

**Professional
Pharmacists
Australia**

Submission on the Interim Report of the Review of Pharmacy Remuneration and Regulation

Introduction

Professional Pharmacists Australia (PPA) appreciates the work undertaken by the Panel in producing the interim report. We are also disappointed by the attitude and obstruction of the Pharmacy Guild of Australia (the Guild) in light of the fact that this Review was a part of the 6th Community Pharmacy Agreement negotiated and signed off by the Guild.

We note and support the aim of the Panel was to focus on the requirement of a flexible framework which is:

- Consistent with a forward-looking twenty year time frame
- Allows and encourages innovation in community pharmacy
- Is adaptable to the changing needs of the Australian public and the broader healthcare system.

We believe that the Panel, in the production of this Report and the options, has succeeded in raising these issues for discussion by the profession, consumers and other stakeholders.

We believe it is critical for all stakeholders that the profession of pharmacy:

- is seamlessly integrated into the health system,
- is a provider of services that are consumer focussed and appropriate to their scope of practice,
- these services fulfil a social need,
- is of a consistently high standard,
- is delivered at a fair price to the taxpayer and the members of the profession, and
- ensures improve community outcome from \$18 billion investment by Government.

We also believe that the Report must not be seen as a tweak of the status quo and just a way to help Government negotiate prescription fees.

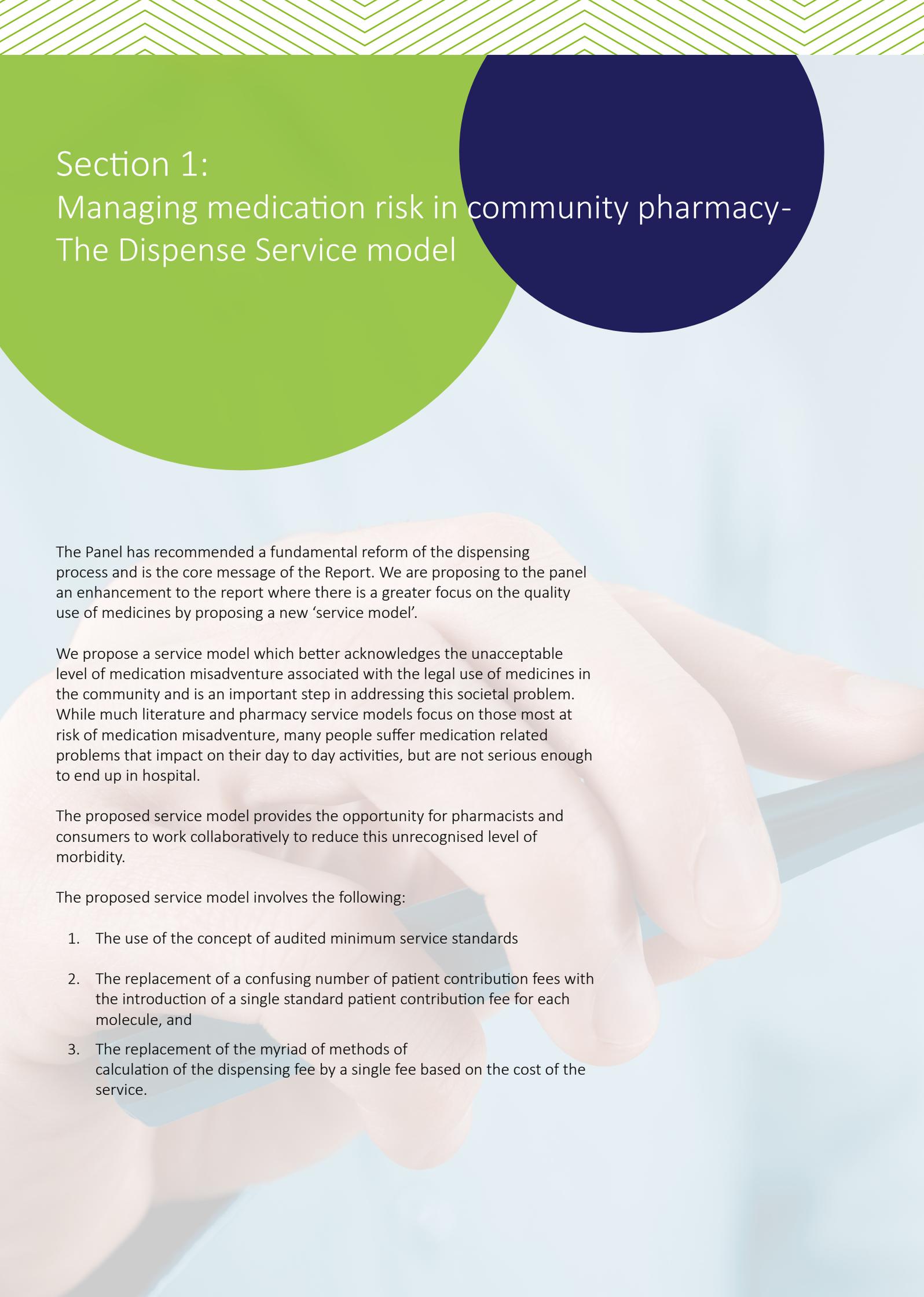
This submission is divided into three sections. The first is to recommend a restructuring of the Report in such a way to make it easier for stakeholders to understand certain key concepts around managing medication risk.

We believe that there needs to be a stronger link between the quality use of medicines and the access to affordable medicine arms of the National Medicines Policy to underpin the reasoning for reform to the way pharmacists supply prescription medicines. Further, there needs to be a simple explanation of the proposed remuneration method. Only following the discussion with the Panel, after the report was released, we better understood how the standardised remuneration could drive quality. However, not everyone is going to have that opportunity. Hence our belief for the need to rewrite that section.

In the second section, we will address specifically the options raised in the Interim Report. Finally we will make a brief suggestion on an implementation process for this reform package. The third section provides some guidance on implementations strategies. We agree with the Panel that the basis of this report is built on the understanding that community pharmacies with a PBS approval number are an agent of the Government. Our discussions in the submission are based on this understanding. The recommendation should therefore only be judged by the benefit to health consumers.

We have also provided an example of a “mind map” of the reform proposal. It may be a useful communications technique aimed at helping readers visualise and organise information. (See Appendix 1)





Section 1: Managing medication risk in community pharmacy- The Dispense Service model

The Panel has recommended a fundamental reform of the dispensing process and is the core message of the Report. We are proposing to the panel an enhancement to the report where there is a greater focus on the quality use of medicines by proposing a new 'service model'.

We propose a service model which better acknowledges the unacceptable level of medication misadventure associated with the legal use of medicines in the community and is an important step in addressing this societal problem. While much literature and pharmacy service models focus on those most at risk of medication misadventure, many people suffer medication related problems that impact on their day to day activities, but are not serious enough to end up in hospital.

The proposed service model provides the opportunity for pharmacists and consumers to work collaboratively to reduce this unrecognised level of morbidity.

The proposed service model involves the following:

1. The use of the concept of audited minimum service standards
2. The replacement of a confusing number of patient contribution fees with the introduction of a single standard patient contribution fee for each molecule, and
3. The replacement of the myriad of methods of calculation of the dispensing fee by a single fee based on the cost of the service.

We understand the meaning of each of these three concepts as:

1. The minimum service standard (MSS)

The Panel proposes that there be a minimum service standard that is auditable and enforceable. Every PBS agent will be required to ensure that their secure pharmacies remain consistent with this standard. The Panel recommends that the PBA and the PSA standards/ guidelines form the basis of this minimum standard. This minimum standard will then expressly be part of any PBS approval.

Pharmacists will be expected to work to that standard. This is a key requirement to put quality back into the dispensing process. The aim of the MSS is to improve the quality use of medicines by reducing the risk of medication misadventure while ensuring continued access to affordable and safe medicines.

This link between Access to affordable medicines and Quality use of medicines and the policy aim of reducing the harm associated with the use of medicines is not clearly expressed in the Report. We believe this meshing is a critical link that policy makers need to understand when assessing this pharmacy reform.

We **RECOMMEND** that the final Report focusses on explaining the importance of linking the two arms of the NMP and how the proposed dispense services demonstrates such linkage.

We **SUPPORT Option 3.1** in regards to establishing minimum services but with changes outlined below (viz. the addition of the tier 2 service).

We **SUPPORT** the use of PSA guidelines to dispensing medicines, with the addition of a monitoring statement (which we believe is being considered in the new updated PSA version) in conjunction with Pharmacy Board of Australia Guidelines in Dispensing. We would expect that the pharmacist would follow the following procedure; take/check a medication history, dispense safely, provide relevant information/advice for safe and effective use and offer to monitor outcomes (including checking if patient compliance is satisfactory). We would expect the pharmacist to check for safety/effectiveness/compliance at the time of dispensing each repeat by having a conversation with the patient at the time of dispensing.

We **RECOMMEND** the addition of a second tier to the proposed service model.

The second tier would address issues associated with the provision of medicines and their ongoing management for patients deemed at high risk of medication misadventure (eg multiple medication, multiple diseases, age, recent hospital admission etc). Here pharmacists would be expected to undertake the steps in the MSS but monitor the patient's outcomes more rigorously through regular contact (the monitoring schedule could be determined for example by the pharmacokinetic properties of the drug or as outlined in a medication management plan devised by the prescriber) to assess symptoms progress (objective and subjective), support/ intervene as appropriate and liaise and refer to the patient's doctor in a timely manner.

Consideration should also be made to link this second tier service with other medication management services currently available such as Medscheck, provision of dose administration aids, and the Homes Medicines Review service.

There is real potential to promote inter-professional collaboration between the GP and pharmacist through the sharing of a care plan for the high risk patient. The care plan can include many of the current programs but:

- must have a written plan and monitoring
- must facilitate modern interaction between the doctor and pharmacist
- should use big data analysis and data analytics to identify the priority patient and extrapolate to a type of patient eg on more than x medications, over age of y, frequency of GP/specialist visits, recency/frequency of hospital separations.

The definition of high risk patients can ensure the care plan can be implemented within budget restraints. Assessment of the program will show the investment is cost benefit positive as shown by fewer hospital admissions and other benefits.



We **RECOMMEND** that an electronic patient case notes system (whether via MyHealth card or computer based data bases) be established to enable patient interaction information be recorded (and thereby being available for auditing and practice research purposes). We recognise the ideal system may be some time off, but this should not delay implementation.

Therefore we **SUPPORT Option 2.8**, but with the proviso of ensuring community pharmacies have their own electronic patient case notes that supplement the e-health card.

We **RECOMMEND** an auditing process to ensure pharmacies and community pharmacists are abiding with the service parameters. We suggest that a system similar to that used in auditing General Practitioners should be investigated.

In addition, we **RECOMMEND** the addition of the Pharmacy Board of Australia's "Guidelines for Proprietor Pharmacists" to the dispensing guidelines as a further tool to assist auditors.

We **RECOMMEND** that the Panel places greater emphasis on describing the necessity to mesh the policy foundations and how this is used to define the service and associated obligations. It's not that clear in the report as it is presently constructed.

2. A single standard patient contribution fee for each molecule

We believe this initiative is designed to decrease confusion around what patients pay by establishing a single charge for each PBS molecule and eliminate the discounting of PBS prescriptions. The Panel felt that the current business model emphasis on discounting prescription prices is taking away the focus on the quality use of medicines aspect of a dispensing service. Every pharmacy would supply the medication at the same price, patient choice of the pharmacy would then revert to other factors, including the quality of the service provided to the patient.

We **SUPPORT Option 2.1** ie the removal of pricing variations and **Option 2.2** (removal of \$1 discount). These options should be seen as an integral component of the reformed dispense service where the focus shifts from supply to quality where supply is one component. We believe that this component cannot be separated from the proposed dispense service model.



3. A single dispensing fee

This is perhaps the most contentious recommendation and the most poorly explained in the Interim Report.

We **UNDERSTAND** that the Panel envisage that a single dispensing fee (in combination with the single standard patient contribution fee) will favour those pharmacies that provide the best quality of service (when combined with points one and two above). This is the key concept in the proposed approach designed to shift the dispensing service from one focussing on maximising prescription output to one focussing on quality of care. The Panel proposes this is best achieved by simplifying the dispensing fee based on the costs involved in providing the minimum service standard.

We **UNDERSTAND** that the Panel recommends the development of an efficient dispense benchmark firstly to ensure a quality service is being provided for the taxpayer funding, and secondly to determine a fair dispense fee. To determine the benchmark, access to the data that owners have in running their pharmacy to ascertain a fair dispensing fee for providing the service envisaged in point 1 is necessary. The Guild refused to cooperate, and so the Panel went to secondary sources to estimate a fair dispensing fee and came up with the fee of between \$8.50 and \$11. As Professor King noted in conversation with PPA, if they had provided the data, the suggested fee may have been higher. We suggested that indeed it may need to be higher, but sympathise with the difficulty faced by the Panel being denied the primary data for such a calculation.

We **RECOMMEND** that the Panel provide a simple contextual explanation to the concept that underpins the reasoning for the topic “Basis of Efficient Dispensing Cost/ Remuneration”. This is the section of the Report that is most likely to be attacked as a means of undermining the necessary reform to the current business model (in terms of PBS medications at least). Dr March noted that he better understood what underpinned this calculation and the reasons for the approach following the face to face explanation. He admitted that he was highly sceptical of the reasons behind the benchmarking process and considered it just a method of reducing income for pharmacies (and therefore pharmacists).

However, his opinion changed following that conversation. It is therefore likely most other readers may also have difficulty with the reasoning.

We believe, as agents of the Government, that pharmacy owners should be required to provide appropriate data to enable the Government, on behalf of taxpayers, to determine a FAIR level of remuneration for the proposed dispense service.

We **SUPPORT Option 4.1, Option 4.2, Option 4.3, Option 4.4 and Option 4.5.**

We **RECOMMEND** that an independent statutory body with the necessary expertise, and by definition is therefore outside the lobbying ability of the Guild, be established to provide recommendations to Government.

Managing medication risk pre/post hospital discharge

The Panel acknowledges the risk of medication misadventure across the hospital journey. This has been an ongoing and almost intractable issue that must be addressed. Pharmacists can make a contribution to reducing this risk.

We **SUPPORT Option 2.10** concerning managing medicines upon discharge.

Managing medication risk in aged care facilities

Further we are concerned about the same issue facing residents living in the aged care sector. Evidence has previously shown an unacceptable level of medication related harm either upon transfer between hospital and aged care, or while in an aged care facility.

As a first step, we **RECOMMEND a new Option mirroring the aim of Option 2.10** being included in the Final Report. We suggest that this Option should focus on timely and accurate communication around medications and changes to medications between the hospital pharmacy, the aged care facility, and currently the community pharmacy providing medications to the aged care facility.

We further **RECOMMEND** that the Panel recommend the Government **explore a model of funding for pharmacists to be employed (initially 1-2 days) at aged care facilities** to be part of the care team with an express mission to provide a range of quality use of medicines services designed to reduce medication risk. Pharmacists need to be part of the team, and need to regularly interact with the other team members to first build inter-professional relationships and secondly provide the expertise on issues around medicines. Currently, there is no funding for such positions, and aged care facilities do not employ pharmacists.

Leveraging pharmacy and pharmacist capability

Historically community pharmacists have been seen as suppliers of medicines (prescription and OTC) and the advent of the PBS reinforced this role. The clinical role only started to be explored in the mid-1990s. Even now, most income continues to come from dispensing PBS medicines. Only around 4-5% of the CPA monies are available for clinical services.

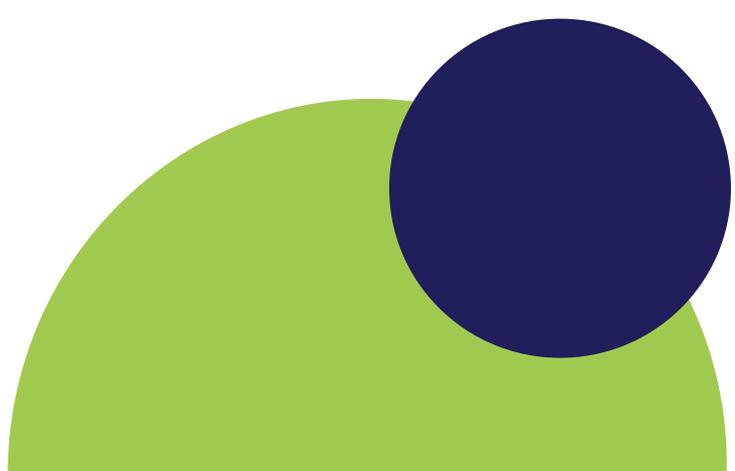
The Guild has jealously guarded its PBS income throughout each CPA. When pharmacists have called for extra money for remunerating clinical (professional) services, until recently Guild members have rejected

those calls and told these pharmacists to get their own funding (though perhaps not in such nice words). The Panel suggest that it's time for the profession to actually work together to campaign for funding of clinical services separate from the CPA system. Many of the profession would agree with these sentiments, but for the elephant in the room, the Guild. They have long resisted reform and even now consider that the present business model needs no reform. What makes it even more difficult is to convince the Government for even the necessity for change (let alone the how and the when) when the Guild has such strong political lobbying power. We are concerned that the main message of the proposed prescription service reforms, namely managing (reducing) medication risk, is weakened by delinking the supply of medications, albeit at a higher quality level, from other professional services that support better medication management for the individual.

We **SUPPORT Option 8.2(a), (b), (c) and (d) and Option 8.1**

We **REJECT Option 8.2 (e) and PROPOSE a new Option 8.2(e)** where medication management programs be funded sustainably under a revamped CPA and adequate funding for non-medication management programs be found outside PBS expenditure.

We **ADD a further Option (f) RECOMMENDING** a review of the functions of the Pharmaceutical Benefits Division and the Quality Use of Medicines Group of the Department of Health with the aim of meshing policies and programs relating to access to medicines with the quality use of medicines. The CPA should be informed by a meshed access and quality framework.



What's needed to support reducing medication misadventure?

Having clearly explained the new model of care around the provision of prescriptions and how that service would be funded, the next stage of the report should look at the tools that support the reform. In this case it's all about communication.

Electronic health record

The need for e-health card (My Health card) to be used by the public and the health practitioners was identified as a priority. This is seen as a key communication tool for the stakeholder; community pharmacists will be able to review the medication history on the card to assess for accuracy and safety, and community pharmacists should have access to post discharge medication lists and plans.

We **SUPPORT Option 2.8**

Electronic Prescription Service

The Panel supports extending the current electronic prescription service but with the addition of the patient having the choice of which pharmacy the prescriber sends the prescription.

We **SUPPORT Option 2.7** and **Option 2.9**

Provision of Consumer Medicines Information

The Panel expressed concern about the inadequacy of information and the inconsistent access to such information and recommended the provision of CMIs as per PSA guidelines. We note the fact that CMIs are written more for legal reasons than for easily understood information. We believe they are particularly unwieldy if the aim is to provide useful individualised consumer medicines information. Indeed, the complexity is such that pharmacists need to actively explain the relevant components of the CMI to a patient.

Therefore, just handing a person a CMI is poor practice because the information is not individualised to the particular person. Unfortunately this is common because having a conversation takes time, and under the current business model, time must be spent on dispensing not informing.

We do not disagree with **OPTION 2.6** as an interim measure, but we **RECOMMEND** that a more consumer friendly CMI tool be developed in coming years to replace the current CMI format.

Labelling

We **SUPPORT Option 2.4**

Pharmacy Atlas

We **SUPPORT Option 2.5**, though noting the practical difficulty of keeping on online Atlas up to date.

Machine dispensing

We **SUPPORT Option 10.6**

Section 2: System reforms:

This section looks at the changes to the system that supports community pharmacy when providing either the dispense service or other clinical services.

Reform of location rules

The Panel was established to provide independent advice to the Government on a range of topics around the remuneration and regulation pertaining to the industry. We believe it is an abrogation of that independence if the Panel does not proceed with the tabling of Options 5.1, 5.2 and 5.3 in the Final Report. Indeed, we would have thought that the Panel should have continued with the process regardless of the decision of the Minister following lobbying by the Guild. We believe it should be up to the Minister to accept or reject your recommendations given by the Panel, not for the panel to self-edit in advance. We also note that the current Government is unlikely to be in power for the period that this Review is considering ie twenty years. This advice could be useful for future incoming Governments to consider.

We **RECOMMEND that Options 5.1, 5.2 and 5.5 be published** in the final report.

For the record, we **SUPPORT Option 5.1, Option 5.2 Alternative 1 and Option 5.3 Alternative 1.**

We **SUPPORT** Option 5.4 and Option 5.5.

Transparency and evaluation mechanisms

The lack of transparency and poor reporting, evaluating and monitoring mechanisms have been the trademark of all CPA (6CPA being no different). We fail to understand how successive Governments have allowed this to occur.

The Veteran Mates program is an example of the value of the collection, analysis and dissemination of clinical data for the benefit of both consumers and health practitioners.

We **SUPPORT Option 5.10 and Option 5.11**

Community Pharmacy Services for Aboriginal and Torres Strait Islander People

We **SUPPORT Option 9.1 and Option 9.2.**

We **RECOMMEND a new Option 9.3** which provides for Aboriginal and Torres Strait Islander Specific Programmes as defined in 6CPA be transferred to oversight by an appropriate ATSI organisation and funded sustainably.

Legislation

PBS Safety Net

We **SUPPORT Option 2.3** – great idea!

Harmonising Pharmacy Legislation

We **SUPPORT Option 5.9**

Listing Generic Medicines

We **SUPPORT Option 10.5**

Timely Medicine Access (CSO)

We believe that wholesaling arrangements have no place in any CPA.

We **SUPPORT Option 6.1 Alternative 1**

Supply of high cost medicines

We are concerned about the potential for owners to lose substantial amounts of money if there is a problem of supply of these medicines, even at the level of \$700-\$1000.

We understand the dilemma facing Government, wholesalers and pharmacy owners over the handling of high cost medicines, a situation that will only become more common in coming years. Obviously, Government funders would be concerned if there was a laissez-faire approach conducted by pharmacists when ordering expensive medicines. We suggest a compromise – we agree with the concept of a cap but we suggest a three strikes rule. Start the cap at \$200, but if there is an issue, then the cap increases to \$700 and if there is a further issue then the cap is removed and the pharmacy is required to cover the full cost. This should provide sufficient incentive for the owner to either carefully supervise the supply of high cost medicines, or train his/her staff on the necessity of careful ordering.

We **RECOMMEND** a “three strikes” stepped approach to the supply of high cost medicines.

Placement of Medicines in the Pharmacy

Pharmacists are legally required to be involved in the sale of Schedule 3 medicines (Pharmacist only) and be available for consultation with Schedule 2 (Pharmacy Only) medicines. Pharmacies have been granted a monopoly on these medicines in return for fulfilling their professional responsibilities around the storage and supervision of these medicines. There are variations between States on storage requirements, with some States requiring both S3 and S2 being stored behind the counter while others allow S2 medicines stored away from the counter but in a position that enables supervision by the pharmacist. There is a need for harmonisation of the laws pertaining to supply and storages of these medicines.

We **SUPPORT Option 3.3.**

We **SUPPORT Option 3.4.**

Remuneration for other services

We rate this option a low priority although it makes sense. No government would be willing to take on a fight with other professions around standardising prices for services. We do not think it's worth the political capital.

We **REJECT Option 4.6.**

Rural Pharmacy Maintenance Allowance

The current option depends on some extend to the PhARIA system currently being used to assess allowances. During 5CPA, the Program Reference Group raised this matter of relevance of the PhARIA system and recommended a review of the system with the view of replacing it with a better system.

This has yet to occur, and it is necessary first step in the decision process around allocation of allowances.

We **RECOMMEND changing Option 5-8** to include as the first step a review of the PhARIA system in terms of its applicability and relevance to current requirements.

We **SUPPORT** the current **OPTION 5.8a, and 5.8c.**

We **RECOMMEND** changing **Option 5.8b** by adding the phrase “in consultation with the Local Health Network “.

Further issues

We **SUPPORT Options 10.1, 10.2, 10.3, 10.4, and 10.5.**

Future Community Pharmacy Agreements

We believe that pharmacy should be integrated into the health system and not treated as a separate entity. By treating community pharmacy as a separate entity, we believe that Governments feel they have “addressed pharmacy” with the signing of CPAs and so forget about including pharmacy in discussions with the rest of the health sector when addressing wider health issues.

The reality is that there needs to be a negotiations-based mechanism for determining remuneration for the supply of PBS prescriptions provided by community pharmacies on behalf of the Government.

We have previously argued for the linking of medication management services defined under professional services in the current CPA with the reform of dispensing services as a further means of managing medication use risk.

We **RECOMMEND Option 7.1 be altered** to include any medication management services that are linked to dispensing (and with the provisos and wider representation discussed in revised Option 7.4)

We **SUPPORT Option 7.2.**

We **RECOMMEND Option 7.3 be altered** to exclude medication management services from this option. However, we are concerned that there is no further recommendation on how the remaining services be addressed. There is a need for funding of these services. One option would be to provide a pool of funding to be distributed to Local Health Networks to administer and distribute based on local need.

We **RECOMMEND Option 7.4 be altered** to include of Professional Pharmacists Australia as the body that represents employee pharmacists. It is positive that the panel has recommended the inclusion of the Consumer Health Forum and the PSA. There is however no representative of employee pharmacists in an agreement that discusses pharmacy remuneration. It is not credible to argue the PSA represents employee pharmacists given most of their committees are made up of Guild members and given the historic joined at the hip approach they have with the Guild on many issues such as location and ownership rules. Despite those rules acting against the interests of the majority of their members, they maintain support for that anti-competitive protection in the interests of the minority of their members who are owners.

Section 3: Implementation strategies

Good reform requires more than the logic of the argument. All change occurs in a political environment and it is sensible for the panel to consider how best to argue the case. The following are some key elements:

Framing the message

The principle reason for the proposed changes should be framed around safety. The message should be aimed at getting support of Government, consumers and pharmacists, and marginalising the pharmacy rent seekers who resist change. The implied question is “Do you support reducing harm associated with the use of medicines”?

If yes, these reforms will assist, if no, what are you doing in pharmacy then!

Be clear on goals

The report aims to improve community health outcomes ie reduce risk of medication misadventure through the reformed dispensing strategy and by assisting people better manage their health through the primary health strategy led by Local Health Network. It also aims to improve outcomes from an investment of over \$18 billion of taxpayer dollars.

To ensure we have a sustainable system to support pharmacy and fully utilise skills of pharmacists in the interests of consumers.

Be clear why medicines supply and use are so important

There is probably no greater reason for us living longer and healthier lives than the positive effects of medicines.

Be clear on why improvements are so important.

As the population ages, people are living with multiple chronic conditions and rely on multiple medications. It is critical people use their medications properly, use the right medication and that we check the medication is working and is not causing harm. If we get this wrong, people suffer and there are huge costs with hospital admissions (and probably aged care admissions) and worse. Our elderly and our most vulnerable Australian are most at risk.

Outline of a possible implementation process

There are a number of examples found overseas of implementation programs that introduce fundamental changes to the way pharmacists work. Perhaps the most compelling example is the Scottish Government’s transformation of the role of pharmacy, where they require all pharmacists to be of a standard of a clinician. The Governance arrangements are shown in Diagram 1 and are taken from the online document ¹.

Diagram 1:

The Governance arrangement used by the Scottish Government to implement the policy “Prescription for Excellence”.

Governance arrangements are being developed and will comprise:

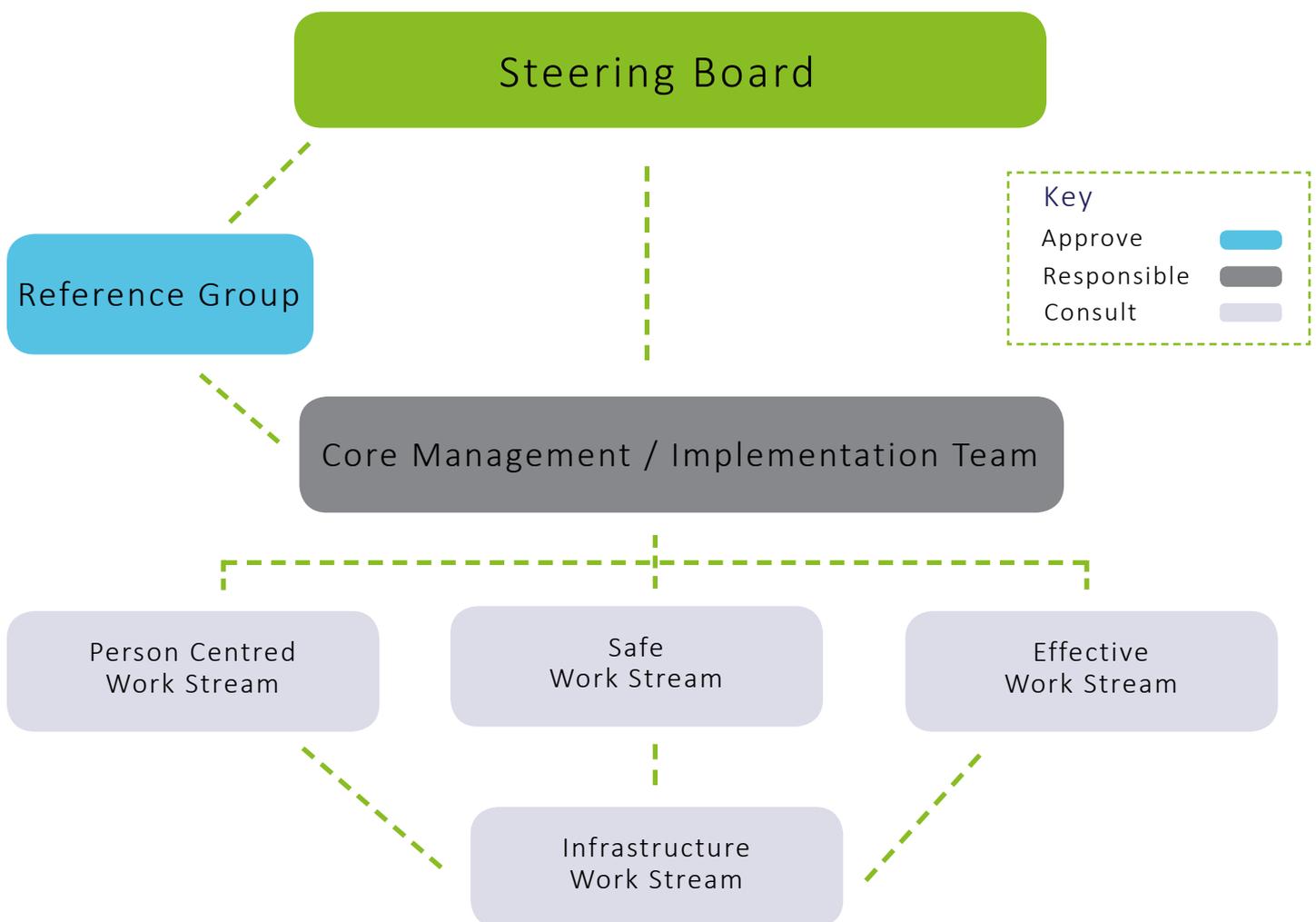
Steering Board- this will consist of key Scottish Government and NHS contents to oversee and prioritise implementation

Reference Group- this will consist of a wide range of stakeholders and will act as a sounding board

Core Implementation/Management Group- this will consist of leads overseeing and working groups

Working Groups- this will be people on the ground developing a response to each action point contained in Prescription for Excellence. A number of Working Groups are in the process of being established.

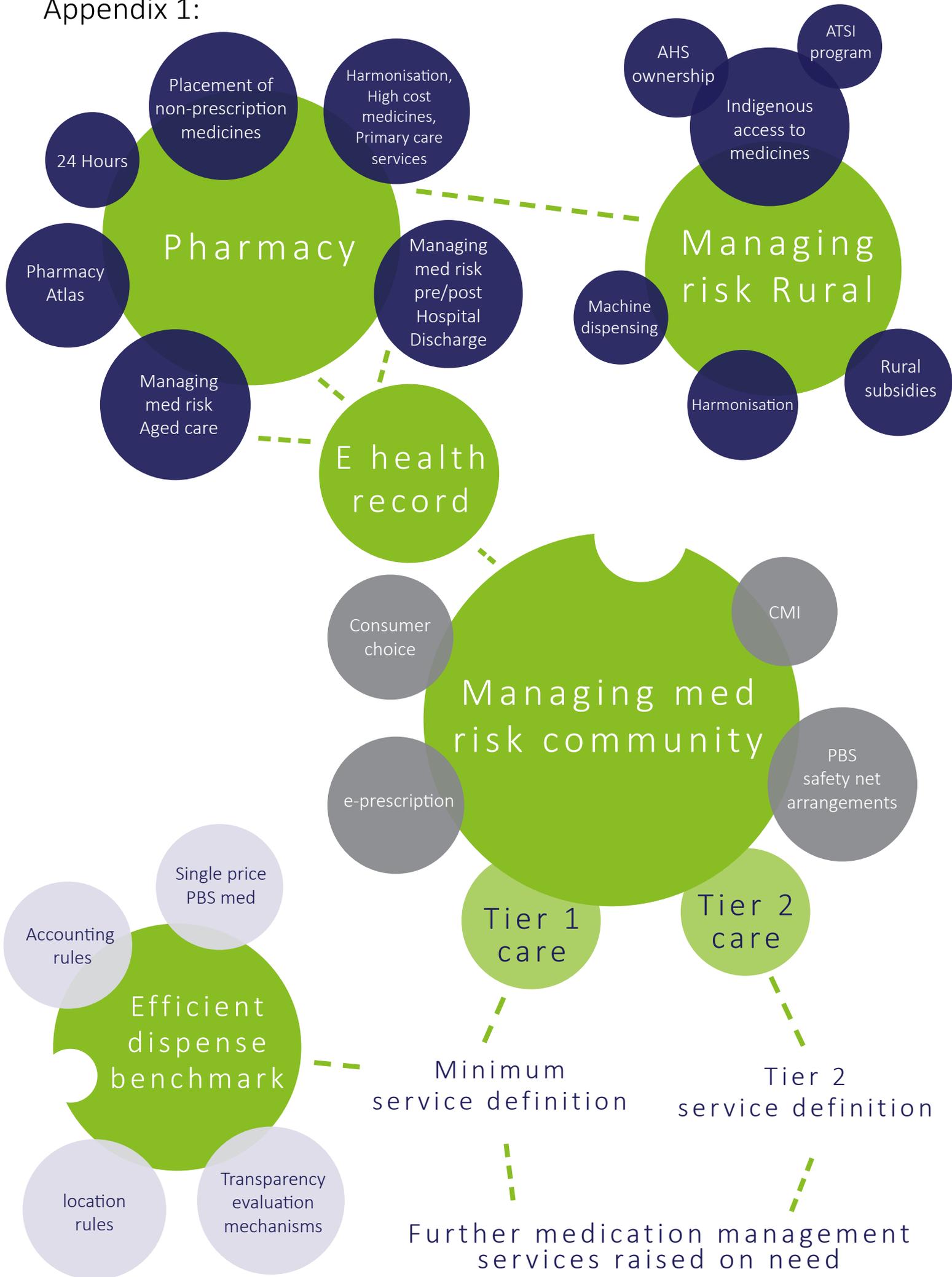
Prescription for Excellence Government Chart



While this Report does not recommend such a fundamental change as the Scotland program, the strategies and processes used in Scotland should inform the implementation process for Australia.

There is little doubt that the Government will need to take a leadership role in this reform and for all stakeholders to be included equally in overseeing the reform process.

Appendix 1:





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