be able to provide high quality care for patients in any setting. However, traditionally different settings have prioritised the development of varying clinical skills. As an element of contemporary management of conflicts of interest,

SHPA does not believe that monitoring of requirements should be overseen by a party of CPA negotiations.

OPTION 3-2: COMPLEMENTARY MEDICINES – SUPPLY FROM PHARMACIES

Community pharmacists are encouraged to:

- a. display complementary medicines for sale in a separate area where customers can easily access a pharmacist for appropriate advice on their selection and use**
- b. provide appropriate information to consumers on the extent of, or limitations to, the Therapeutic Goods Administration (TGA) role in the approval of complementary medicines. This could be achieved through the provision of appropriate signage (in the area in which these products are sold) that clearly references any limitations on the medical efficacy of these products noted by the TGA.**

SHPA supports both Options and believes the community pharmacist is the most appropriate health professional that a patient can speak to when deciding if complementary medicines are an appropriate component of their treatment. In relation to educating consumers about the infrastructure and regulation of complementary medicines SHPA believes community understanding could be greatly enhanced if the Therapeutic Goods Administration took a larger role in educating the public on what TGA registration means, its value for products and how to identify registered products, rather than relying solely on the pharmacist to deliver appropriate information.

OPTION 3-3: PLACEMENT OF PHARMACY ONLY AND PHARMACIST ONLY (SCHEDULE 2 AND SCHEDULE 3) MEDICINES WITHIN A PHARMACY

Access to Pharmacy Only (Schedule 2) and Pharmacist Only (Schedule 3) medicines should be clearly separated from complementary medicines within a pharmacy.

Options to achieve this might include:

- a. ensuring that all Pharmacy Only (Schedule 2) and Pharmacist Only (Schedule 3) medicines only be accessible from 'behind the counter' in a community pharmacy so that a consumer must always seek assistance or advice in obtaining these medicines**
- b. requiring that complementary medicines are not displayed 'behind the counter' in a community pharmacy.**

SHPA supports the provision of evidence-based medicines, and believes that all patients should have access to appropriate pharmacist consultation when purchasing medicines and both options presented in Option 3-3 would achieve this intent.

OPTION 3-4: SALE OF HOMEOPATHIC PRODUCTS

Homeopathy and homeopathic products should not be sold in PBS-approved pharmacies. This requirement should be referenced and enforced through relevant policies, standards and guidelines issued by professional pharmacy bodies.

SHPA supports the provision of evidence-based medicines, and given the lack of evidence for the efficacy of homeopathy does not support their use, endorsement or sale through PBS-approved pharmacies. This position has been previously referenced publicly by the Australian Pharmacy Liaison Forum of which SHPA is a member³¹.

Chapter 4: Community Pharmacy Remuneration by Government

OPTION 4-1: ACCOUNTING INFORMATION

As soon as possible following the completion of this Review, the government, in consultation with the Pharmacy Guild of Australia and other stakeholders, should:

- a. **determine a set of accounting principles that will apply for community pharmacies in order to provide the relevant information needed to determine the best-practice benchmark cost of a dispense (as these terms are defined in this report)**
- b. **require community pharmacy (as a condition of being approved to dispense PBS medicines) to provide the necessary accounting information to inform consideration in the development of each Community Pharmacy Agreement (including as a basis for the determination of a best-practice pharmacy). The relevant accounting information should be provided for each financial year and no later than 31 December of the following financial year (beginning with 31 December 2018)**
- c. **designate a body within the government (although potentially an existing independent statutory authority with the relevant expertise such as the Pharmaceutical Benefits Remuneration Tribunal or, more broadly, the Australian Competition and Consumer Commission) to provide a recommendation to the government on the best-practice benchmark cost of a dispense as required over time by the government. The first such advice is to be provided as soon as practical and certainly before the end of 2019. The timing of later determinations will depend on the process used in the future by the government to set the remuneration for dispensing PBS medicines the information and advice submitted to the government should form the basis for the average remuneration for a 'dispense' to community pharmacy in the future and certainly from the expiration of the Sixth Community Pharmacy Agreement. The provision of appropriate accounting information should be an ongoing requirement to support the development of each Community Pharmacy Agreement.**

SHPA does not intend to advise on the funding of pharmacy activities specific only to community pharmacy settings. SHPA would appreciate guidance from the Panel regarding the likelihood of the CPA funding agreement continuing to set the prices for PBS medicines remuneration which does impact on hospital pharmacy practice heavily.

OPTION 4-2: REMUNERATION TO BE BASED ON EFFICIENT COSTS OF DISPENSING

The remuneration for dispensing paid by government and consumer co-payments to community pharmacy should be based on the costs of dispensing for an efficient pharmacy.

SHPA believes pharmacy services reflect excellent return on investment, and that stakeholders should be able to demonstrate this in any discussion of remuneration, and determination of an efficient price.

However, this option is dependent on the ability to define and evaluate the specific processes that comprise 'dispensing' and the specific inputs and outputs that form this activity. SHPA has concerns that these have not been defined within the Review and specifically what components of cognitive services are included with "dispensing".

SHPA reiterates our recommendations regarding the various components associated with dispensing and recommend that these must be clearly defined and evaluated to determine remuneration for these services.

The dispensing process and how this relates to pharmacist cognitive services associated with medication dispensing must be clearly articulated as the Review is currently unclear on this fundamental issue.

SHPA recommends a dispensing fee model which provides two tiers for the stages of clinical review and dispensing, and a time-based scale for patient counselling. This revised model would enable a pharmacist to be paid for the greater complexity required in the dispensing of medicines such as chemotherapy, whilst also acknowledging the value of reviewing the medication of targeted populations and those taking a large volume of medicines daily. Critically it would protect against poor practice such as inadequate counselling for repeat prescription of high-risk medicines, and encourage pharmacists to acknowledge those simple episodes of care which do not require significant review or counselling.

Table 1. Dispensing fee remuneration- current vs proposed

Dispensing prescription tasks	Current 6CPA model (one set payment)	Proposed (tiered payments)	
		Standard	Extended
Clinical review	Applies for all dispensing, irrespective of complexity and time required for preparation, clinical review and patient counselling episode Dispensing fee = \$6.93 AHI fee = \$3.49 plus 3.5% for medicines over \$180, capped at \$70 Wholesale-mark up = 7.52% of the exmanufacturer- price, capped at \$69.94	Standard (low risk medicine in low complexity patient)	Extended (high risk medicine e.g. chemotherapy)
Medication preparation and labelling		Standard (Prepared medication ready for use, requiring labelling only)	Extended Topical compounded, aseptic preparation (e.g. chemotherapy)
Patient counselling		< than 5 minutes	> 5 minutes

Whilst managing a tiered funding model is complex, SHPA believes it is no more complex than other healthcare transactions in which reimbursement reflects the complexity of the consultation and would enable greater value to be captured and remunerated.

In addition, we recognise the differences between services delivered in a metropolitan and a regional location are significant. SHPA’s initial submission to the Panel suggested adjustments for the payments to pharmacies to reflect the patient cohorts serviced by that pharmacy, like principles as used in hospital pricing. These could be extrapolated to account for the differences in pharmacies when attempting to establish the costs of dispensing for an efficient pharmacy.

- Population estimates (same as those used to identify Primary Health Networks)
- An adjustment for location for three groups: outer regional, remote and very remote as defined by the Independent Hospital Pricing Authority. (The Independent Hospital Pricing Authority uses the following adjustment values for these categories: metropolitan and inner regional 100 per cent, outer regional 107 per cent, remote 115 per cent and very remote 121 per cent)

An adjustment for socio-economic factors based on Socio-Economic Indexes for Areas described by the Australian Bureau of Statistics within the specific Primary Health Network. SHPA is concerned that the use of an ‘efficient’ price indicates a determination to avoid considering the complexity of efficient pharmacy which would include consideration of the length of a consultation and distinguish between initial and repeat transactions. For the record SHPA has included above a table outlining a preferable approach to reimbursing dispensing.

OPTION 4-3: BENCHMARK FOR AN EFFICIENT DISPENSE

On the basis of the information that has been made available to the Panel, and given the data limitations, the Panel considers that the current benchmark for a best-practice dispense be set within a range of \$9.00 to \$11.50. This should be reflected in the average remuneration paid to a pharmacy for a dispense.

SHPA reiterates our recommendations regarding the various components associated with dispensing and recommend that these must be clearly defined and evaluated to determine remuneration for these services.

The dispensing process and how this relates to pharmacist cognitive services associated with medication dispensing must be clearly articulated as the Review is currently unclear on the fundamental issue.

As discussed previously if the benchmark for dispensing is only to be implemented in community pharmacy settings SHPA has no comment. However, if the benchmark is to be utilised more broadly (as occurs with current CPA pricing) SHPA believes greater analysis and consultation is required, in partnership with ongoing reviews of the Pharmaceutical Reforms. Whilst ongoing reviews are occurring of the PBS medicines in hospital program SHPA cannot commit to a dispensing benchmark.

SHPA notes that public hospitals currently do not receive a dispensing fee when dispensing PBS medicines, instead receiving a mark-up on wholesale prices. SHPA advocates for a fairer dispensing fee that accurately reflects the level of clinical pharmacy services that are involved with the dispensing of medicines for hospital patients for all medicines including S100 at the point of discharge and at outpatient pharmacies.

OPTION 4-4: REMUNERATION FOR DISPENSING – FORMULA

The remuneration for dispensing should be a simple dispense fee based on the efficient, average, long-run incremental cost of a dispense in a community pharmacy.

SHPA does not support the adoption of a simple dispense fee to be applied in all settings. As discussed previously SHPA supports a tiered dispensing fee which recognises the differing levels of clinical service included in provision of medicines in any setting. SHPA is concerned that the justification for dispensing remuneration discussed in the Interim Report does not include recognition of the clinical pharmacy service provided to the patient as the primary reason for a dispensing fee in either community and hospital settings. As a healthcare service SHPA believe this should be the priority for fee establishment rather than the commercial viability of community pharmacies.

In relation to the establishment of an 'efficient' benchmark SHPA is also concerned that the wide variety of services provided in community pharmacy settings will be discounted in this standardisation. The value of community pharmacies in rural and regional areas, and as support for hospital pharmacies in these locations, should not be compared alongside metropolitan efficiency.

Table 2. Model for MBS payment and tiered PBS payment for pharmacists' services

Dispensing prescription tasks	Proposed (PBS tiered payments)		MBS payment
Clinical review	Simple (low risk medicine in low complexity patient)	Extended (high risk medicine e.g. chemotherapy)	Complex medicines consult HMR/RMMR
Medication preparation and labelling	Simple (Prepared medication ready for use, requiring labelling only)	Extended Topical compounded, aseptic preparation (e.g. chemotherapy)	
Patient counselling	< than 5 minutes	> 5 minutes	High-risk patient HMR

SHPA reiterates our recommendations regarding the various components associated with dispensing, and that these must be clearly defined, and evaluated, to determine remuneration for these services.

OPTION 4-5: REMUNERATION LIMITS

If the government does not place an upper limit on the wholesale payment for a community pharmacist then the government should adopt a two-part tariff payment for the remuneration (i.e. a payment that involves a fixed payment per dispense, plus a payment that varies with the relevant cost of the medicine) to the pharmacist.

Under either a flat fee or two-part tariff, the average payment for a dispense should equal the required fee determined by the government, following the acceptance of Option 4-4.

As discussed previously if this is only to be implemented in community pharmacy settings SHPA has no comment. However, if remuneration limits are to be utilised more broadly (as occurs with current CPA pricing) SHPA believes greater analysis and consultation is required, in partnership with ongoing reviews of the Pharmaceutical Reforms. Whilst ongoing reviews are occurring of the PBS medicines in hospital program SHPA cannot commit to a dispensing benchmark.

OPTION 4-6: REMUNERATION FOR OTHER SERVICES

Government should require that if the same service is offered through alternative primary health outlets then the same government payment should be applied to that service, regardless of the specific primary health professional involved.

SHPA does not support applying the same payment for similar services across healthcare, recognising variations may exist in the quality of care. Enabling greater access to pharmacy services is one of SHPA's highest priorities and the delivery of pharmacy services outside traditional pharmacy settings has potential to substantially contribute to preventive health efforts and improved acute care. Regardless of the practitioner, consumers, as outlined in the Australia Charter of Healthcare Rights, deserve high quality and safe care wherever and

whenever care is provided. This care must address the principles: Access, Safety, Respect, Communication, Participation, Privacy and Confidentiality.

However, whilst elements of pharmacy services would benefit from wider adoption, SHPA believes that dispensing of medicines is not within the remit of this option, and that professional services should only be remunerated if they are provided by appropriately credentialed health professionals acting within their scope of practice. Pharmacists are key members of the multidisciplinary team involving collaborative prescribing and treatment. Evidence supports member feedback that discharges of patients provided by other health professions such as nurses can result in poorer medicine adherence, less medicine knowledge, more GP visits and a higher risk of rehospitalisation³². SHPA is aware that this can occur in private hospitals which often do not operate an onsite hospital pharmacy service and are unable to provide pharmacy services after business hours.

Chapter 5: The Regulation of Pharmacy for Medicine Supply

LOCATION RULES

Following on from the federal government's commitment to the current pharmacy location rules in the 2017-2018 Budget, and the Review's decision to remove 5.1, 5.2, 5.3 from the final report, SHPA has not commented on these options.

OPTION 5-4: LOCATION RULES – POLICY OBJECTIVE

If the government retains the pharmacy location rules (or some version of these rules) following the end of the Sixth Community Pharmacy Agreement then the policy objective of these rules should be clearly stated and the rules modified to ensure that the desired outcomes are achieved over the medium term.

The objective of the pharmacy location rules should be to assist the Australian consumer to ensure equitable and affordable access to medicines for all Australians, consistent with the National Medicines Policy, with evidence to demonstrate the achievement of this objective.

SHPA believes the priority for regulation around the location and ownership of pharmacies should be to ensure equitable and optimal access for the Australian community. It is critical that 'unintended' service gaps for consumers are not created due to location rules or funding models which do not prioritise the effective delivery of health services for the Australian community. The rules as they exist have not encouraged innovation to address providing equity of access, and have created access and equity issues for patients in remote and very remote areas.

SHPA agrees that if pharmacy location rules are to be maintained, the aims and objectives of the location and ownership rules should be shifted to become more consumer focused. The aim should be that all Australians have access to the medicines that they require and the professional pharmacist services that are needed to support every consumer to safely and effectively use their medicines.

OPTION 5-5: LOCATION RULES – OWNERSHIP AND LOCATION

In areas where pharmacy location rules are maintained, any group of two or more pharmacies, each of which are located within 1.5 kilometres of another pharmacy in the group, that have an overlapping ownership should be considered to be a single pharmacy for the application of the location rules. The nominal 'location' of this single pharmacy would be the location of the pharmacy within the group that had the smallest turnover (in terms of the number of Pharmaceutical Benefits Scheme scripts dispensed) in 2016. For avoidance of doubt, a group of pharmacies would be considered to have an overlapping ownership if any individual or set of individuals have ownership of at least 20 per cent of the equity in each of the community pharmacies in that group. It is also considered that this option should be implemented five years after this Review to allow an appropriate time frame for transition. The oversight of this option should be undertaken by the Australian Competition and Consumer Commission.

As this does not relate to the direct provision of healthcare SHPA does not intend to comment on this option.

OPTION 5-6: INFORMATION ON PHARMACY OPENING HOURS

The Pharmacy Atlas (Option 2-5) should include information on pharmacy opening hours.

SHPA supports Option 5-6 and the development of an 'atlas' or web directory of pharmacy services, if a similar or effective service does not already exist. In the recent Victorian 'thunderstorm asthma' epidemic this resource, with the inclusion of opening hours, would have been a great aid for consumers and hospital emergency departments. SHPA strongly believes that the listing of non-evidence based services would be detrimental.

OPTION 5-7: 24-HOUR PHARMACY INFORMATION AND RELATED SERVICES

The government should investigate the feasibility of a 24-hour telephone and or internet 'pharmacy hotline' to provide medicine information to consumers Australia-wide.

SHPA supports this option, noting that innovative hospital pharmacists and hospital pharmacies are already using technology to deliver clinical pharmacy services including medicine information and medicine review to patients who experience access barriers. Hospital pharmacists also currently provide medicines information phone lines for the public in limited capacities. This existing infrastructure in hospitals could provide a cost-effective basis for similar services if expanded. SHPA's Standards of Practice for Medicine Information Services³³ is highly relevant for this initiative

OPTION 5-8: RURAL PHARMACY MAINTENANCE ALLOWANCE

In situations where there is more than one pharmacy within a 10-kilometre area that is receiving the Rural Pharmacy Maintenance Allowance (RPMA), the government should:

- a. only make payments to a single pharmacy in the area**
- b. ensure that the pharmacy that receives the RPMA is based on the programs offered by that pharmacy, including services, opening hours and location (centrality and ease of access)**
- c. ensure that the selection process is transparent.**

SHPA is pleased to see the Interim Report's inclusion of SHPA's proposed parameters for payment adjustments for an RPMA, but notes that SHPA did not recommend having only one pharmacy within a 10-kilometre area receive the RPMA as suggested by the Panel. Feedback from SHPA members has indicated that rural hospital pharmacies are unable to access the RPMA despite the benefit it would offer for improving the delivery of PBS medicines on hospital discharge and outpatient clinic attendances to rural communities. On a few occasions, a joint application between hospital and community pharmacies has been developed for RPMA funded roles. We can see great benefit for the community from these

kinds of initiatives which may be more difficult to progress if some pharmacies are arbitrarily unable to apply.

OPTION 5-9: HARMONISING PHARMACY LEGISLATION

As early as practicable, the Australian Government, through the Australian Health Minister's Advisory Council, should seek to harmonise all state, territory and federal pharmacy regulations to simplify the monitoring of pharmacy regulation in Australia for the safety of the public. In the long term, a single pharmacy regulator could be considered. As an interim measure, state and territory registering bodies need to coordinate with the Australian Health Practitioner Regulation Agency to ensure that pharmacy regulations are being adequately monitored for best practice of pharmacy and the safety of the public.

SHPA supports in principle any measures that reduce the inconsistencies in pharmacy regulation between different jurisdictions, noting that it contributes to both practitioner and consumer confusion, and can lead patients being unable to access medicines.

OPTION 5-10: TRANSPARENCY

It is important that, for each program that involves public funding, there is sufficient transparency as to the amount of funding provided by the government and the amount of funding provided by the recipient of the service.

SHPA supports this option and its requirement for increased transparency of pharmacy remuneration and performance, and achievement of the National Medicines Policy. SHPA also believes the best practice models for conflict of interest and corporate governance should be adopted to safeguard the reputation of the sector, and support the development of the evidence-base for pharmacy cognitive services to enable the sector to improve its advocacy.

In particular SHPA believes that funding for pharmacy innovation should be independent, and equally support applications from non-community pharmacy settings to enable the development of the evidence-base.

OPTION 5-11: EVALUATION MECHANISMS

The government should require the establishment of appropriate evaluation mechanisms to measure compliance and performance.

SHPA supports Option 5-11 and the principles espoused in the *Australian Government's Expenditure Review*³⁴ documentation which are in line with the principles outlined in our original submission. As a healthcare service, pharmacy program funded by the government should adhere to the same regulations required for funding other health activities.

As part of the advocacy for pharmacy services as a component of integrated healthcare, SHPA supports the development of a business case for the Medical Services Advisory Committee regarding the establishment of a MBS item for clinical pharmacy consultation services. This would ensure pharmacy services are assessed with the same rigor as other

health services, and appropriate remuneration was provided by the Federal Government to enable consumer access³⁵.

Chapter 6: The Distribution of Medicines to Community Pharmacy

OPTION 6-1: COMMUNITY SERVICE OBLIGATION REMOVAL, RETENTION OR REPLACEMENT

6-1. ALTERNATIVE 1: The government should remove the Community Service Obligation (CSO), and suppliers of PBS-listed medicines should be placed under an obligation to ensure delivery to any community pharmacy in Australia within a specified period of time (generally 24 hours), with standard terms of trade offered to the pharmacy (such as four weeks for payment) using one or more of a specified panel of wholesalers as follows:

- a. an initial Panel of around five wholesalers would be approved. It is expected that these will include the existing CSO Distributors**
- b. the relevant terms of trade and other supply conditions may vary between medicines. For example, for high-cost medicines or medicines that have cold-chain supply requirements, the supply conditions may differ from those for low-cost medicines to ensure that there is not an unreasonable risk or cost placed on either community pharmacy or consumers**
- c. a cap should be placed on the amount that a community pharmacy contributes to the cost of a medicine. This cap should be in the range of \$700 to \$1000.**

6-1. ALTERNATIVE 2: The government should retain the current CSO arrangements but ensure that all service standards, such as the 24-hour rule, are uniformly implemented.

6-1. ALTERNATIVE 3: The government should conduct a separate review of the CSO to ensure current arrangements demonstrate value for money. A review would also present an opportunity to potentially streamline existing or remove unnecessary regulation. Such a review would require the full cooperation of the CSO Distributors, which would provide financial data and other relevant information to government.

SHPA does not intend to comment on specific matters of the community pharmacy supply. However, an evaluation of existing arrangement to inform the reform of any current process is the approach that SHPA supports.

OPTION 6-2: SUPPLY OF HIGH-COST MEDICINES

In line with Option 6-1, patients should be able to receive high-cost medicines from the community pharmacy of their choice. A cap should be placed on the amount that a community pharmacy contributes to the cost of a medicine. This cap should be in the range of \$700 to \$1000 so that all PBS-approved community pharmacies can supply all PBS medicines required by the public.

SHPA supports the introduction of a cap for medicines in a community setting. However, SHPA believes it is important to note the key role hospital pharmacy plays in the provision of High Cost Medicines for many patients. SHPA believes that patients should be able to receive medicines (irrespective of their cost) from the pharmacy that is most appropriate to provide the care to them. In the case of some generally high-cost medicines prescribed by specialists used to treat complex diseases and require complex monitoring by pharmacists, it is also appropriate for supply to be via hospital and outpatient settings. It is important that supporting consumer access to community pharmacy does not prohibit consumers from accessing beneficial hospital pharmacies when community pharmacy services are unsuitable. For example, titrating doses of anti-transplant rejection medicines and analysing blood pathology results is best done by hospital pharmacists who have access to both the prescribing specialist as well as the patient's hospital medical records.

Furthermore, in some rural and regional areas, the hospital pharmacy can be a preferred pharmacy for complex or High Cost medicines. This might be due to proximity, or a lack of privacy for healthcare consultation in the community setting. In other cases the hospital may choose not to charge the co-payment for certain patient cohorts to increase access and support medicine adherence. This is a significant patient benefit for populations who face barriers to medicine access in other settings.

Chapter 7: Future Community Pharmacy Agreements

OPTION 7-1: SCOPE OF COMMUNITY PHARMACY AGREEMENTS – DISPENSING

The scope of discussions under future Community Pharmacy Agreements should be limited to the remuneration and associated regulations for community pharmacy for the dispensing of medicines under PBS subsidy and related services, including the pricing to consumers for such dispensing.

SHPA believes this proposed change to the scope of the CPA demonstrates a lack of appreciation of how pharmacy services are remunerated in non-community settings, and the role of the CPA. SHPA supports in principle the limitation of future Community Pharmacy Agreements to remuneration and regulations for community pharmacy for dispensing of medicines. However this represents a significant change from pharmacy funding and planning, and risks negatively impacting people leaving acute settings, receiving outpatient treatments and accessing chemotherapy clinics. Traditionally, aside from setting dispensing fees, the CPA has also funded a range of projects which operated outside community pharmacy settings such as primary healthcare and in transition from hospital, as well as informed PBS remuneration for dispensing in hospitals and the collection of co-payments.

According to the most recent figures, but before recent increases in provision of Hepatitis C medicines, 17 per cent of all PBS expenditure occurs in a hospital setting. Dependent on the ongoing Department of Health review of processes supporting the dispensing of PBS medicines in hospitals, this could be clarified in a separate agreement. However, until this hospital-specific agreement is established, limiting the CPA to only community pharmacy settings is premature in isolation of options clearly defined across all sectors dispensing PBS prescriptions. In particular the SHPA would appreciate greater clarity of what comprised 'related services', as this terminology can cover a wide range of essential pharmacy activities equally applicable to hospital settings.

SHPA reiterates our recommendations regarding the various components associated with dispensing and recommend that these must be clearly defined and evaluated to determine remuneration for these services.

The dispensing process and how this relates to pharmacist cognitive services associated with medication dispensing must be clearly articulated as the Review is currently unclear on the fundamental issue. This option is unclear as to what existing services associated within dispensing are included.

OPTION 7-2: SCOPE OF COMMUNITY PHARMACY AGREEMENTS – WHOLESALING

The government should ensure that the regulation and remuneration of wholesaling of PBS-listed medicines should not form part of future Community Pharmacy Agreements.

As mentioned in SHPA original submission, SHPA recommends a cost-benefit analysis be undertaken to inform discussion of pharmacy wholesaling. SHPA supports the recommendation that regulation and remuneration of wholesalers is not best placed in Community Pharmacy Agreements. However, greater clarity is required around how this

important area of supply could be more effectively managed. Recognising the limitations inherent in Australia's geographic size and location we would not support a completely 'free market' solution that might reduce timely access to medicines.

Medicines shortages are a growing concern for pharmacists with the potential for significant impact on patient care as well as substantial cost. In our recent report *Medicines Shortages in Australia: A snapshot of shortages in Australian hospitals*, SHPA members reported shortages of 365 different commercial products across 154 different active ingredients³⁶. We believe the data collected in this survey should encourage greater consideration of strategic approaches to reducing the impact of shortages, notably the requirement for improved notification from manufacturers or wholesalers. This would require legislative change as the issue of an Australian Register of Therapeutic Goods (ARTG) number includes no implicit requirement to ensure supply, or notify inability to supply, to the Federal Government.

In practice, the burden of managing widespread medicine shortages is currently being borne by hospital and community pharmacies across the country, where it is a destabilising factor in efforts to improve clinical collaboration and patient care. A systemic approach to both supply and notification has the potential to substantially improve efficiency and increase hospitals' capacity to support optimal patient care. As medicines shortages continue to increase and overseas this would address a growing pressure on healthcare in Australia.

OPTION 7-3: SCOPE OF COMMUNITY PHARMACY AGREEMENTS – PROGRAMS AND SERVICES

The regulation and remuneration of professional programs offered by community pharmacies should not form part of future Community Pharmacy Agreements.

SHPA would support the development of a pharmacy workforce plan which included the regulation and remuneration of professional projects, including those enhancing the pharmacy scope of practice and supporting the development of pharmacy technicians, in all pharmacy settings. This would enable the removal of pharmacy projects and support for innovation from the CPA as proposed. SHPA would be pleased to collaborate with other pharmacy stakeholders, including the Pharmaceutical Society of Australia, to jointly develop a comprehensive workforce plan.

As healthcare services, all pharmacy services and programs (aside from the Pharmacy Trial Program) funded by the federal government should be evidence-based. This is best ensured by utilising the assessment process of the Medical Services Advisory Committee (MSAC)³⁵. Ideally the transfer of this process would include support for the establishment of MBS items for consultations with independent pharmacists such as Home Medicine Reviews. We do recognise however that the MSAC process is difficult to negotiate and traditionally requires substantial sponsorship from professional bodies or manufacturers, this may be a barrier for the diverse field of pharmacy organisations to address. Until professional programs can be supported through a workforce plan, or assessed by MSAC, SHPA believes removing them from the CPA should occur when alternative funding options have been developed to ensure that patients are able to access appropriate cognitive services provided by pharmacists.

Appropriate stakeholder engagement is imperative in the development of professional programs outside of the CPA. SHPA believes that a broader consultation with pharmacy and

health stakeholders, including SHPA would deliver a more patient-focused outcome. Consultation with stakeholders including SHPA would enable a more strategic approach to meeting the needs of the Australian community, and encourage leadership and innovation by the different workforce groups, rather than enabling retail priorities to take priority. In the long-term the separation of funding for pharmacy services and medicines into MBS and PBS funding streams would more appropriately support healthcare outcomes.

SHPA's membership represents leaders in hospital and clinical pharmacy in all settings. Their expertise has informed the successful implementation of most pharmacy innovations in recent decades – from the introduction of clinical review outside hospital settings to the provision of expert medicine services such as chemotherapy in outpatient clinics and now in the home. Our members have proven expertise in leading pharmacy innovation and implementing professional service programs which meet consumer need. Their contributions to any planning or development of professional programs, and that of SHPA as a whole, would be invaluable.

OPTION 7-4: COMMUNITY PHARMACY AGREEMENT PARTICIPANTS

The parties invited to participate in future Community Pharmacy Agreements must include the Pharmacy Guild of Australia (as a representative of many approved pharmacists), the Consumers Health Forum of Australia (as the peak representative consumer body in Australia on health-related matters) and the Pharmaceutical Society of Australia (as the peak representative body for pharmacists in Australia).

SHPA supports the steps the Panel have taken to improve representation of the broader pharmacy sector and healthcare providers in the consultation of the CPA. The inclusion of the Pharmaceutical Society of Australia and Consumers Health Forum are welcome recognition of the inappropriateness of sector-wide negotiations occurring exclusively with pharmacy owners. The SHPA is confident better outcomes can be achieved with greater engagement.

Due to the important role the CPA plays in determining PBS remuneration in all settings it is imperative that SHPA is included as a representative of the hospital setting where 17 per cent of PBS expenditure occurs. Without relevant expertise informing the Agreement it cannot be scoped as relevant to all settings and opportunities for efficiency and effectiveness will be lost. Limiting stakeholder involvement is also contrary to federal government advice for negotiating regulations, which specify that all affected stakeholders should be included³⁷.

SHPA welcomes the opportunity to work with other pharmacy and healthcare stakeholders, including the Pharmaceutical Society of Australia and the Pharmacy Guild, to progress pharmacy remuneration and regulation in all healthcare settings.

Chapter 8: Health Programs Offered by Community Pharmacy

OPTION 8-1: DOSE ADMINISTRATION AIDS – STANDARDS

The government should establish clear, enforceable minimum standards for the supply of medicines by community pharmacies, including for dose administration aids (DAAs). There should also be appropriate compensation provided to community pharmacies for the dispensing of medicines using DAAs (in recognition that this tends to be a higher-cost activity than dispensing in manufacturer’s packaging).

SHPA supports adherence to pre-existing minimum standards for supply of medicines including the provision of DAAs³⁸. These would be relevant for both community and hospital settings where DAAs are often not currently provided for patients unless they are at extremely high-risk of medicines mismanagement. Hospitals would appreciate appropriate compensation for dispensing medicines using DAAs in recognition that this tends to be a higher-cost activity. Many hospital patients are high-risk for medicines mismanagement¹⁶ and would benefit from DAAs if greater funding was available. Feedback from SHPA members indicate this is a particular concern for CTG patients.

OPTION 8-2: COMMUNITY PHARMACY PROGRAM – KEY PRINCIPLES

The range of programs offered by community pharmacy should be underpinned by the following principles:

a. be based on evidence of effectiveness

As stated in our principles and previous submission SHPA strongly supports the delivery of pharmacy programs based on evidence. Greater flexibility of criteria for eligibility of settings to provide programs would be beneficial for innovation and enhancement of pharmacist roles and services. The transition of care area would benefit from greater flexibility of such criteria to enable innovative forces in hospital pharmacy to scale up long established trial programs.

SHPA believes that the evidence-base showing improvements for patients in blood pressure and cholesterol control, diabetes, and medication management, resulting from pharmacist-led medication review, justifies the expansion of the HMR program for high-risk patients⁵. Equally strong evidence supports the widespread introduction of a hospital referral pathway with a study showing patients aged 51–65 years exhibited a 25 per cent reduction in hospital admissions³⁹. In addition, SHPA supports the Interim Reports’ recognition that accredited pharmacists are best placed to provide HMRs in the community.

b. may or may not involve government paying for some or all of the cost of the service to some or all patients

SHPA supports the greater provision of non-dispensing services to the community by community pharmacies to meet consumer need. Research shows there are wide range of possible funding for these services when developed which include private health insurers and consumer funded⁴⁰ and SHPA supports investigation and development of program models that do not rely entirely on government funding.

- c. may in some cases be offered on the basis of each community pharmacy choosing whether or not to offer the program (with all community pharmacies being eligible to offer the program). In other cases, the program will only be available (with government payment) through pharmacies/pharmacists that are selected by the government (for example, through a tender process or as a result of negotiation between the government and the relevant pharmacies or pharmacists)**

SHPA agrees with the option outlined. As stated previously key principles inform the delivery of pharmacy services - the services provided must have four key elements for clinical care: appropriately skilled pharmacist, appropriate setting, correct clinical information and collaboration with patient, carer and medical team and that remuneration of pharmacy services reflect these elements. The provision of pharmacy cognitive services is a matter for the individual pharmacist or pharmacy owner in conjunction with their funder. We support the greater provision of pharmacy services through MBS items payable to the pharmacist.

- d. for some programs, government remuneration for the program will be channelled through the users of the program (or their representatives) so that the users will decide which community pharmacies (or pharmacists) to use to deliver the program**

SHPA supports the flexibility of pharmacy program remuneration to enable payment by those who use the program if remunerated by the government through a scheme such as the National Disability Insurance Scheme (NDIS). This could also be applicable to programs occurring in hospital settings.

- e. adequate funding for the above needs to be found outside PBS expenditure.**

SHPA supports the funding of pharmacy services outside of PBS expenditure, given that investment in clinical pharmacy services are essential to achieve objectives in the National Medicines Policy and maximise return on investment for supply of PBS medicines to the community. SHPA believes that individual pharmacists (not pharmacy businesses) should be remunerated for providing professional services (regardless of the setting) through the MBS similar to other allied health professionals such as physiotherapists, health professionals such as dentists, and medical practitioners.

Chapter 9: Access to PBS Medicines and Community Pharmacy Services for Aboriginal and Torres Strait Islander People

OPTION 9-1: ACCESS TO MEDICINES PROGRAMS FOR INDIGENOUS AUSTRALIANS

The access to medicines programs for Indigenous Australians under the section 100 RAAHS Program and the Closing the Gap PBS Co-Payment Measure should be reformed so that the benefits to the individual follow that individual, regardless of where the prescription is written or dispensed.

SHPA supports this option. We also believe that the section 100 RAAHS program should be brought into line with the mainstream PBS to allow better reporting of medicines utilisation and access to pharmacist-led medicines management services. SHPA is aware of numerous instances where consumers eligible for Closing the Gap (CTG) prescriptions are disadvantaged in accessing medicines and experience greater barriers than other consumers. This is due to the inequitable provision of CTG prescriptions exclusively through GPs and not in hospitals. In response to this clear inequity some hospitals have introduced policies which do not request a co-payment from CTG consumers for discharge or outpatient medicines, instead bearing the cost in their operational budgets.

OPTION 9-2: ABORIGINAL HEALTH SERVICE PHARMACY OWNERSHIP AND OPERATIONS

All levels of government should ensure that any existing rules that prevent an Aboriginal Health Service (AHS) from owning and operating a community pharmacy located at the AHS are removed. As a transition step, these changes should first be trialled in the Northern Territory, and governments should work together with any AHS that wishes to establish a community pharmacy.

SHPA supports the intent of option 9-2 but questions its implementation believing a not-for-profit service may be more appropriate than a commercial pharmacy. SHPA recognises the important need to improve consumer access to pharmacy services in remote areas. Rather than allowing a community pharmacy co-located with AHS SHPA believes it would be more appropriate for AHSs to operate a service modelled on a Section 94 public hospital pharmacy, providing not-for-profit pharmacy services and care focused specifically on addressing the needs of the patients. Such pharmacies operated by AHSs should also be eligible for the same types of payments for dispensing and professional services. SHPA supports any measures that would increase the level of pharmacy services provided to patients of an AHS, and their ability to access medication review services and pharmacist's advice when required. We recognise this could also be achieved by funding the employment of clinical pharmacists as part of the AHS healthcare team.

Chapter 10: Further Issues

OPTION 10-1: SECTION 100 HIGHLY SPECIALISED DRUGS

The Highly Specialised Drugs (HSD) Program under section 100 of the National Health Act 1953 (Cth) should be reformed to remove the distinction between Section 100 (Community Access) and other medicines listed within Section 100 HSD arrangements. This should include, for example, harmonising access and fees regardless of where the medicine is dispensed.

SHPA supports this option and believes that greater harmonising of medicine and consumer categories in the PBS would be beneficial for both hospital and community settings. However the supply of medicines in both hospital and community settings such as those under the HSD program cannot be easily harmonised due to pre-existing differences in PBS funding. These include the lack of dispensing fees as discussed in option 4-3. Without certainty as to the reform of PBS in hospitals and an alternative pathway for fee revision, the CPA remains the key conduit for pharmacy remuneration and regulation.

As noted in SHPA's earlier submission, SHPA believes that a uniform remuneration structure for the supply of PBS medicines for both hospital and community pharmacies would reduce complexity and apparent anomalies. A table of proposed remuneration is below for consideration.

Table 3. Contrast of current CPA PBS medication funding model with uniform model

Scenario: 400 bed public hospital (Principal Referral) with 400 S85 items daily and 25 S100 items daily @ mean \$15.00 wholesale price	Public hospital (dispensed price)	Community pharmacy	Current hospital remuneration model	Current community remuneration model applied
S85 Medicine			Per prescription	Per prescription
Wholesale Mark Up	11.1% of the ex-manufacturer price	7.52% of the ex-manufacturer price, capped at \$69.94	\$0.74	\$0.50
AHI fee	\$0.00	\$3.49 plus 3.5% for medicines over \$180, capped at \$70	\$0.00	\$3.49
Dispensing fee	\$0.00	\$6.93	\$0.00	\$6.93
S100 medicine	\$600 (e.g. only)			
Mark Up	0%	4-tier capped at \$40*	\$0.00	\$40.00
AHI fee	\$0.00	\$0.00	\$0.00	\$0.00
Dispensing fee	\$0.00	\$6.93	\$0.00	\$6.93
Annual remuneration			\$750k pa	\$1200k pa

*10% for drugs with a price ex-manufacturer of less than \$40;

* \$4 for drugs with a price ex-manufacturer of between \$40 and \$100;

* 4% for drugs with a price ex-manufacturer of between \$100.01 and \$1000;

* \$40 for drugs with a price ex-manufacturer of greater than \$1000

OPTION 10-2: CHEMOTHERAPY COMPOUNDING – PAYMENTS

There should be no difference in the remuneration paid by the government for the compounding of chemotherapy medicines in any facility that meets the minimum quality and safety standards. In particular, there should be no additional payment for medicines that are prepared in a facility that exceeds the minimum standards.

SHPA supports the harmonising of equitable payments for chemotherapy at the level of current remuneration received by TGA licensed supply sources. SHPA is confident that Australians being treated with chemotherapy in public or private hospitals receive highly effective chemotherapy medicines regardless of the TGA licensing of their originating facility. According to our members there is no therapeutic difference in chemotherapy medicines provided by TGA licensed compounders and non-TGA licensed compounders. There is no difference in efficacy or effectiveness, and both will achieve the same clinical and patient outcomes.

SHPA would like to note the important role that licensed compounding facilities have for many health services, especially rural and regional hospitals to ensure timely access of medicine due to their ability to bulk compound and distribute. Without such facilities, timely medicines supply may be impractical in some areas. For this reason, it is important that widespread access is maintained through the support of viable alternatives to onsite preparation.

OPTION 10-3: CHEMOTHERAPY COMPOUNDING – UNIFORM MINIMUM STANDARDS

There should be a clear, uniform set of minimum quality standards for all approved chemotherapy compounding facilities based in a hospital, a community pharmacy or elsewhere. These minimum standards should:

- a. **not require that a compounding facility be Therapeutic Goods Administration (TGA) licensed to meet the minimum requirements**
- b. **mean that a TGA-licensed facility clearly satisfies the minimum standards**
- c. **reflect the variety of settings that are appropriate for the preparation of chemotherapy medicines, including ‘urgent’ preparation in a hospital setting or a community pharmacy setting.**

SHPA supports this option, and believes minimum quality standards play an essential role for healthcare facilities. SHPA endorses the *Pharmaceutical Inspection Cooperation Scheme Guide to good practices for preparation of medicinal products in healthcare establishments*⁴¹, and SHPA’s *Standards of Practice for Safe Handling of Cytotoxic Drugs in Pharmacy Departments*⁴² to inform the development of any further minimum standards. SHPA is aware that the Pharmacy Board of Australia is developing Guidelines on Compounding of Medicines to cover the Compounding of Sterile Injectable Medicines (unpublished), and this should be included in uniform minimum standards for all compounding premises.

OPTION 10-4: CHEMOTHERAPY COMPOUNDING – PRACTICE MODELS

Existing practice models in place in public hospitals for limited trade of medicines prepared onsite, such as radio pharmaceuticals, should be considered for providing greater access to chemotherapy arrangements.

SHPA supports Option 10-4 in order to enable greater access for patients to essential medicines. Depending on existing arrangements greater distribution of medicines prepared onsite can be beneficial, however care must be taken to ensure compliance with guidelines⁴³. Consultation between interested organisations would be necessary to trade possibilities are optimised in this highly restricted area.

OPTION 10-5: GENERAL MEDICINE – LISTING ARRANGEMENTS

When an ‘original’ (or ‘branded’) medicine comes off patent then the government should hold a tender for the listing of generic versions of the medicine. The government should limit the number of generic versions of a particular medicine to be listed to a relatively small number that is still sufficient to allow for patient choice (e.g. four generics and the original brand of the medicine). The chosen generics should be those best able to meet the distribution and other conditions required by the government at the least cost to the PBS.

SHPA supports the intent of this option to increase use of generic medicines in community pharmacies, and to reduce consumer confusion. Public hospitals across Australia lead the adoption and dispensing of generic medicines in all jurisdictions. We note that existing hospital arrangements specify a singular generic brand in each jurisdiction depending on the supply agreement reached with a wholesaler. If the hospital initiates a new medicine regimen the first brand adopted in hospital has the potential to create consumer confusion when it differs from brands in community pharmacies. In order to support implementation of this option we suggest that greater consultation with the relevant state purchasing authorities would be beneficial for creating optimal listing arrangements. Current practice indicates that limiting the reimbursement price is more effective than limiting the number of generics to ensure cost-efficiency. An elimination of generic medicines has recently given some wholesalers a perverse incentive to increase their price.

SHPA has recently demonstrated leadership in this area through our study of the prevalence of shortages of medicines in hospitals⁴⁴. Our results indicate that any changes to the policies directing use of generics would need to manage the inherent risk in having fewer suppliers of medicines and potential supply chain failure exacerbating the risks of medicines shortages, which invariably affect the quality of patient care and waste precious resources. Medicine shortages are a growing problem for hospital and community pharmacies alike and offer a substantial risk to high quality patient care³⁶.

OPTION 10-6: MACHINE DISPENSING

The government should trial the use of machine dispensing in a small number of relevant secure locations in communities that are not currently adequately served by community pharmacy. Such machine dispensing should be appropriately supervised and allow real-time interaction with a remote pharmacist. The range of PBS medicines available through machine dispensing also needs to be limited and should be based on an assessment of risk.

SHPA supports Option 10-6 in principle and would be supportive of innovative methods to improve access to medicines for rural and regional populations. It is essential that patients are able to have a private consultation with a skilled pharmacist when accessing medicines from a machine in a secure location, and that medicines are appropriately labelled including with patient-specific information and DAA are provided if appropriate³⁸.

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